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Outcomes of Interagency Training to Safeguard Children:

Final Report to the Department for Children, Schools and Families and the Department of Health

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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Children, Schools and Families.

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Summary

Introduction

The study sought to develop an evidence base for interagency training to safeguard children. It was carried out in partnership with the training coordinators in eight LSCBs in four parts of England and with the support of an advisory group.

Specific measures were developed to assess the outcomes of both generic and specialist courses on such topics as “Introduction to safeguarding” and “Safeguarding disabled children”. These measures generally performed reliably and were sensitive to change.

In addition to assessing outcomes, the project sought to describe the context and mechanisms through which interagency training is planned and delivered and also to estimate the costs.

Interagency training is not an end in itself but should be seen as a necessary and vital component of the safeguarding children process.

Findings

The context of interagency training

- Interagency training for safeguarding children is an unusual example of partnership working in that it is mandated by central government but not resourced via ring-fenced funding.
- Interagency training relies very significantly on the good will of partner agencies and professional and personal relationships developed parochially.
- There are obvious strengths to this approach, but also weaknesses. In particular, the system is vulnerable to changes in personnel and highly dependent on a few people, specifically the training coordinator and their support staff.

Mechanisms for the delivery of training

- Interagency training is organised by a training coordinator, generally employed by the LSCB, and support staff, and working with a training subgroup (TSG) of partner agency representatives.
- Training sub groups TSGs were good examples of effective partnership working, with members believing that their agency’s and the partnership’s goals with respect to interagency training were interdependent and mutually beneficial.

The content of training

- The interagency training programmes are very substantial and offer training on important safeguarding issues in accordance with the guidance in *Working Together.* The courses are short, the great majority being for one day only.
- Interagency training makes a substantial contribution to learning the skills and knowledge of the *Common Core* and therefore to the training of children’s workforce in general.

Delivery of training

- Training courses are led by enthusiastic, skilled and experienced trainers using participative educational models.
- Trainers need more recognition and initial and on-ongoing support than is currently received by the LSCB.

Outcomes of the interagency training courses

The findings from the series of evaluations of the range of courses included in this study are remarkably consistent in a number of ways.

- The overall pattern of learning outcomes was consistent across different types of courses.
    - In line with the study hypothesis, there were no statistically significant changes in scores between registration on a course and its start.
    - At the end of the course, the objective and subjective scores we measured: knowledge of the substantive topic; attitudes to service users; and self-efficacy in relation to knowledge of safeguarding policies and procedures as well as in working with service users and other professionals, all increased. These gains may be attributed to the effects of the courses.
- Improvements were not simply highly statistically significant, but the 'effect sizes' (a more informative measure of the strength of an effect) were "large" or "very large" across the range of scales produced for the evaluation.
- Positive outcomes were found consistently in all the eight study sites (LSCBs) in four parts of the country.
    - These are not local effects and we can generalise from the findings with a degree of confidence.
    - The numbers of courses (139) and participants (nearly 1,500) studied is unprecedented in this area and these add weight to the conclusions and practice and policy implications.
- Analyses showed that the effects were, in almost all cases, consistent across participants.
    - There were positive outcomes, irrespective of the participants' gender, age, ethnicity, service experience and even when they had been 'required' rather than volunteered to attend the course.
- The opportunity to learn together to work together was very highly valued by participants, even more so at the end of the course than at the beginning.
    - By the end of the course there were very substantial improvements in their self-reported understanding of the roles of different professionals who engage in work to safeguard children and in their confidence and comfort in working with these colleagues.
    - At follow-up 3 months later, these gains had been maintained, but the response rates at this stage were disappointing and the evidence is correspondingly weaker.

Value for money?

Training is a major investment for the delivering and participating agency and incurs indirect as well as direct costs. An approach to the estimation of these costs was developed and used to compare the contributions of LSCB partner agencies to the costs of delivering interagency training under the auspices of the Board. This analysis demonstrated how, through supplying their own professional staff to act as trainers, by sharing the use of their training facilities and by the time spent as members of training support groups, some partner agencies were making substantial in-kind contributions in addition to their "annual subscription" to the Board.

- The costs of a day's training per participant in the region of £100, which compares favourably to the fees charged by commercial organisations for training on safeguarding children and local courses have considerable advantages in terms of creating opportunities for networking.
- They were seen by partner agencies as good value for money.

Practice implications

- The research evidence on some topics was not well understood and there were no improvements in assessed knowledge at the end of the course. This was especially true of knowledge about the effects of parental mental health problems on children, but also relevant for courses on domestic abuse and female genital mutilation. The evidence-based content of these courses should be reviewed.
- In order to evaluate the outcomes of training rigorously, training coordinators and trainers could consider using the measures developed in this study to evaluate the pre- post-outcomes of their courses.
- There is a large degree of overlap between single- and multi-agency training courses offered in-house by larger partner agencies such as health and education. However, the extent to which the content of courses varies between agency providers needs further examination in order to avoid duplication of delivery and better use of available resources. The content and evidence-base of these courses should be reviewed.
- The pool of generic and specialist trainers needs to be expanded. An internal audit of training capacities in both the LSCB and partner agencies would help identify areas in which recruitment is needed and where training staff secondment could alleviate undue training pressures on a few dedicated trainers.

Policy implications

- There should be a more robust system nationally for prioritising and disseminating key training issues for individual LSCBs. In many places, training programmes are planned for the most part by training coordinators with training sub group and partner agency input varying from site to site. There is clear evidence that *Working Together* priorities are highlighted in most programmes. Specific issues, for example as arising from local Serious Care Reviews are also included in some programmes, but what about national priorities or training implications of cases? There remains a potential vulnerability in a system where training priorities for a large number of staff in a LSCB are prioritised by so few people.

- A more robust and shared interagency arrangement for providing training is needed to ensure that the whole programme does not 'collapse' in the absence of one key person. In each of the eight sites included in the study, a skilled and experienced Training Coordinator is critical in ensuring the effective operation of the training programme,

including its planning, structure and delivery. We have noted the benefits and risks of substantial reliance on one individual. TSGs should plan in advance and develop contingencies in order to ensure that programmes are not halted by staff sickness or loss.

- There is an urgent need to address the overwhelming lack of rigorous evaluation of courses provided by LSCBs. As most courses across LSCBs had very similar learning outcomes, there would be benefits of producing a standardised approach to evaluation nationally which would enable comparisons about the functioning and performance in relation to interagency training across LSCBs. The approaches to evaluation, as well as the measures developed and employed in this project, could form the basis of a shared evaluative strategy to interagency training.

- Better and more transparent arrangements for funding interagency training are needed for LSCBs to be able to invest strategically in its training programme and to expand their range of courses beyond basic level training to more complex safeguarding issues. Structural differences in the way in which programmes are delivered are perhaps inevitable, given the variance in organisational arrangements across local areas. However, funding arrangements for training in many LSCBs are currently hidden and costs are unclear. As funding for interagency training is currently taken from the LSCB and single agency budgets, it would be preferable for ring-fenced central government finance to be allocated to LSCBs specifically for training purposes.

- An expanded programme of 'training for trainers' is needed, including standards and accreditation. A very wide variety of trainers is used, both from partner agencies within LSCBs and external trainers. There is little standardisation about the support or training offered to trainers from the LSCB. A minimum set of standards, which specifies experience and training competence, should be considered. A national system of accreditation for people training on interagency training courses to safeguard children would be desirable. This would enable better quality control and consistency between areas and would also allow LSCBs to share and exchange trainer. Wider 'training for trainers' is particularly important if a more rigorous approach to evaluating courses is to be taken nationally.
- Consideration should be given to building LSCB interagency courses into the postqualifying professional development frameworks for different groups of professional staff. This would both raise the status of courses and also help to draw in professional groups who are currently under-represented in the programmes, such as more experienced workers (over 5 years in service), doctors and staff working in adult services.
- One of the essential content areas inherent in all the courses evaluated was the need to inform practitioners of the evidence base within specific areas of practice. As the evidence base is continually developing, findings taught in many courses may therefore have a relatively short shelf life. Practitioners should not be reliant on intermittent and infrequent LSCB courses to keep up-to-date with the latest research, however this is a difficult task for busy practitioners, whatever their professional designation. We were struck by the lack of any core courses which taught staff about the importance of, and processes involved with, evidence based practice. For many practitioners, access to up-to-date and emerging research evidence is limited. Interagency training coordinators or TSGs could provide a role here, through the provision of regular research briefings to all staff who are part of the LSCB in addition to the provision of direct training courses. In this way, we believe that TSGs have a direct role to play in shaping the research mindedness of the whole LSCB.

1. Introduction

1.1. Safeguarding Children: a shared responsibility and the need for interagency training

> "Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise." *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children* (HM Government, 2006, Sec. 1.14)

Official inquiries, policy guidance and research reviews have consistently advocated that if professionals concerned with safeguarding children are to work together more effectively they should learn together to work together (Department of Health, 1999, HM Government 2006). Interagency training had been provided under the auspices of Area Child Protection Committees since their establishment following the 1974 inquiry into the death of Maria Colwell at the hands of her stepfather, which highlighted a serious lack of coordination among services responsible for child welfare. In turn, Local Safeguarding Children Boards (LSCBs) were established as part of the government's response to the statutory inquiry into the death of Victoria Climbié (2003). The new concept of 'safeguarding' embraced the narrower concept of 'child protection' as one of its elements but refocused interagency collaboration onto a broader agenda of prevention of harm and promotion of wellbeing.

As such, LSCBs were charged with the *statutory* responsibility, amongst others, to:

> …ensure that single-agency and inter-agency training on safeguarding and promoting welfare is provided in order to meet local needs. This covers both the training provided by single agencies to their own staff, and inter-agency training where staff from more than one agency train together (Sec. 3.22).

Working Together explains that:

> Training for multi- and inter-agency working means training that will equip people to work effectively with those from other agencies.
>
> This work typically takes place in two ways:
>
> - **single-agency training**, which is training carried out by a particular agency for its own staff; and
> - **inter-agency training**, which is for employees of different agencies who either work together formally or come together for training or development (Sec. 4.2)

The guidance does not prescribe interagency training; rather it recommends a combination of both. It nevertheless asserts, without offering any evidence, that:

> Training delivered on an inter-agency basis is a highly effective way of promoting a common and shared understanding of the respective roles and responsibilities of different professionals, and contributes to effective working relationships (Sec. 4.2)

It is the ***outcomes of interagency training*** that is the subject of this report.

But, the guidance also suggests, probably wisely, but again without supporting evidence that:

> "Training on safeguarding and promoting the welfare of children can only be fully effective if it is embedded within a wider framework of commitment to inter- and multi-agency working, underpinned by shared goals, planning processes and values." (Sec 4.24)

Consequently, the report also includes an evaluation of ***the context for interagency training*.**

Who is interagency training for?

Training and development for interagency work at the appropriate level should be targeted at practitioners in voluntary, statutory and independent agencies who:

- are in regular contact with children and young people
- work regularly with children and young people, and with adults who are parents or carers, and who may be asked to contribute to assessments of children in need
- have particular responsibility for safeguarding children (p. 15).

Training and development are also relevant to operational managers and those with strategic responsibility for services (p. 15). Legislation and guidance regarding the general content and processes surrounding training for interagency working are outlined in WT. However, as no two LSCBs are the same, it may be expected that each will have its own programme of training and delivery mechanisms, as well as systems for analysing the impact of any training delivered.

1.1.1. Purpose, aims and values of interagency training

According to *Working Together*,

> The purpose of training for interagency work is to help develop and foster the following, in order to achieve better outcomes for children and young people:
>
> - a shared understanding of the tasks, processes, principles, and roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare;
> - more effective and integrated services at both the strategic and individual case level;
> - improved communication between professionals, including a common understanding of key terms, definitions and thresholds for action;
> - effective working relationships, including an ability to work in multi-disciplinary groups or teams; and
> - sound decision-making, based on information sharing, thorough assessment, critical analysis and professional judgement. (pp. 91-92)

In particular, staff coming into contact with children and their families should:

- be aware of the predisposing factors and indicators of child abuse, as well as the steps necessary to respond to concerns about the welfare of a child;
- able to exercise professional skill in terms of effective information sharing and the ability to analyse this information;
- have the knowledge and skill to collaborate effectively with others, both within their own agency and across organisational boundaries and disciplines, in order to safeguard the well-being of children; and,
- have a sound understanding of the legislative framework and the wider policy context within which they work, as well as a familiarity with local policy and procedures.

Further, all training in safeguarding and promoting the welfare of children should create an ethos that:

- values working collaboratively
- respects diversity
- promotes equality
- is child-centred
- promotes the participation of children and families in the processes. (p.14)

1.1.2. Integration of *Common Core Skills*

Following work with professionals' and employers' organisations and user and carer representatives, the then Department for Education and Skills published guidance on training and development to support *Every Child Matters* and the *Children's Workforce Strategy* (DfES, 2005a). The *Common Core of Skills and Knowledge* (DfES, 2005b) provides guidance to service managers for the content of in-service and inter-agency training, which is also suggested as a tool for training needs analysis (DfES, 2005b, p. 4). The *Common Core* guidance sets out ***six areas of expertise*** that everyone working with children, young people and families should be able to demonstrate:

- effective communication and engagement
- child and young person development
- safeguarding and promoting the welfare of the child
- supporting transitions
- multi-agency working
- sharing information.

Two of these areas are central to the evaluation of the outcomes of interagency training: 'safeguarding and promoting the welfare of the child', and 'inter-agency working'. Joint training for interagency working should also integrate the values of the *Common Core of Skills and Knowledge*[1] for the Children's Workforce.

> "The Common Core reflects a set of common values for practitioners that promote equality, respect diversity and challenge stereotypes, helping to improve the life chances of all children and young people and to provide more effective and integrated services. It also acknowledges the rights of children and young people, and the role parents, carers and families play in helping children and young people achieve the outcomes identified in Every Child Matters." (Common Core, p.4).

1.1.3. Roles and responsibilities of partners

Employers and local authorities (LAs) have distinct yet inextricably linked roles and responsibilities laid out in *Working Together* in relation to joint training for interagency working.

> "Employers are responsible for ensuring their employees are confident and competent in carrying out their responsibilities, and for ensuring employees are

[1] HM Government (2005), http://www.everychildmatters.gov.uk/_files/37183E5C09CCE460A81C781CC70863F0.pdf

aware of how to recognise and respond to safeguarding concerns. Employers should also identify adequate resources and support for inter-agency training." (p.14)

"LAs and their partners are responsible for ensuring that workforce strategies are developed in the local area, including making sure that the training opportunities to meet the needs of the workforce are identified and met by LSCBs. The LSCBs should work within the workforce strategy to manage the identification of training needs; use the information to inform the planning and commissioning of training; and check and evaluate single- and inter-agency training." (p.14)

1.2. The evaluation of training for safeguarding children

As mentioned in the previous section, LSCBs are responsible for ensuring that there is 'a process' for evaluating the effectiveness of training. It is also expected to ensure that outcomes from the evaluation of training inform the planning of future training. In practice, training is evaluated by what are known in the trade as "happy sheets". These are the familiar feedback sheets distributed at the end of a training course which ask trainees to rate such things as: the clarity of directions to the training venue; the comfort of the training rooms; the quality of the food; the effectiveness of the various presenters and so on. These forms sometimes ask whether the participants "learned" about the topic and/or the extent to which the aims and objectives of the course were achieved, although they do not remind the participants what those aims and objectives were. There is generally a box for open comments. Where this is completed, trainees are likely to comment enthusiastically about the presenters, complain about the ventilation, sound system or the food, and suggest that the course was too short/long. This information can be valuable: if the trainers are poorly rated, then they can be given constructive feedback, or alternative presenters be engaged for the next course; and if the venue is unsatisfactory, it can be changed. It is generally more difficult to decide how to deal with conflicting responses to the question about the length of the course, however. What these evaluations do not actually tell us is whether or not the hoped for outcomes of the training were achieved. This deficiency is not restricted to training about safeguarding children.

In a related field, Bailey et al. (2003) surveyed all mental health trusts and social services departments in England for the Department of Health only 26 of the 66 organisations which responded (response rate 25%) said that they systematically evaluated postqualifying training initiatives and in almost all cases the evaluation was confined to the trainees' satisfaction with the programmes provided. Similarly Clarke (2001) reported that post course satisfaction was the predominant approach to training evaluation in social services departments. While these evaluations may provide useful feedback to trainers (depending on the quality of the questions asked and the response rate), they cannot tell us about the *outcomes* of training.

1.2.1. Research on the outcomes of training on safeguarding children

Carter et al. (2006) published a systematic review of training and procedural interventions concerned with improving child protection. They identified 15 papers on the evaluation of training in relation to safeguarding children: six each in the US and UK, one in Hong Kong, one in Japan and one in Spain. Eight of these were follow up studies only, but seven papers described pre- and post- training designs. Five of these were of single agency training, all involving doctors or nurses. Myers (1996) in the US evaluated a course to train nurses as witnesses in court cases involving child abuse; and Weintraub et al. (2002) and Henry et al. (2003) reported evaluations of awareness raising course for nurses in the US and Japan respectively.

Studies with doctors and/or medical students were carried out by MacLeod et al. (2003) who investigated teaching junior doctors to recognise child abuse and neglect; by Palusci and McHugh (1995); and by Socolar et al., (1998) who used a randomised controlled trial to evaluate a programme to improve doctors' knowledge of, and case file recording of child sexual abuse in another US hospital; this involved giving written feedback on their documentation. Finally, Burton et al. (2002) reported an evaluation of the use of videoconferencing in order to provide realtime consultations with clinicians who were assessing children for signs of sexual abuse in a rural state in the US. There is also a small scale study (n=12) from the US of investigative interviewing (Freeman and Morris, 1999) for child sexual abuse investigations. Although such training is intended for both police officers and social workers, the participants in the evaluation were only social workers

The reviewers identified just one evaluation of the outcomes of interagency and interprofessional training. This was by Cerezo and Pons-Salvador (2004) who reported the evaluation of a 5-year programme of training in the detection of abuse involving social workers and health professionals and the (single-agency training) of teachers as part of the initiative. This programme, which took place in the Balearic islands of Spain, was actually focussed on "detection" and not on interagency working. Consequently, the outcome measure used was the number of referrals to social services rather than the immediate effects of training on knowledge, attitudes or self confidence; there was no attempt to assess interagency aspects.

It is fair to conclude that, in contrast to a substantial number of studies of interprofessional education and training in health and social care for adults (Barr et al., 1999, 2005; Freeth et al., 2002; Zwarenstein et al., 2005), the evidence base for interprofessional and interagency training for safeguarding children is decidedly thin.

Finally, it should be noted that none of the studies reviewed by Carter et al. (2006) considered the costs of any of the training provided.

The costs of interagency training

The cost of training programmes, including the costs to agencies of their staff participating in courses, is likely to be considerable. However, these have not previously been estimated. These costs are likely to be contributed "in kind" as well as through direct funding; the proportion of the costs borne by the partner agencies is not known. Given the importance of fair distribution of resources and costs and also of 'value for money', this topic is likely to be a matter of considerable interest.

1.2.2. Aims and objectives of the study

The overall *aim* of this study was to develop an evidence base for interdisciplinary training to safeguard children through the following *objectives*:

1. To assess (i) the scope and content of programmes commissioned by LSCBs and (ii) the participation in courses of professionals and others in contact with and/or working with children.
2. To investigate the context for training, specifically, how LSCBs carried out their responsibilities under the statutory guidance and the experiences of training co-ordinators and trainers.
3. To evaluate the learning outcomes of selected interagency training courses.
4. To investigate the extent to which learning is put into practice by participants.
5. To estimate the costs of providing and participating in training.

1.3. A partnership approach to evaluation

This study adopted a naturalistic or observational approach. It was designed to investigate *how thing are*, rather than to set up an interagency training programme and then to assess its outcomes. It should be clear that the latter approach would not have enabled us to answer our research questions about context, mechanisms and outcomes. Consequently we began by recruiting a group of LSCBs which were willing to participate in the study. Crucially, however, they were not to be simply the *objects of study*, but *partners* in the evaluation. We cannot stress this point too much.

The foundation of the partnership was that the research team and participating LSCBs agreed to collaborate on the evaluation of specific training courses provided during a particular year (2007-8). In practice this meant first, that the research team planned the evaluation and designed the measures. The LSCB interagency training co-ordinator and his/her staff administered the measures and collated the responses, as will be described in Chapter 4. The research team analysed the data and presented the findings for discussion to the training co-ordinators at a series of workshops which took place during the course of the study. This collaboration thereby enabled the LSCB to fulfil its responsibility to evaluate its training.

However, this bald description does not do justice to a highly collaborative process, or to the extent of the involvement of the training co-ordinators in the implementation of the study. Thus, in addition to the very considerable task of administering literally thousands of questionnaires, the training co-ordinators:

- Identified with the research team suitable courses for inclusion in the evaluation
- Discussed the feasibility of possible research designs and agreed which were, and which were not, feasible
- Reviewed the outcome measures and assisted with their piloting and assessment of test-retest reliability
- Reviewed the contents of semi-structured interviews for use with LSCB partners, interagency trainers and service users
- Facilitated access to the LSCB training groups and to a mix of internal and external trainers
- Participated in interviews themselves
- Collected and collated detailed information on the costs of providing training and collated data on the job titles of staff participating in a selection of training courses
- Discussed interpretation of the emerging findings.

These tasks were carried out through a series of six one-day workshops with the members of the research team and with numerous phone calls and email interchanges. The very substantial amount and range of data presented in this report would simply not have been possible without this partnership. We like to think of it as a model of interagency (LSCB-university) working and we hope that this project represents rather good 'value for money', at least as far as the commissioners are concerned.[2]

1.4. Recruitment of participating LSCBs

From an initial database of all LSCBs in England, the research team selected three geographical regions within which to base the study; namely London, the Midlands, the

[2] DCSF/DH funding for this project amounted to £105k

South West and the North East. These regions were chosen in order to ensure diversity of LSCB in terms of size of population served, rural and inner city areas, culture and ethnicity.

In each of these three regions, contact details for the Chairperson and Interagency Training Co-ordinator of each LSCB were established. Letters were sent addressed to all Chairs and copied to Training Co-ordinators including written details of the project and inviting the LSCB to submit an application to take part. As the research team wanted to be assured that any participating LSCB would be in a position to contribute meaningfully to the study, an explicit set of inclusion criteria was developed and LSCBs were asked to address these criteria in their applications. Specifically, these were:

- a well-established structure for the commissioning and provision of training (e.g. training sub-committee and training co-ordinator/s); and
- a substantial programme of **interagency** training courses, including courses on black and minority ethnic issues and/or on safeguarding disabled children.

The recruitment of well-functioning programmes was intended to enhance the chances of effective collaboration in the project and the identification of good practice from which others may learn.

In total, 12 LSCBs returned fully completed applications within the deadline. A number of other LSCBs contacted the team to indicate that they were supportive of the research, and highly interested in the results, but were not currently in a position to submit an application. Mostly, this was because LSCBs were relatively newly formed and did not have established and functioning training programmes or because there was no training co-ordinator in post. Interestingly, a number of other LSCBs from outside the target regions found out about the study and enquired about taking part, highlighting widespread interest in the project. Several potential applicants indicated that they were aware of the poor quality of their own internal evaluations of training and stated that they wished to take part in order to improve their evaluative strategies. There was little evidence of a rigorous approach to evaluating the impact of training in the overwhelming majority of LSCBs.

All applications were considered carefully according to the criteria identified above and the eight successful LSCBs were selected. We anticipated selecting two LSCBs from each of the four regions. However, as only one valid application was received from the London region within the deadlines set, it was only possible to select one London LSBC. Accordingly, three LSCBs were chosen from the South West in order to compensate for this shortfall, as this was the region generating the most high quality applications.

Within each of the eight study areas, participants were intended to be: members of the LSCB responsible for commissioning training; staff who attend a selection of courses at Levels 1, 2 and 3; trainers; and, in some cases, carers who receive the services of trainees.

1.5. Structure of this report

The report is comprised of fourteen chapters. The first provides an introduction to interagency training for safeguarding children and reviews relevant government mandates and literature in the field. The second chapter delves into the organisation of training in the eight study sites and, reports findings from observation and interviews with members of the LSCB training sub groups and the interagency training coordinators. The third chapter covers the content and delivery of training and reports findings of the interviews with interagency trainers about the delivery of training and the support they receive. The methodology for the evaluation of the outcomes of the interagency training courses is provided in the fourth chapter. It focuses on the research design employed and data entry, validation and analysis. The next eight chapters take closer looks at the quantifiable outcomes of the individual training courses evaluated in the research project. Chapter eight on safeguarding disabled children also integrates findings from interviews with trainees

attending safeguarding disabled children training. The thirteenth chapter provides a description and analysis of the cost of both delivering training and participating in training. The final chapter provides a summary of the main research findings and possible implications for policy at local and national level.

1.6. References

Barr,H., Hammick,M., Koppel,I., and Reeves,S. (1999) Evaluating interprofessional education: two systematic reviews for health and social care. *British Educational Research Journal*, 25: 533-44.

Barr H., Koppel I., Reeves S., Hammick M., and Freeth D. (2005) Effective interprofessional education: argument, assumption and evidence. Oxford, Blackwell Publishing.

Bailey, D., Carpenter, J., Dickinson, C. and Rogers, H. (2003) Post Qualifying Mental Health Training. London, National Institute of Mental Health, www.nihme.org.uk.

Burton D., Stanley D., and Ireson C. (2002) Child advocacy outreach: using telehealth to expand child sexual abuse services in rural Kentucky. *Journal of Telemedicine and Telecare*, 8, S2: 10–2.

Carter, Y., Bannon M., Limbert , C., Docherty, A. and Barlow, J. (2006) Improving child protection: a systematic review of training and procedural interventions, *Archives of Disease in Childhood*, 91:740-43.

Cerezo, A. and Pons-Salvador, G. (2004) Improving Child Maltreatment detection systems: a large scale c ase study involving health, social services and school professionals. *Child Abuse and Neglect*, 28: 1153-69.

Clarke, N. (2001) The impact of in-service training within social services. *British Journal of Social Work*, 31: 757-74.

DfES (2005a) Children's Workforce Strategy, London, DfES.

DfES (2005b) Common Core of Skills and Knowledge for the Children's Workforce, London, DfES.

Dept. of Health (1999) Working Together to Safeguard Children. London, Department of Health.

Freeman, K. A. and Morris, T. L. (1999) Investigative interviewing with children: evaluation of the effectiveness of a training program for child protective service workers. *Child Abuse and Neglect*, 23: 701-13.

Freeth, D., Hammick, M., Koppel, I., Reeves, S. and Barr, H. (2002) A Critical Review of Evaluations of Interprofessional Education. London: LTSN for Health Sciences and Practice, King's College.

Glasby, J. and Dickinson, H. (2008). Partnership working in health and social care. Bristol, Policy Press.

H.M. Government (2006) Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. London, DCSF.

Henry BM, Ueda R, Shinjo, M, and Yoshikawa C. (2003) Health education for nurses in Japan to combat child abuse. *Nursing and Health Sciences*, 5: 199-208

MacLeod C, Dorman O, Livingstone A, McCormack, Lees J, and Jenkins M. (2003) Teaching junior doctors to recognise child abuse and neglect. *Medical Education*, 37: 1046.

Myers JL. (1996) Workshop effectiveness: nurses as witnesses in court cases involving physical child abuse. *Journal of Nursing Law*, 3: 35-44.

Palusci, V. and McHugh, M. (1995) Interdisciplinary training in the evaluation of child sexual abuse. *Child Abuse and Neglect*, 19: 1031-8.

Socolar, R., Raines., B, Chen-Mok, M., Runyan, D., Green, C. and Paterno S. (1998) Intervention to improve physician documentation and knowledge of child sexual abuse: A randomised controlled trial. *Pediatrics*, 101: 817–24.

Weintraub, B., Lazzara, P., Fuchs, S. and Wiltsek, D. (2002) Child Maltreatment Awareness for Hospital Providers. *International Journal of Trauma Nursing*, 8: 81-3.

Zwarenstein, M., Reeves, S., and Perrier, L. (2005) Effectiveness of pre-licensure interprofessional education and post-licensure collaborative interventions. *Journal of Interprofessional Care*, 3: 148-65.

2. The Organisation of Interagency Training

2.1. Introduction

This chapter concerns the second aim of the study, "To investigate the context for training, specifically, how LSCBs carried out their responsibilities under the statutory guidance and the experiences of training co-ordinators and trainers."

It is important to note that unlike many examples of partnerships in which agencies come together voluntarily to collaborate (e.g. Hastings, 1996; Mackintosh, 1992), LSCBs are a 'forced partnership' mandated by central government mandate and takes place without any additional funds. This *mandated collaboration* has the potential to affect the success of interagency working (Rodriguez et al. 2007). For example, partner agencies may feel that the costs borne are too high and that they have been forced into relationships that appear suboptimal to them yet potentially beneficial to the LSCB as a whole. Rodriguez and colleagues suggested that networks that have been mandated by central governmental have different dynamics than those that come together by mutual consent. However, even within a strong and well-established culture of mandated collaboration, interagency training regimes may vary considerably across LSCBs.

The success or failure of joint training for interagency working is also affected by past working relationships between partner agencies, and between Area Child Protection Committees and partner agencies. If there is a history of positive working relationships prior to the formation of the LSCB, then it is more likely that interagency working under the LSCB will continue as before. This too holds true for working relationships that do not share a common vision to child protection, are not characterised by trust and reciprocity, and where autonomy is lacking (Glasby and Dickinson 2008). On the other hand, it may be the case that partner agencies 'forced' or 'mandated' to work together are more likely to be successful; the responsibilities set down to them by central Government act as a unifying force, which can act as an impetus for overcoming some of the challenges and barriers encountered in effective interagency working in the past. Vested interests, lack of organisational and role clarity, inter-professional antagonisms, and funding conflicts may no longer take centre stage as each agency has the responsibility to contribute and collaborate under government legislation. Moreover, having clear objectives handed down by government in terms of training content and participation is less likely to result in parallel and potentially conflicting agendas in terms of interagency training.

There are myriad elements in the process of joint training for interagency work, all of which have the capacity to influence the outcomes of training and as a by-product effective working. Among these are: the exercise of roles and responsibilities of the partner agencies in a given LSCB; their involvement in, and contribution to, the delivery of training; the existence of essential elements of training infrastructure (i.e. a training subgroup (training sub-group) and suitably skilled interagency trainers); the capacity of the training and development system to identify and meet local training needs; and systems of monitoring and evaluation.

2.2. Methods: Case studies in eight LSCB sites

As described in Chapter 2, the study took place in eight LSCBs. These were providing substantial programmes of interagency training and the Chair of each LSCB had written to the research team to confirm the Board's participation in the study. Consequently, it was possible for one of the research team to undertake a detailed qualitative study of the operation of the training sub-groups (training sub-groups) in each site between January and February 2008. The methods used are described below.

2.2.1. Analysis of documents

A range of relevant documents was reviewed. These included: annual reports and business plans; training strategies; training programmes; and, minutes of the training sub-group (or equivalent) meetings. This documentary evidence provided a valuable source of information about the formal goals and aims of the training programmes. Content analysis of the minutes of training sub-group meetings also provided a useful record of any problems with regards to the implementation of the training programmes.

2.2.2. Observation

Non-participant observation of meetings of the training sub-group was used to collect information about the processes through which needs and plans were discussed and about how decisions were made about interagency training. This was done by attending training sub-group meetings in six of the eight sites taking part in the project. Prior to attending the meeting, the project researcher reviewed minutes of the last two training sub-group meetings to acquaint himself with the recent history of major issues being dealt with by the respective training sub-groups. Permission was received to take notes of the meeting, including personal observations of group dynamics and the process by which training issues were tabled and discussed.

2.2.3. Interviews with key informants

An understanding of the context and process of interagency training was informed by a series of personal and telephone interviews with key stakeholders: the agency managers/representatives who sit on the training sub-groups and the training coordinators, who organise and deliver training. The main topics covered by the personal and telephone interviews are summarised in Box 1 below.

BOX 1: TOPICS COVERED IN THE KEY INFORMANT INTERVIEWS

Target Group	Main Topic Areas
Agency Managers	• Purpose, shared understanding, and effectiveness/efficiency of training • Role/responsibility of: Employers; Training Sub Group • Content of training; Target audience; Success factors; Quality assurance
Training Coordinators	• Primary role/responsibility with regard to the current inter-agency training • Attitudes/perceptions of current Inter-agency training • Support from LSCB • Success of current training programme and areas for improvement

Agency managers

Training coordinators were asked to provide an up-to-date list of names and contact details of members of the training sub-group (or equivalent). They were also asked to identify the chair and sub-chair of the training sub-group, chair of the Quality and Performance (Q&P) sub-group (or its equivalent) and the business/finance manager responsible for safeguarding. E-mails were sent to selected members of the training sub-group and chairs of the Q&P inviting them to be interviewed in-person or via telephone. Attached to the e-mail was an information package containing an overview of the research project and “frequently

asked questions and answers". The goal was to have at east one member from each partner agency (in some cases, more than one member represented a particular partner agency) interviewed for the project. Forty-five agency managers were approached for an interview and in total, 39 (87%) key informants were interviewed. Those that were not interviewed were unavailable mainly because of leave/sickness or extreme pressure of work. Table 1 below summarises the partner agencies represented in the interviews. The majority of those interviewed came from the local authority or the health authority/Primary Care Trust (PCT).

TABLE 1: PARTNER AGENCY REPRESENTATIVES INTERVIEWED

PARTNER AGENCY	**SITE A**	**SITE B**	**SITE C**	**SITE D**	**SITE E**	**SITE F**	**SITE G**	**SITE H**	**TOTAL**
Council (SCB)	0	3*	2*	1	2	1*	2*	1	**12**
Health	1	2	1	1	1*	2	1	2*	**11**
CYPS	2	0	0	3*	0	0	0	0	**5**
Police	1	0	1	0	0	1	0	1	**4**
Education	1*	0	0	0	0	1	0	1	**3**
Connexions	0	1	0	0	0	0	1	0	**2**
Probation	0	0	0	0	0	0	1	0	**1**
NSPCC	0	0	0	0	1	0	0	0	**1**
Total	**5**	**6**	**4**	**5**	**4**	**5**	**5**	**5**	**39**
Chair of Q&P	0	0	***1****	***1****	0	***1***	0	0	3
Business/finance manager	0	1**	***1****	***1****	0	***1***	***1****	0	5

Note: * Chair of training sub-group, ** Interviewed as member of training sub-group, ***bold-italicised*** denotes same person.

Training coordinators

In addition to being partners in the research programme, all eight training co-ordinators were interviewed using a semi-structured interview schedule specifically designed to solicit their opinions on the current training regime and any improvements needed.

2.2.4. Data collection and analysis

During the course of the personal and telephone interviews, answers to questions posed were written on survey instrument proformas devised specifically for the key target groups. Participants were also asked for permission for the use of quotations or paraphrased material in this report and in any published materials based on the research project. Permission was granted in all cases subject to respondent anonymity. Hand-written notes were then transcribed into electronic format and tabulated by site in spreadsheet format.

A process of emerging themes was used to categorise responses into general statements which reflected the context and process of interagency training and collaboration in each project site. Thus, if there was agreement on a particular topic area, e.g. the training programme needs more funding, then the general statement would be "training programme requires more funding". If, on the other hand, there was disagreement by some partner agency representatives with regard to funding, the statement would be "some felt that funding levels are adequate, while others felt that more funding is needed". The same process was applied for each topic/question area and series of interviews. This cumulative process of thematic analysis allowed us not only to compare and contrast opinion on joint training for interagency working within sites but also between sites. Thematic content

analysis of interview data was informed by West and Markiewicz's (2006) *Effective Partnership Working Inventory* (see below).

2.3. Results

2.3.1. Roles and responsibilities of partner agencies

Several key roles and responsibilities of the partner agencies were identified in the agency manager and training coordinator interviews.

Leader

There was consensus that one key partner agency, generally children and young people's services (CYPS) plays a major role in ensuring that every partner agency is fully aware of safeguarding issues and that those in key roles have specialised knowledge. This key partner agency takes a lead role in organising, coordinating, and providing training and is responsible for ensuring:

> "*…that interagency training is planned and delivered according to standards laid out in Working Together".* (Agency manager, Site F)

so that, in the words of another, *"…all staff that have contact with families get trained up".* (Agency manager, Site G) and "*…that multi-agency training happens with effective partnership"* (Agency manager, Site D)

Some partner agencies also had a development role, e.g. running an early years curriculum and training head teachers in-house, while others took responsibility for identifying special training areas which need to be delivered either in-house (single-agency) or through interagency training, e.g. on neglect, child prostitution. Still others, especially in health, provided in-house training, apart from that offered by the LSCB. Equally important, partner agencies were responsible for ensuring that staff were made aware of interagency training, that the right staff went on the courses, and that the effectiveness of the training was evaluated.

Training coordinators (in conjunction with the training sub-groups) also played a key role in ensuring that the training programme was meeting the needs of staff in partner agencies, as two training coordinators pointed out:

> *"I am responsible for designing, delivering and coordinating a series of multi-agency learning and training opportunities"*. (Training coordinator, Site A)
>
> *"I am responsible for planning and coordinating the whole of the training programme"* (Training coordinator, Site B)

Provider/Purchaser

There were differences between sites in terms of the provision of training-related resources (people, places). Most provided trainers, who were also usually a member of the training sub-group, for the interagency training programme. However, provision of training and trainers was not consistent between sites or within sites; in some instances, the partner agency did not provide any trainer. The number of training days provided by 'in-house' trainers from the various partner agencies varied, as did the number of 'freelance' trainers commissioned by LSCBs to provide interagency training (e.g., Site H relied wholly on external/freelance trainers). Other partner agencies provided training venues (considered an 'in-kind' contribution to core funding) in addition to trainers. In some sites, the key partner agency had both purchaser/provider role, i.e. to provide training for the LSCB and purchase training from it. One site relied completely on purchasing (commissioning) training and hiring the training venues (Site H). In this one site where commissioning made up the entirely of

the training programme, the training coordinator was responsible for arranging the external or 'freelance' trainers.

Funding

Most partner agencies made a contribution of some kind to core funding of interagency training. In some sites, this was referred to as an "annual subscription".

> *"Some partner agencies provide more core funding than others and some none at al" (*Agency manager, Site E).

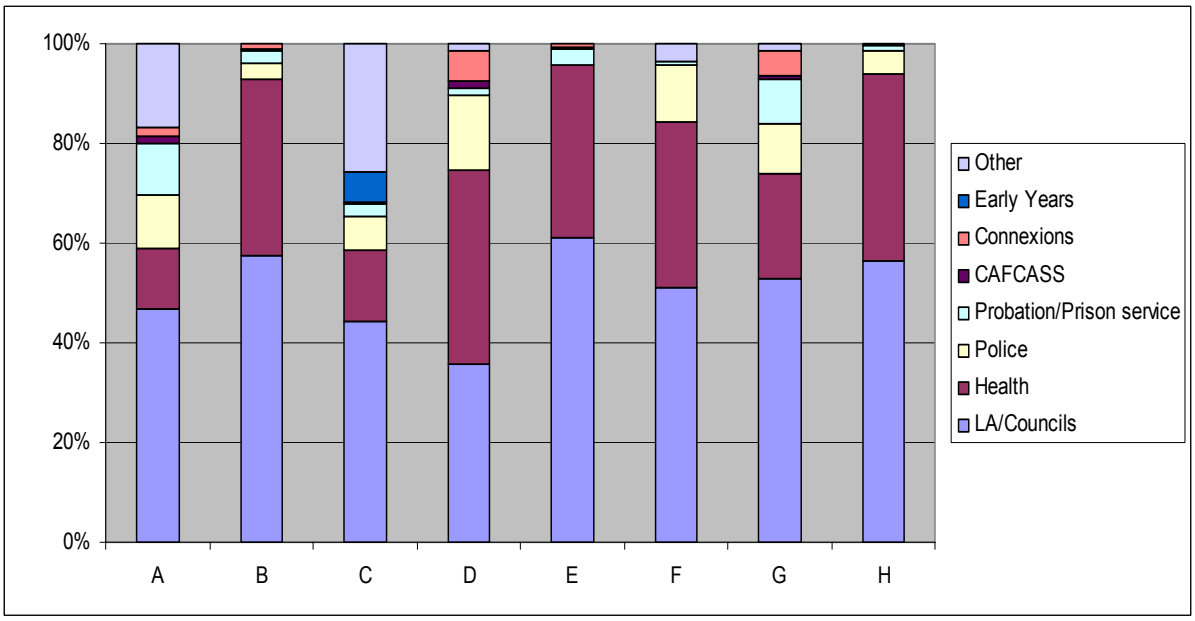
In addition,

> *"Some partner agencies provide single agency training, e.g. training to school governors, which is paid for by governor services" (*Agency manager, Site E).

Contributions to core funding varied between and within sites. Some sites provided fiscal contributions, whereas others provided contributions 'in-kind' in terms of staff and venues for interagency training e.g., the Probation Service and NSPCC provide training and venue *in lieu* of a core funding contribution in two sites (Sites E and F). In some sites, the training coordinator was funded by one of the partner agencies and in others they worked directly for the LSCB. This has implications for the funding of interagency training as some partner agencies consider this a contribution in-kind to training.

The costing exercise outlined in Chapter 13 applies nominal monetary values to each of these actual and in-kind contributions. After having applied costing estimates for actual and in-kind contributions, we found that some partner agencies contributed substantially more to core funding than others. As Figure 1 shows, LA/Councils were for the most part the biggest single contributors in all sites (ranging between roughly 40 and 60 per cent). Health also played a key role in funding, but was a larger contributor to core funding in some sites than others. Aside from these 'key funders', we found that the contributions of other key partner agencies varied depending on the site. For example, police services contributed to core funding in 7 out of the 8 sites and Connexions in 6 out of the 8 sites.

FIGURE 1: PROPORTION OF CORE FUNDING CONTRIBUTED BY PARTNER AGENCIES BY LSCB



2.3.2. Single vs. Interagency training

Education services

Across the project sites, certain partner agencies were more likely to provide single agency rather than interagency training. This was particularly true for education, where the sheer numbers of staff needing to be trained (teachers, head teachers, governors) exceeded the capacity of the LSCBs to meet such training needs and where difficulties arise in allowing substantial numbers of staff from any given school environment to attend whole day courses. Single agency training was carried out primarily to meet Level 1 (Foundation) training needs. For staff requiring Level 2 and above training, it was more often the case that staff were directed to the LSCB or that the LSCB was commissioned to provide this training in-house. In the case of the former, education staff were trained jointly with staff from other partner agencies, whereas in the latter they are trained with colleagues from education services.

The extent to which education staff attended single and interagency training was also influenced by government's guidance on child protection in education. On 1st January 2007 the government issued the guidance document *Safeguarding Children and Safer Recruitment in Education*[3]. This document was intended to be used as a tool for self assessment to enable schools to meet their statutory duties as defined by Section 175 of the *Education Act 2002.* In short, it places a duty on LEAs, and on governing bodies of schools and FE institutions to make arrangements for carrying out their functions with a view to safeguarding and promoting the welfare of children. It also requires LEAs and governing bodies to have regard to any guidance issued by the Secretary of State in drawing up those arrangements. It is also used as a tool for self assessment and as evidence to support the school's Self-Evaluation Form (SEF) and preparation for Ofsted inspection.

Health services

The very large number of health staff in the acute and community trusts also influenced the provision of single versus multi-agency training in the health services, another case in which single agency training is mandatory for 'front-line' staff. Many partner agencies have developed their own in-house' training strategies, which results in dual training sources of their staff, i.e. single agency for foundation training and inter-agency (LSCB) for Level 2 and above.

> *"Some provide in-house training, apart from that offered by LSCB, e.g. health"* (Agency manager, Site G).

In some cases, the training provided by LSCB and the health trust overlapped:

> *"There is a wider programme of single agency training in health than in the LSCB but there are overlaps."* (Agency manager, Site F).

Training coordinators in some sites commented that they have been commissioned by education and health services to provide single agency training to education but that at times the demand to meet these training needs exceeds their capacity:

> *"Increasing the number of basic introduction courses results in great demand for them [courses] and need to provide more…Not enough trainers to fill demand for course, i.e. there is a real issue with training capacity"* (Training coordinator, Site B).

[3] DfES (2006), http://publications.teachernet.gov.uk/eOrderingDownload/Final%206836-SafeGuard.Chd%20bkmk.pdf

2.3.3. Recruiting staff for interagency courses

Making sure the most appropriate staff members attend interagency training was seen as very important. The extent to which the recruitment of staff to courses was systematic varied both between sites and partner agencies. In most sites, the recruitment was formalised, for example:

> *"[It's] A key part of supervision task across partner agencies – it's done through staff appraisal and professional development plans, and monitoring and performance review*" (Agency manager, Site H)

However, in other partner agencies it was less well organised: *"[It's] Ad hoc and not very systematic at the moment"* (Agency manager, Site C). Another commented: that the *"system is not working very well in reality, most people by-pass designated persons and go straight to the training co-ordinator"* (Agency manager, Site D).

Many training coordinators stated that partner agencies releasing staff was an important issue in staff attendance at interagency training: *"Releasing staff to attend training is a huge problem for some partner agencies"* (Training coordinator, Site F), which accounts for low partner agency representation on some training courses. One added: that *"All partner agencies need to recognise the need for interagency training and release staff to attend"* (Training coordinator, Site G).

Promotion and publicity

Training coordinators played a key role in the production and dissemination of the programme of training. Training booklets/programmes/brochures, which specify 'target audience' and course pre-requisites, were distributed by training coordinators (in some cases hard copies, in others electronically via e-mail or the LSCB web site) to lead/designated people in partner agencies, who were then responsible for ensuring that staff needing training are informed, thus:

> *"Designated person signposts particular course to certain people, i.e. certain staff are directed to certain courses"* (Agency manager, Site D).

In some partner agencies, the process stopped there; that is, staff were responsible for making sure they applied for, and attended training. In other partner agencies, it was the line manager's responsibility for making sure the right staff attended interagency training.

National guidance relevant to certain partner agencies (eg. Ofsted) also dictated which staff should attend training.

> *"Normally based on targeting audiences, e.g. designated child protection officers, early years, private nurseries"* (Agency manager, Site C).

Selection criteria

In general, 'lead people' or 'agency reps' (also referred to in some sites as 'signposted people') in the partner agencies were informed about the training event (usually via the training coordinator), who are then responsible for identifying staff that needed training and put their names forward and/or instructed them to attend. The process was described in the different sites as follows:

> *"Usually done through line manager/supervisor in terms of filtering course participants"* (Agency manager, Site C).

> *"Up to individual practitioner's line manager, who sees who needs training and 'advises' attendance"* (Agency manager, Site F).

> "*Rely on agency coordinators/reps to provide lists of people"* (Agency manager, Site C).
>
> *"Nomination form has to be signed by an officer in partner agency who makes sure they have the proper pre-requisites; then sent to named person/link person on training sub-group"* (Agency manager, Site G).
>
> *"Some partner agencies have automated systems which remind staff when they need to be re-trained, e.g., education"* (Agency manager, Site C).

There were also differences between the statutory and voluntary sectors; in the former, it was part of the staff review but *"There are certain situations where certain staff are obligated to go to training"* (Agency manager, Site D). In contrast, *"There is no jurisdictional control over the voluntary sector in terms of staff being trained up"* (Agency manager, Site A). One training coordinator added: *"Need to widen out Level 1 courses to independent and voluntary sector"* (Training coordinator, Site F).

The ways in which staff were selected to attend interagency training also varied between and within sites. Typically, application/booking forms went through line managers who reviewed the application and then send it on to the training coordinator or administrator in the LSCB. However,

> *"Some partner agencies have an application form (wherein they [staff] have to state why they want to attend the training), which is then reviewed by line manager… while other partner agencies have training departments which review application after the staff manager"* (Agency manager, Site B). But, "*Other partner agencies employ self-selection; these people are vetted by the training coordinator prior to attending"* (Agency manager, Site E).

In the allocation of places, one manager explained that *"There is usually 'quota system' for course participants per partner agency, but not ring fenced in any formal way"* (Agency manager, Site A). But elsewhere it was done, *"Usually on a first come first served basis"* (Agency manager, Site C). Training coordinators across the sites played a key role in the allocation of training places to partner agencies as well as monitoring partner agency representation.

A common theme running through the agency manager and training coordinator interviews was the need to get the right balance and mix of staff on the training courses:

> *"The training coordinator reviews the applications and tries to get the right mix or balance of agencies/participants"* (Agency manager, Site E).

In some sites and for specific partner agencies, there were recruitment difficulties. For example one said that *"In some partner agencies there has been a targeting strategy but it's difficult to recruit/attend, e.g. education*" (Agency manager, Site F). Another, in the same site remarked that there had *"Also been some difficulties with certain professions attending, especially doctors"* (Agency manager, Site F).

Training sub-groups reviewed those agencies who were not responding well to courses; they tried to address this by reviewing course attendances and got in touch with those who did not come. Members of training sub-group were asked to follow-up the individuals concerned. But, as one manager explained, the *"Problem is that there is no real check on who attends the courses, as this is mostly left up to line manager reviews"* (Agency manager, Site B). While a member of one training sub-group explained: *"The Training Support Group puts pressure on agencies not attending"* (Agency manager, Site F) and

another said: *"Despite efforts, certain agencies just do not attend or send course participants"* (Agency manager, Site A)

2.3.4. LSCB responsibilities

The training sub-group along with the training coordinator (also called the training manager in some sites) played vital roles in all aspects of interagency training, from developing the training strategy to commissioning and delivering the courses and evaluating them in terms of feedback. The training sub group and training coordinator were the primary means through which the programme of interagency training gets carried out in all but one of the project sites. In one site, there was no training sub-group, but its functions and roles had been integrated into another LSCB sub-group concerned with "quality and performance".

Supporting the training coordinator and the trainers was seen as a key role of the training sub-group across all sites and by several agency managers. The training sub-groups also play an important role in development and training:

> *"Its role is to establish, review, and update training programme and training packages"* (Agency Manager, Site B).
>
> *"Establishing training priorities and capacities…working together to develop training strategies"* (Agency manager, Site D).

Again, the role of the training coordinator in drafting, implementing and monitoring training strategies and programmes strategies was vital.

In addition to drafting and reviewing the training strategy or training plan, the training sub-group monitored its implementation and that national guidance was being adhered to. Key task identified included:

> *"Ensuring that training plan is carried out and that needs are being met"* (Agency Manager, Site B).
>
> *"Ensuring that training offered is what is needed, 'fit-for-purpose', and based on staff appraisals, and SCRs [Serious Case Reviews]"* (Agency Manager, Site C).
>
> *"Make sure courses get delivered despite problems, e.g. lack of trainers, admin staff"* (Agency manager, Site D).
>
> *"Making sure all partner agencies are 'singing from the same hymn sheet' with regards to staff training and development"* (Agency manager, Site D).

The training sub group liaised with the training coordinator and Board on new and emerging training issues:

> *"Identifying national and local training priorities"* (Agency manager, Site A).
>
> *"Get a clear understanding of local and national development issues*" (Agency manager, Site D).

It was evident that members of the training sub-group acted as intermediaries between their representative partner agencies and the training sub-group. These were described as follows:

> *"We take back key messages to our agencies about developments in interagency training"* (Agency Manager, Site B).
>
> *"We provide guidance to partners in terms of training standards"* (Agency Manager, Site B).

"Soliciting input from key people and trainers" (Agency manager, Site D).

"Making sure perspectives of different agencies are heard and represented in the training programme" (Agency manager, Site E).

Further, the training sub-groups and training coordinators played key roles in publicising and promoting the programme of interagency training to participating partner agencies:

"Ensuring training on offer is advertised to staff, so people know what is on offer" (Agency Manager, Site C).

Training Sub-Groups as facilitators of interagency working

It became apparent that the training sub-groups across the sites play an important role in facilitating working relationships between partner agencies in a more general sense. Thus, the activities of the training sub-group were seen as important in:

"…breaking down prejudices, misperceptions, misunderstanding between partner agencies" (Agency manager, Site A).

"Getting strategic 'buy-in' from some partner agencies, e.g., police services" (Agency manager, Site C).

"Being a forum for ideas exchange" (Agency manager, Site E).

"Getting key people to work together with aim of getting agencies to know one another" (Agency manager, Site F).

"Fostering [inter]professional relationships through the training" (Agency manager, Site F).

"Ensuring that training is actually taking place within a 'multi-agency perspective' and language" (Agency manager, Site A).

2.3.5. Training infrastructure

In all but one site responsibility for training was delegated to a training subgroup. In Site H, where a dedicated training sub-group was not present, lead responsibility for interagency training has been subsumed into the Q&P sub-group. Site H was also distinctive in that interagency training was wholly commissioned 'out of house'. However, this structure presented difficulties as the training sub-group was the primary means through which interagency training is developed and monitored:

"It should act as a driver for change, but this is challenging as training has been subsumed into Quality and Performance…[now] it is an add-on." (Agency manager, Site H).

The membership of the training sub-group or its equivalent varied between project sites. As Table 2 shows, some were dominated by the Council as was the case in Sites B and C, whereas others were made up primarily from CYPS (Site D) or Health (Sites G and H). Police and probation services had low membership levels relative to the other partner agencies, aside from Site E. Attendance varied across LSCB sites, where documentation revealed that roughly 75 per cent of members attended training sub-group meetings.

TABLE 2: PARTNER AGENCY MEMBERSHIP ON TRAINING SUB GROUP

SITE	A	B	C	D	E	F	G	H
Council	1	5*	4*	0	4	5*	1*	2
Health	3	2	1	4	2*	3	5	6*
CYPS	2	1	2	7*	0	1	2	3
Police	1	1	1	1	2	0	1	1
Education	2*	1	1	1	1	1	1	2
Connexions	1	1	2	1	0	0	1	0
Probation	1	0	1	0	1	1	1	0
NSPCC	0	0	0	0	1	0	1	0
Total members	11	11	12	14	11	11	13	14

Note: * Chair of training sub-group/equivalent
Site H=Quality & Performance Sub-Group

"Sleeping partners"

Partner agency membership on a training sub-group does not necessarily mean active involvement with the various tasks undertaken by the training sub-group. Interviews with agency managers and training coordinators suggested that there were certain partner agencies whose representatives neither regularly attended the meetings nor shared fully in the range of tasks necessary to deliver interagency training:

> *"I do not feel that there is an equal commitment shared by all members of partner agencies…some people are more active than others…there is a difference between attending and doing"* (Agency manager, Site E).

Some agency managers believed that these 'sleeping partners' felt their contribution to interagency training started and ended with a fiscal contribution to core funding. It was noted above that some partner agencies contributed more "in kind", but even in this respect there was some sentiment that some partner agencies were more likely to contribute than others. This was particularly the case in terms of contributions to the pool of active trainers:

> *"No consistency in contribution to training pool from partner agencies - and some partner agencies do not contribute at all"* (Internal trainer, Level 1).

Training coordinators adding: that they are *"Looking at more in-house involvement from other key partner agencies, which is still very social services led….and expanding the pool of trainers to include more partner agency representation"* (Training coordinator, Site H).

The key role of the training co-ordinator

The importance of the training coordinator in the organisation and delivery of interagency training cannot be understated. As touched upon earlier, they are the key person responsible for designing, delivering and coordinating a series of multi-agency learning and training opportunities. In seven of the eight sites training coordinators delivered training themselves. They were also responsible for drafting and reviewing the training strategy and the training budget. They promoted interagency training and, with the help of their administrators, circulated the training programme to partner agencies. Some also managed administrative staff and provided training as well as support for the trainers. In two sites (Site F and Site G) the training coordinator was the chair of the training sub-group; and all acted as intermediaries between the training sub-group and the LSCB itself. Training coordinators commissioned training courses and generated revenue through delivering safeguarding courses to non-contributing partner agencies, such as voluntary and private sector organisations. Finally, they played a key role in monitoring and reviewing courses at all levels of delivery.

Models of providing training: commissioning and providing in-house.

There was a continuum in terms of interagency training delivery models; on one end are training sub-groups which provided all training themselves, using staff from the partner agencies; and on the other, sites which commissioned all its training from external, freelance trainers . However, the majority of SCBs provide the bulk of interagency training in-house supplemented with the commissioning of specialty courses at Level 3 and above such as on female genital mutilation, where local expertise may have been lacking.

2.3.6. Facilitators and barriers

In this section, we analyse the facilitators and barriers to interagency partnerships in the provision of interagency training using West and Markiewicz's (2006) *Effective Partnership Working Inventory.* The inventory aims to measure seven dimensions which are known from research within the field of organisational psychology to be critical to the development of effective partnership working (Fig.2). Each domain has a number of key components and we assess the extent to which these were present, and whether further development was requited.

FIGURE 2: SEVEN DIMENSIONS OF EFFECTIVE PARTNERSHIP WORKING

Source: West and Markiewicz (2006) in Jelphs and Dickinson (2008, p. 81)

1) *Shared commitment to goals and objectives*

From the interviews it appeared that all members of the training sub-groups ***were clear about their own agency's goals***[4] with respect to interagency training, i.e. fulfilling the mandate of *Working Together* and *Every Child Matters,*

> *"Key partner agency ensures that every partner agency is fully aware of child protection issues and that those in key roles have specialised knowledge"* (Agency manager, Site E).

[4] The key components of each domain are indicated in ***bold italic*** font, thus.

and they were also ***clear about the partnership's goals***, i.e. to effectively train key workers, *"Ensuring that all staff in partner agencies are fully up to date and ready to carry out their roles in the community"* (Agency manager, Site F).

There was widespread ***belief that the goals*** of the LSCB generally and the interagency training specifically were ***valuable.*** However, as interagency working and training were mandated by government legislation, it is not the case that partner agencies ***entered into the partnership willingly***. They have since come on board and are quite committed to the policy and practice of interagency training and its favourable outcomes.

2) *Interdependence of outcomes*

All partnership members believed ***their agency's and partnership's goals*** with respect to interagency training ***are interdependent*** and mutually beneficial, e.g.

> *"Training silos not an effective use of existing resources and do not meet basic tenets of how inter-agency training and policy guidance should be done" "* (Agency manager, Site B).

All partnership members believed that ***innovation is required to achieve these*** and there was evidence of Innovation following reviews of existing training programmes and implementation of new ones based on agency training needs analysis or emerging from SCRs.

All partnership members believed that ***the skills and experience brought to the partnership by all the different partners are essential to the success*** of the training sub-group and interagency training. In some sites, there was a wide range of experience and representation on the training sub-group, whereas in others, it was more limited. There is also widespread concern that the independent sector – particularly voluntary organisations – is not well represented on the training sub-group. In addition, there is room for improvement and greater scope for more trainers from the partner agencies to deliver training as part of the training pool. Thus, *"The biggest challenge is getting broader involvement by the voluntary sector"* (Agency manager, Site B).

3) *Role clarity*

There were differences in the extent to which each of the partner agencies ***understand their own and each other's role within the partnership***. Many interviewees considered that there was no clear indication of their specific role on the training sub-group: *"We need to be clearer about what we want partner agencies to do and why"* (Agency manager, Site H). Only a couple of agencies had thus far developed 'terms of reference' for the training sub-group.

There did appear to be any formal process to ***ensure that power and status relationships are agreed and described***. For the most part, the training sub-groups worked very well but this had more to do with the commitment of the lead persons from the partner agencies who actually attended. But this commitment –in terms of attending meetings and equal sharing of tasks arising from the training sub-group – varied across sites; some members were clearly more committed than others.

There was evidence that all the training sub-groups could ***work constructively to resolve conflicts which may arise about status or role***. Interviews with agency managers did reveal some inter-professional conflicts, but these were minimal, with some respondents stating that this had more to do with the person than with the partner agency. Again, this varied from site to site and was closely linked to the positive working relationships which had been formed between members of the training sub-group over time.

4) *Cultural congruity*

The interviews revealed that members of the training sub-groups ***understand the differences between cultures across home teams or across organisational cultures,*** particularly between the representative partner agencies. However, it is also clear that these cultural differences had not negatively impacted on the work and objectives of the training sub-groups and the interagency training, albeit they are hindrances at times. Again, most training sub-groups appeared to have very good working relationships; in some senses they had formed their own separate cultural identity as a group. It could be argued that the demands of interagency training and the need to work closely together to meet them had resulted in cultural solidarity.

Some training sub-groups ***spend time to develop effective processes for working together***, although the ways in which they do so varied from site to site. Some used annual away days to strategise about the forthcoming training programme, whereas others build this in to the schedule of training sub-group meetings. Other sites did not appear to have additional time to spend on fostering such processes for working together given the demands of their regular occupation. Many agency managers commented that it would be helpful to spend more time to talk. All members of the training sub-group had the interagency training commitments as an add-on to their current job and many were already finding it difficult to keep up to their regular workloads. There was almost unanimous agreement that the members would like to be allotted time for working on interagency training.

Although some training sub-groups spend time to develop more effective working, it was less evident that they ***regularly review working and interpersonal relationships***. training sub-group meetings were infrequent, generally once every couple of months for two to two and a half hours; the agendas are full of task-orientated work which needs to be agreed and assigned, with little time left over for any review working and interpersonal relationships *per se*.

5) *Focus on quality and innovation*

Through the work of the training sub-groups, members from partner agencies ***demonstrate a concern for quality which is focused aims of the partnership***. Interviews and observation of the training sub-groups revealed that there was great concern for the quality of the training and the extent to which it was meeting the needs of the partner agencies. They all used participants' 'happy sheets' as the main source of data for quality control, but there was otherwise no systematic process in place in any of the sites to ensure the quality of interagency training. One member when asked about quality said that it was *"Difficult to know really when we don't measure the effectiveness really well"* (Agency manager, Site C). Another insisted that *"Evaluation and performance management needs to be improved"* (Agency manager, Site F). A third observed that there was,

> *"Not much in addition to course evaluations…we are struggling with this issue…little or no follow-up of users of services, i.e. how do we measure this?…should we base this on referrals, something else?"* (Agency manager, Site H).

Interviews revealed that most training sub-groups ***encourage positive challenging and regular constructive debate about working practices.*** However, these arose out of the good working relationships, rather than being something which was purposefully initiated by any one member or the chair. Some respondents stated that they felt able openly to question some of the aspects of the interagency training, knowing that the training sub-group meeting 'environment' was a safe place to engage in such debates.

Training sub-groups were more inclined to share their experiences of good practice than to ***share learning from errors and mistakes***. In some sites, these took place in annual reviews of their training programmes, whereas for other training sub-groups this is an on-going process.

Many members of the training sub-group ***provide practical support for innovation in working practices***. This included the co-delivery of courses, assisting with the development and/or review of a particular course, feeding in new research in a particular field, and peer review of courses delivered. The degree to which this happened in the sites varied.

6) *True cooperation*

There is limited evidence to suggest that all partnership members ***define the requirements for effective partnership working***. Although the word "partnership" was uttered during the course of many interviews, no examples were given as to how the training sub-groups went about defining its requirements. On the other hand, there was an indication that at least one site has undertaken steps to ***design integrated policies and working practices*** for interagency training. In this site, the partner agency training team has worked closely with the LSCB training team to ensure that the in-house training policies and practice closely resembled the LSCB's:

> *"Our training strategy is written around LSCB training strategy"* (Agency manager, Site G).

The extent to which LSCBs and the constituent training sub-groups ***provide training for partnership working at all levels of the partnership*** varied between sites. In some sites, much effort has been put into inviting senior managers to sit in on the training courses, with mixed success. There was some sense that some managers only paid lip service to the principles of interagency training. Some sites have held annual away days for senior managers; some were considered successful but others not so much.

All training sub-groups had taken steps to ***ensure effective communication processes exist and are managed effectively***. There were systematic distributions of training programmes and course content, both in hardcopy and via the web. Lead persons were updated frequently about changes in course dates and pre-requisites. There was also clear and timely distribution of materials for upcoming training sub-group meeting. In short, effective communication was one of the obvious strengths of the training sub-groups. As commented upon by many members of the training sub-groups interviewed, they had very good, committed, and effective training coordinators as well as administrative staff, who ensured that the training programme was well delivered, well publicised and well organised.

7) *Interprofessional trust and respect*

Based on the interviews, it was not clear the extent to which members of the training sub-group ***understand the professional roles of each group*** in the LSCB. In all LSCBs there were a number of sub-groups and committees, each of which had a distinct – albeit interrelated role – in the development and implementation of interagency training. The chairs of the training sub-groups appeared to have a clear understanding of the roles of each of the sub-groups, but not the partner agency members. In addition, it was not clear the extent to which members of the training sub-group ***understand the different ways of working traditionally adopted by each group*** in the LSCB. Finally, not clear from interviews the extent to which members of the training sub-group ***provide constructive feedback to colleagues from all professional groups***.

2.4. Discussion

2.4.1. Fit for purpose, one size fits all?

The generic guidelines offered in *Working Together* (2006) had not resulted in homogenous training and delivery mechanisms across the various sites. Each site has its own local training needs and history. There were, however, similarities in the structures established: all but one site has a training sub-group, which took the lead role in organising and delivering interagency training. In each site, a highly skilled and committed training coordinator played an indispensable role in making sure that the programme of training was delivered and monitored.

Idiosyncratic mechanisms and processes characterised by local needs and organisational capacity had also resulted in quite disparate funding and training regimes across the various sites. No two LSCBs displayed identical partner agency membership on training sub-group, contributions (fiscal or in-kind), commitment to, and active involvement in the organisation of interagency training.

2.4.2. A vulnerable system, a flexible system, and or an evolving system?

A vulnerable system

We have noted above the key role played by the training coordinator in developing, maintaining and delivering the training programme. There are clearly positive aspects and risks with arrangements based so significantly on the efforts of, in many cases, one individual. From a positive perspective, this means that there is often a great deal of ownership of the programme by a training coordinator who has developed and shaped the programme over the course of several years. It is obvious that for some training coordinators the personal investment that they had put into the programme was a significant factor in ensuring that the programme continued. However, there is clear vulnerability in relying so significantly on one individual. This vulnerability was highlighted in one of the sites during the course of the study. The departure of the training coordinator on extended leave impacted on the effective implementation of the programme; replacement staff had to be brought in to deliver training and other administrative staff had to take on additional work roles. Moreover, several LSCBs responded to the original invitation to apply to take part in the study by explaining that were currently not offering any inter-agency training as they were 'between' training co-ordinators.

It is abundantly clear that the training coordinator and his/her admin staff are the most important actors in ensuring the effective and efficient delivery of interagency training across all project sites. When this element breaks down, it has a knock on effect to all other parts of the process, from the training strategy to negotiating the training budget and monitoring outcomes of the training courses. And the nature of the tasks involved mean that it is not easy to replace this key person without their being a steep learning curve in the role. The needs of staff working in the various partner agencies means that interagency training should not be put on hold. Clearly, a more robust and shared inter-agency arrangement for providing training is needed to ensure that the whole programme does not collapse in the absence of one key person.

A flexible system

Another key feature of the organisation of interagency training was its flexibility; this took many forms. For example, many sites were able to respond to local training needs quite quickly (e.g. as a result of SCRs) or having intermittent 'mopping-up' or special

commissioned courses to deal with oversubscription. In the case of SCRs, we can suggest that this is an example of *forced* flexibility in that training needs arising from such a critical incident need to be addressed as quickly and effectively as possible.

Lead persons from the partner agencies showed flexibility in offering to take on more training and additional responsibilities arising from the training, e.g. poor course evaluations. The training sub-groups have shown flexibility in terms of the various tasks and responsibilities they carry out, particularly in dealing with emerging training needs and dealing with inter-organisational issues such as active involvement in the training sub-group and contributions towards training (particularly with regards to the training pool). Above all, the training coordinators showed great flexibility in their role across all the sites in responding to training needs, whether that be in terms of low course attendance or lead persons in partner agencies wanting to send more course participants.

In contrast, some aspects of the organisation of interagency training can be characterised as being inflexible. One key example is the type and amount of the contribution to core funding and interagency training. Some partner agencies had a set amount of funding which they contribute each year, whereas others contributed in-kind or not at all. Another area of inflexibility was the amount of time lead persons could contribute to interagency training and the training sub-group. In no cases were lead persons allotted any extra work time to carry out their tasks. Many commented that they would like to be able to contribute more to interagency training but were prevented from doing so by pressure of their regular work. There also appeared to be some lack of flexibility in terms of certain partner agencies releasing staff to attend the training courses. This was particularly acute in the education sector as the cost of replacement teachers was prohibiting schools from sending more teachers on interagency training courses.

An evolving system

Like any other endeavour in the field of human services, no programme or service is born fully matured. There were teething pains in each of the sites, but each appeared to have responded, or was planning to respond, to the wide array of challenges presented to them. Most of the sites had evidently come a long way in developing working relationships between the partner agencies and continued to do so in a variety of ways, including away days and special sessions for senior managers. The new LSCBs appear to be gaining authority in the field of interagency training for safeguarding children.

One area which needs improving is the systematic monitoring and evaluation of interagency training courses. Almost all sites based their evaluations of the effectiveness of training solely on post-course “happy sheets”. In a few, additional feedback was gathered through the lead persons in partner agencies asking course participants what they thought of the course they had attended. This was usually fed back to the training sub-group for discussion. There was clear recognition from the interviews that the system of course evaluation needs to be improved. We hope that the measures developed and employed in this project might be useful in this respect.

2.4.3. What could make it work better?

In conclusion, there is good evidence that interagency partnerships for the organisation and delivery of training under the auspices of LSCBs can work works, at least in these case studies. But it is not perfect. The interviews revealed several areas for improvement in the project sites and we conclude with an outline of these:

1) Increasing funding for interagency training

There was a persistent concern about the perceived inadequacy of funding for interagency training across the project sites, e.g.:

> *"More funding from the Board to carry out training activities, for example to enable us to hire a second trainer"* (Agency manager, Site A).
>
> *"The LSCB needs a better understanding of the costs of training"* (Agency manager, Site D).
>
> *"Training budget needs to increase in order to reflect true cost of delivering training"* (Agency manager, Site D).
>
> *"Increase in base funding/resources for training, in order to recruit more trainers…more funding equals more trainers equals more courses"* (Training coordinator, Site C).
>
> *"Resources limit the scope of training which could be done"* (Training coordinator, Site C).
>
> *"Increasing the budget for particular specialist training, i.e. being able to bring in consultant specialist for training"* (Training coordinator, Site B).

In this context, it should be remembered that there is no direct funding from central government to support interagency training. The level of financial contributions made by the various partner agencies, and who made them, generally reflected historical patterns inherited from the predecessor ACPCs. The result was considerable variation and a system which is vulnerable to the withdrawal of funds in a cold economic climate. The case for ring-fenced central finance should surely be considered.

2) Increasing training capacity within the LSCB

Many sites encountered periods where their capacity to deliver interagency training was surpassed by the increased demand brought about by new policy and practice mandates:

> *"Has to be some acknowledgement of 'capacity' given widening scope and areas of responsibility"* (Agency manager, Site F).

In one site (B), an agency manager's recognition for *"Increased capacity for delivering range of courses, i.e. the 'training pool' "* was echoed by the training coordinator's question, "*how many people are available to deliver training for how many courses".* But this was not necessarily very easy, as another explained,

> *"There are many in-house experts but difficult to identify who they are, i.e. with the aim of recruiting them to be involved in the delivery of interagency training"* (Training coordinator, Site G).

As the highlights show, increasing the capacity for training is not just a matter of money; the training sub-groups and training coordinators need to be able to call on the services of a substantial group of skilled and enthusiastic trainers with the time to commit from the range of participating partner agencies.

3) Reaching the right people to attend training

Getting the right people to attend the training courses as well as having the 'right mix' of course participants on the day continued to present challenges for the training sub-groups and the training coordinators. As one agency manager explained:

> *"Getting better at choosing the right people which attend the courses will make IA training more effective/efficient"* (Agency manager, Site C).

But, another commented that the training sub-group was already considering different approached, for example:

> *"[We are] looking at ways of increasing awareness to those people not able to access training due to work or financial constraints, for example, having to pay for supply teachers very expensive, which makes it very difficult for classroom teachers to attend."* (Agency manager, Site B).

This is one of the one of the attractions of computer aided e-learning, which had already been commissioned by some of the LSCBs for foundation level learning.

> *"Could think more laterally about how we deliver training, e.g. integrating e-learning into the training programme"* (Training coordinator, Site D).

4) Releasing staff to attend training

A common theme across the sites was the difficulty for partner agencies releasing staff: *"Need more of the workforce to be released to attend training courses*" (Agency manager, Site C) and *"Managers need to release staff to attend training courses"* (Training coordinator, Site B). One training coordinator added that *"Certain partner agencies are not regularly sending course participants, e.g. education, police"* (Training coordinator, Site F).

5) Reduce the duplication/replication of training

Some suggested that training resources and budgets should be pooled in order to reduce duplication. Thus:

> *"Training silos are not an effective use of existing resources and do not meet basic tenets of how inter-agency training and policy guidance should be done"* (Agency manager, Site B).

Another suggested that,

> *"We need to carry out proper audit of current single- versus multi-agency training to see where there is duplication"* (Agency manager, Site H).

However, a manager in one site considered that,

> *"A reduction in the duplication of training across partner agencies is unlikely to happen as this would necessitate most ceasing [to provide] single agency training"* (Agency manager, Site F).

6) Improve monitoring and evaluation of the impact of training

We have already suggested that current course monitoring and evaluation systems need to be improved. This was clear in the interviews and through review of the documentation. One interviewee expressed this succinctly:

> *"Consistent monitoring and evaluation of learning outcomes and impact of* interagency *training to ensure high standard of interagency training"* (Agency manager, Site A).

Another said that*: "We need evidence-based evaluations of the impact of the courses"* (Agency manager, Site B) and a third suggested, *"Looking at different models of training and how we measure effectiveness?"* (Agency manager, Site A).

Some training sub-group members were suggesting that they *"Need to follow-up with course participants to see what the impact has been of the training on their practice"* (Agency manager, Site F) with *"Having 3-6 month 'impact follow-ups' "* (Agency manager, Site G).

7) Increase involvement from statutory partners and expand involvement from non-statutory partner agencies

As we have explained above, there was some feeling about the unequal involvement of partner agencies and a concern in many of the LSCBs and that involvement from the voluntary sector was lacking entirely. As one member expressed it:

> *"Some people are more active than others…there is a difference between attending and doing"* (Agency manager, Site E).

Conclusion

Mackintosh (1992) distinguished three different types of outcome that a partnership may be trying to achieve: synergy, transformation, budget enlargement. Interagency training has an element of '*synergy*' as it brings together partner agencies with different assets and powers to create something where the whole is greater than the sum of its parts. There was also some sense, noted above, that the work of the training sub-group leads to '*transformation*' in that it brings partner agencies together to change the objectives and culture of the organisations, with the direction of change depending on the power of each individual partner. However, this was more an unstated rather that stated outcome. Although *enlargement* of the training budget did result from resources contributed to core funding by partner agencies, unlike in many cases of interagency partnerships there was no additional government money to promote the activity.

There was evidence of varying degrees of 'resource' and 'policy' synergy as outlined by Hastings (1996). Agency managers commented repeatedly on the 'added value' from the resources contributed to core funding; they believed that there has been increased effectiveness and to some extent efficiency. In terms of policy synergy, it was suggested that there had been new perspectives and solutions developed in some of the LSCB sites with respect to the courses delivered and special awareness raising sessions held (e.g. for Board members).

Hastings (1996) building on Mackintosh's concept of 'transformation', suggested that different outcomes can occur depending on the power balance between partners. The interviews revealed that there were indeed power imbalances in the training partnerships, particularly between health and social care and other partner agencies, but they do not appear to have either hampered of facilitated the work of the training sub-groups. There was a clear sense that partner agencies had accepted the need for change and to learn from – and more importantly, about - each other, so 'mutual transformation', whereby all partners change and differences between them begin to reduce), had occurred in varying degrees across the various sites.

Findings from the interviews suggested that collaboration was happening as a direct result of the government mandate. As such this reflects the 'realist' approach identified by Sullivan and Skelcher (2002). However many of those involved were also what these authors term 'optimists', whose behaviour was often altruistic, taking on the important role of interagency training 'champions'. We consider that the organisation of interagency training through LSCB partnerships to be a successful model, particularly when one considers that these are 'forced' partnerships, at least as far as the statutory agencies are concerned, and further that they do not have the carrot of special project funding. The next question concerns the nature of the training itself and who provides it. Then we can ask whether or not it achieves its aims.

2.5. References

Glasby, J. (2007) *Understanding health and social care*. Bristol, Policy Press.

Hastings, A. (1996) ‘Unravelling the process of 'partnership' in urban regeneration policy’, *Urban Studies*, 33: 253-68.

Mackintosh, M. (1992) ‘Partnership: issues of policy and negotiation’, *Local Economy*, 7: 210-24.

Rodríguez, C., Langley, A., Béland, F. and Denis, J.L. (2007) Governance, Power, and Mandated Collaboration in an Interorganizational Network, *Administration and Society*, 39: 150-93.

Sullivan, H. and Skelcher, C. (2002) *Working across boundaries: Collaboration in public services*. Basingstoke, Palgrave.

West and Markiewicz (2006) The Effective Partnership Working Inventory. Working Paper, Birmingham, Aston Business School. Cited in Jelphs and Dickinson (Eds.) (2008). *Working in Teams*. pp 81-84, Bristol, Policy Press.

3. The Content and Delivery of Training

3.1. Introduction

In Chapter 1 (Sec 1.1.2) we explained that the *Common Core of Skills and Knowledge* (DfES, 2005b) provides guidance to service managers for the content of in-service and inter-agency training, and that it is also suggested as a tool for training needs analysis (DfES, 2005b, p. 4). We observed that two of the six 'areas of expertise' in the Common Core are central to the outcomes of interagency training: 'safeguarding and promoting the welfare of the child', and 'inter-agency working'.

In this chapter we begin by assessing the scope and content of programmes commissioned by the sample of LSCBs with reference to the *Common Core of Skills and Knowledge* (DfES, 2005b). We then consider the experiences of those who deliver interagency training, both external/ 'freelance' trainers and 'in-house' trainers drawn from the partner agencies in the LSCBs.

3.2. Methodology

The methodology had two components, (1) to scope the courses being offered and (2) to survey the views of the trainers as described below.

3.2.1. Courses

The training coordinators were asked to supply information about the numbers, types and content of interagency courses provided during one 'training year'. They were asked to categorise them in terms of the 'target audiences' defined in *Working Together* (Sec. 4.19):

- those in *regular contact* with children and young people
- those who *work regularly* with children and young people, and
- those with *particular responsibility* for safeguarding children

Training and development for operational and strategic managers were not included in this study.

3.2.2. Analysis of learning objectives

The learning objectives of the interagency training courses are always stated in the course brochures which are distributed to staff in the partner agencies and beyond. In the following chapters we summarise the stated objectives for the courses evaluated in this study. However, these objectives are inevitably presented very succinctly, typically in around six bullet points. Consequently, at the first workshop with the training coordinators we engaged them in an exercise to identify the learning objectives and teaching methods in relation to the dimensions of the *Common Core*. They were presented with a series of proforma which included the *Common Core* outcomes in relation to: (1) 'safeguarding and promoting the welfare of the child'; (2) 'inter-agency working'; and (3) 'sharing information'.

They were asked to select three courses from their training programme which were intended for the three target audiences listed above. Between the first and second workshops they reviewed the content and teaching and learning methods used on these particular courses and completed the proforma. At the second workshop these were reviewed with the research team.

3.2.3. Views of the Trainers

A purposive sample of internal and external trainers reflecting the range of courses was chosen across the 8 sites. The sampling frame used for the trainer interviews is presented in Table 1 below. The aim was to attain a sample which did not over-represent any one particular LSCB, course level or type of trainer, and which allowed us to highlight key differences between external and internal trainers or between trainers delivering introductory and foundation courses and those delivering Level 2 or specialist courses.

TABLE 1: SAMPLING FRAME FOR TRAINER INTERVIEWS

	EXTERNAL TRAINER	INTERNAL TRAINER	TOTAL
Foundation course	0	1	1
Level 1 child protection	3	3	6
Level 2 child protection	1	2	3
Level 2/3 specialist	1	1	2
Domestic Violence	1	1	2
Total	**6**	**8**	**14**

External and internal trainers

External trainers were defined as any person being commissioned by a LSCB to deliver interagency training but who are not employed directly by the LSCB or one of their partner agencies. During the course of the interviews with Training Coordinators, these people were generally referred to as 'freelance' trainers. Some of these worked on their own, whilst others were part of a private/charitable company which provided consultancy and/or training services. Internal or 'in-house' trainers were defined as those who worked for the LSCB (i.e. the training coordinators) or their partner agencies (e.g. health, social services, children's services). These were generally professionals with special expertise in one or more aspects of safeguarding children; they may or may not have had training and staff development as part of their job description.

Range of courses sampled

We interviewed at least one trainer (both external and internal) for each course level offered by the various LSCBs. Trainers were interviewed who delivered introductory training to safeguarding children (Foundation and Level 1), Interprofessional Working (Level 2), as well as those who delivered Level 2/3 specialist courses such as domestic violence, children with sexually harmful behaviour, parental mental health and safeguarding disabled children.

Interview topics

In addition to gathering some background information such as the trainer's years of experience in delivering training, whom they work for, which specific courses they delivered, their generic (non-training) and training specific qualifications, trainers provided:

1. Reasons for involvement in interagency training;
2. Experience of the training courses: satisfaction and dissatisfaction with training;
3. Initial and on-going support from the LSCB or their employer;
4. Self-ratings on training, support from the LSCB and value of the training 'role'; and

5. Potential benefits to service users.

3.2.4. Interview data collection and analysis

Answers to the questions posed to sample of trainers were written on survey instrument proformas devised specifically for this key target group (see Appendix for further details). Respondents were also asked for permission for the use of quotations or paraphrased material in this report and in any published materials based on the research project. Permission was granted in all cases subject to respondent anonymity. Hand-written notes were then transcribed into electronic format and tabulated by site in spreadsheet format.

3.3. Findings

3.3.1. What training is delivered?

The training year differed between the sites: for some, it was the calendar year but for others it was the financial year. For the purpose of this study, we chose to ignore this difference, so the data pertain to the period January 2007 to March 2008.

The courses delivered during this period were clearly directed at the target audiences described above and reflected the framework described in the previous version of *Working Together* (1999, p. 100). Training was described as being at 'Levels, 1, 2 and 3' (sometimes, A, B and C). Training at level 1 was for staff in 'regular contact'. These courses provided an 'introduction to safeguarding'. Training at level 2, focused on 'working together' and was intended for those who 'worked regularly' with children. In many LSCBs, 'training on particular practice' (in the terms of *Working Together 1999*) was categorised at this level. However, in others it was categorised as Level 3. The data reported in Table 2 below should be read with this in mind.

TABLE 2: NUMBER OF COURSES BY LEVEL OFFERED IN LSCB SITES 2007/8

COURSES AND LENGTH	SITE A	SITE B	SITE C	SITE D	SITE E	SITE F	SITE G	SITE H	TOTAL
Foundation (1 day)	3	0	14	0	0	0	0	0	17
Foundation- E-learning	no	no	yes	yes	yes	no	Yes	no	
Level 1 (1 day)	12	13	11	1	10	0	0	5	52
Level 2 (1/2 day revision)	0	0	6	2	0	0	0	0	8
Level 2 (1 day)	16	0	5	27	10	56	18	7	123
Level 3 (2 day)	16	1	12	3	10	0	0	0	42
Level 3 (1 day)	0	20	16	0	5	8	40	4	93
Level 3 (2 day)	16	6	6	3		0	0	0	31
Total	47	51	48	41	35	64	69	16	366

There was some variation in the pattern of training courses provided at the different levels. Four sites had begun offering free access to e-learning courses which covered "introduction to safeguarding". In other sites, foundation level training was considered to be the task of single agency training. Twenty per cent of the courses were for two days and almost all the remainder were one day in length. It is worth noting that these courses therefore represented a very brief training intervention, although participants were able to take more than one course a year, and some did so.

In addition to generic courses providing an introduction to safeguarding children (level 1) and on working together to safeguard children (level 2), various specialist courses were offered (at level 2 or 3 according to local designation). The most frequently provided courses were on issues which featured in *Working Together* (2006, Chapter, 11). These concerned children "who may be particularly vulnerable":

- Disabled children
- Children living with domestic violence
- Children of drug-misusing parents
- Children of parents with mental health problems
- Sexually abusing young people
- Child abuse and the internet
- Children from abroad, including unaccompanied asylum-seeking children.

And some issues on which *Working Together* (2006, Ch. 6) provided "supplementary guidance":

- Safeguarding children in whom illness may be fabricated
- Female Genital Mutilation

There were a few courses focused on working relationships with families, whose titles included, "Developing and Maintaining Positive Relationships with Children and their Families in Child Protection" and "Skills for Working with Resistant Families".

Some sites offered updates on child development and on specific issues such as young people who were misusing drugs or alcohol.

Finally, most of the sites provided a course designed to improve practice in child protection conferences.

3.3.2. Learning objectives and methods

To a large extent the learning objectives of these short interagency courses were taken directly from the specifications in *Working Together*. This applied also to the specialist courses on for example, domestic abuse and disabled children where key learning objectives are also proposed (see the individual chapters). Consequently, the learning outcomes stated in the LSCB brochures varied very little. Further, there was considerable similarity between courses in terms of the content and methods of delivery. All the training coordinators were members of a national organisation, *Piat* (Promoting Interagency Training)[5], a partnership between the NSPCC and the universities of Sheffield and Nottingham. Piat was established in 1993 "to facilitate links between inter-agency trainers in child protection and to share best practice". In addition to an annual two-day conference for training co-ordinators, Piat publishes training guidelines and course materials and has a network of regional groups. Through the latter, training co-ordinators share their experience and materials and even teach on each others courses. Thus, the training co-ordinators emphasised, the courses evaluated in this study were equivalent in content and teaching methods, although the process within individual courses would vary according to the trainer and the participants.

The variety of interactive teaching approaches employed are a feature of these interagency and interprofessional courses. Learning was seen as being "as much to do with process as it is with content". For example, in an introductory level course, different assumptions, definitions and values which can influence practice and prevent some children and young people from having equality of opportunity and equal protection from harm are typically

[5] http://www.nspcc.org.uk/Inform/trainingandconsultancy/piat/piat_wda62027.html

explored through the consideration of case studies. Participants are asked to score each scenario out of ten, in relation to their concern for harm to the child. They are also asked to provide an explanation for their score and any other questions they may have in relation to the key themes. They are then put into inter-agency groups and asked to compare similarities or differences in their scoring. In a more advance (Level 2) course, the dangers of assuming a shared understanding would be illustrated with detailed discussion of examples from enquiries into child deaths.

These introductory exercises are always followed by a presentation on the definitions of significant harm and the differences between section 17 children in need and section 47 children at risk of significant harm. The roles and responsibilities of the LSCB is given to all participants, both as an explanation and a handout. All participants are informed of the practice and procedures guidance and where they can access it. Specific roles and responsibilities in relation to making referrals and completing assessments are shared. The information sharing protocol as agreed by all agencies is investigated. The importance of Human Rights Act, Data Protection Act and common law of confidentiality are explained. A typical approach involves the use of a flow chart that moves from referral to de-registration. Information is provided at the end of the course on key website addresses and contact details of duty teams to help support their local knowledge.

Specific exercises allow opportunities for reflection and modelling of inter-agency working. Thus, on an introductory course, a second group exercise enables participants to investigate one another's roles and responsibilities. Participants are encouraged to continue this investigation during the breaks and lunchtime.

On a Level 2 course, participants are asked to draw on their experiences of multi-agency working to identify the strengths and challenges of working in an interprofessional way. The exercise is to share where their agency features on a flow chart illustrating the process from referral to de-registration. This may be followed by a quiz based on key local procedures relating to child protection. The participants work together and are allowed to use the procedures manual to help identify the answers.

Making explicit links between the process and the content is an integral part of the experience, and relies on the skills of the trainers and facilitators. The complexity of undertaking child protection/safeguarding work is emphasised. Participants are helped to appreciate that safeguarding and protecting children is not something that can be done on an individual basis and the collaborative working is essential.

3.3.3. Trainers views and experiences

Interviews were completed with eleven out of the targeted sample of fourteen trainers. Table 3 summarises the type of trainer interviewed by course level they delivered training. In terms of the target sample, we were more successful in completing interviews with internal trainers versus external trainers and trainers (both external and internal) delivering introductory level training. This was mainly due to the fact that there are far fewer external or 'freelance' trainers delivering Level 2/3 or specialist courses.

TABLE 3: TRAINERS INTERVIEWED IN THE EVALUATION

	EXTERNAL TRAINER	INTERNAL TRAINER	TOTAL
Foundation course	0	1	1
Level 1 child protection	3	3	6
Level 2 child protection	1	1	3
Level 2/3 specialist	0	1	1
Domestic Violence	0	1	1
Total	**4**	**7**	**11**

Background/past experience

All seven internal trainers worked for one of the various LSCB partner agencies; none were employed directly by the LSCB. Of the four external trainers, three were self-employed and one managed a private day care.

The length of time trainers have delivered safeguarding children courses ranged from 2 to 15 years. Internal trainers, particularly those who delivered Level 2/3 or specialist courses had more years experience on average than those who delivered foundation or introductory level courses. Internal trainers also had more years experience than their freelance counterparts for the same level of course delivered.

Professional and training-specific qualifications

A range of generic (non-training) professional qualifications was reported by the trainers, including Masters and Bachelor degrees, Postgraduate Diplomas and Certificates, NVQs, and City & Guilds. There were no obvious differences between internal and external trainers in non-training qualifications. However, those who delivered courses at Level 2/3 or specialist were more likely to report at least a Postgraduate Diploma or Certificate.

Very few of trainers interviewed had training-specific qualifications. Of the three internal trainers having a training-specific qualification, one reported a Practice Teaching award, one an ENB 998 (teaching and assessment), and the other City & Guilds 7304. Only one of the four external trainers had a training-specific qualification (NVQ4 in training and development).

3.3.3.1. Reasons for involvement in interagency training

The reasons trainers gave for their involvement in interagency training varied. For internal trainers, delivering interagency courses was typically part of their job description, but for some it has been added on to the tasks for which they were initially hired. For example, "*[It's] not formally part of my job description but has been added on*" (Internal, foundation courses). Another trainer added that, "*it is part of my role as named nurse, but not part of the job description*" (Internal, Level 2/3 specialist courses).

External trainers gave a number of reasons for being involved in the training. One had previously worked for social services as a child and adult trainer. After having turned freelance, they were offered commissions to deliver courses in the same local authority where they had worked. Another stated "*the training coordinator approached me just about the time I became freelance*".

The external trainer who is a manager of a private day care facility stated that it is part of her job role. One went to a training day that LSCB was holding and the trainer said that they were looking for trainers and "*thought this would be an interesting thing to do*" (External, Level 2 course).

3.3.3.2. Experience of the training courses

Most trainers (internal and external) report having had very positive experiences with the interagency training courses. Internal and external trainers alike found it an enjoyable experience. One external trainer stated that they "*enjoy it very much…it's fantastic!*", which was echoed by an internal trainer, "*really enjoying it*!".

When asked what they enjoyed most about the training, the richness of the learning opportunity came up on more than one occasion, e.g. "*Very rich when it comes to audiences*

issues and the need for people to carry out their job roles" (Internal, foundation course), with another trainer adding that, "*Training offers a rich learning opportunity - and more so as time passes*" (Internal, Level 1 course).

Satisfactions

According to both internal and external trainers, there were many satisfying aspects of the interagency training. One area of satisfaction was growth and development (professional and personal) and "*actually watching growth and development take place*" (Internal, Level 1 course). Some trainers commented on the opportunity for professional skill development, for example, one trainer stated that "*interagency training provides an opportunity to develop my training techniques/methods*" (Internal, Level 2 courses) and adjust these techniques as "*each time training changes as experiences people bring to the courses changes… revising courses to get them right is useful as well*" (Internal, Level 2/3 specialist). Watching "*professional growth [in the trainees] is satisfying*" (Internal, Level 2/3 specialist).

Other trainers commented on personal growth and development aspects, as well as personal satisfaction received from their involvement in training. For example, one internal trainer stated that they "*get a lot personally out of training people*" and an external trainer that they "*like having hands on training with professionals*". In addition, one trainer stated that they "*liked working with trainers from other agencies*" (Internal, Level 1 course). Furthermore, training was considered by some trainers as an opportunity to give back some of their experience and knowledge of safeguarding children to other professionals.

Another common area of satisfaction was the opportunity to break down inter-professional barriers, which was considered to have, in the past, hindered effective joint working, for example, "*changing from child protection is <u>their</u> responsibility to child protection is <u>our</u> responsibility*" (Internal, foundation course).

Some trainers suggested that the mere fact that professionals from different agencies sat in one room to learn about safeguarding children together is instrumental in "*having different perspectives from different agencies*" (Internal, Level 2 course), which help to "*demystify or break down the silos/barriers between partner agencies*" (Internal, Level 1 course) thereby facilitating proper joint working.

As trainers stated, training "*challenges people's value bases and viewpoints by getting into – and changing – their perceptions and views*" (External, Level 1). This sentiment was echoed by internal trainers as well; one stated stating it was satisfying "*seeing a change in people's perceptions as day progresses…for example, from reluctance in being there to enthusiasm*" (Level 1 course). There was also satisfaction in "*people making professional linkages in real time*" (Internal, Level 1), "*people working together to solve problems*" (Internal, Level 2 course) and "*how people from different backgrounds can learn from each other*" (Internal, foundation course).

Being instrumental in modelling and shaping good practice was another source of satisfaction for trainers. Many commented on the potential practice impact that training might have on participants following course attendance. For example, some trainers received feedback from course participants that the training is really going to change their practice and that "*their eyes have been opened*" (External, Level 2 course). Another trainer "*got the sense that people are better equipped to deal with safeguarding issues*" (Internal, Level 1). One trainer suggested that they have already seen the effect training has had on practice by "*how participant's practice changed after the training*" (Internal, Level 1 course).

The enthusiasm and participation by course participants was also a source of satisfaction to trainers. As one external trainer commented, "*staff who attend are well motivated and…discussion and debate very good in the training sessions*" (Level 1 course).

Challenges and dissatisfactions

There were some reported challenges and areas of dissatisfaction in delivering the training as well. A major challenge for all trainers was being able to change people's attitudes and perceptions about safeguarding children and "*to get people to understand their roles/responsibilities in relation to the big picture and getting away from the 'blame game' "* (External, Level 1).

The attitude of some people coming to the training sessions was not always helpful and "*different perspectives could be a challenge at times*" (Internal, Level 2). For example, one trainer stated that "*some head teachers don't always understand that it is as important for them as it is for social services staff to ensure safeguarding children*" (External, Level 1), while another trainer considered that was difficult at times,

> "…*dealing with professionals' snobbery, secrecy, and stereotypes of other professionals*" as well as " [some] *professionals' views of parents as somehow being subordinate, i.e. not equal members of any given team because they come from dysfunctional families which ignores the ability of families to meet challenges*" (Internal, foundation course).

Interestingly, dealing with these attitudinal challenges was also a source of great satisfaction for some trainers. As one trainer summed up, they,

> "*Enjoy the challenge of training people who are there because they have to be there and watching their attitude change through the course of the day…they end up liking it and this is very satisfying to me*" (External, Level 2 courses).

Training capacity was also a challenge for some trainers, i.e. increased pressures on them to deliver more training as demands for training increases. One of the internal trainers stated that,

> "*I'm the only specialist trainer so it puts a lot of pressure on me as a trainer, i.e. capacity in the sense that I would like to do more*" (Level 2).

Conversely, another suggested that it had been difficult for them to "*break into an established circle of trainers*" (Internal, Level 2/3 specialist course).

Course content

In terms of the course content, one trainer believed that great care needed to be taken to,

> "…*ensure that the material was user-friendly and not very 'chalk and talk' ",* adding that*, "training has to be more interactive/fun, so people go away more positive and confident"* and that *" 'doom and gloom' is not conducive to development "* (External, Level 1 course).

Another major challenge was the great pressure to cover a lot of material, including the "*rapid changes in safeguarding policy over the past 5-6 years*" (Internal, Level 1), in the time allotted for the training course, given as some trainers suggested "*how little knowledge some professionals in the field have with regard to basic child protection policies and procedures*" (External, Level 1). One trainer commented,

> "*There is a great deal to get through in one day, whereas in the past the material was covered in two days, now it is covered in one*" (External, Level 1 course).

Ensuring that course participants "go way with something from training" was challenging. As one trainer pointed out, this must be done "*without dumbing down the content…getting the balance/pitch right*" (Internal, Level 1). It is important that participants are able to "*relate the training and the real life stories told to their own practical experience*" (Internal, Level 1 course).

3.3.3.3. Support and feedback

Initial support

Interviews with internal and external trainers revealed that little initial training support was provided from LSCBs but that some was provided by their employing agency. This was particularly true for internal trainers where we found that four of the seven internal trainers had participated in a 'training for trainers' course delivered by their agency. Only one internal trainer had received training for trainers delivered by the predecessor ACPC "*some fifteen years ago…but nothing else*" (Level 2 course) and one other reported receiving subject-specific training (CAFCARD).

In terms of initial support to external trainers, one had taken a 'training for trainers' course offered by the LSCB and one other said that they "*watched over other trainers before taking the course over, i.e. peer review*". Another external trainer explained that although they did not receive initial training from any agency in particular, the commissioning agency "*did give some funds for preparation time of the courses to be delivered*" and stated that "*they valued the time it takes to prepare*" (Level 1 course).

On-going support

There also appeared to be limited on-going support provided to trainers, both internal and external trainers as well as for different levels of training. Two out of the seven internal trainers said that they did not receive any on-going support (delivered at foundation and Level 1 courses respectively). Of the remaining five internal trainers, one stated that although they do not receive any on-going support "*the local authority provides funding for* [my] *training on a case-by-case basis*" (Level 2 specialist in domestic violence), but another said that "*there are very limited opportunities but do not access because have to pay for yourself*" (Level 2 course).

On-going support for the remaining three internal trainers usually took the form of training for trainers and support from the training coordinator. Additionally, two internal trainers reported meeting periodically with other trainers as group (3-4 times per year) "*to discuss training issues and new content, e.g. how to handle disruptive behaviour [in the training sessions] and the CAF*" (Level 1 course).

External trainers were also unlikely to have received on-going training support. Where this did occur, it was usually from the training coordinators in the form of course reviews, but as one other external trainer stated this was "*not in the way of structured/regular training meetings*" (External, Level 1 course). Only one external trainer met regularly other trainers to discuss emerging issues; this occurred at an away day organised by the LSCB.

Feedback

All but one trainer received regular feedback on the training delivered. Usually, this feedback came from the training coordinator in the form of course evaluations or summaries of course evaluations. These were fed back in person to trainers (internal and external). In addition to training coordinators, lead persons in some participating agencies provided informal feedback, but this was neither consistent nor widespread.

In two cases, internal trainers did report receiving training evaluations in the form of peer review (one Level 1 course and one Level 2 course). One internal trainer had asked course participants for verbal feedback at the end of the training course. An external trainer explained that "*the training commissioner also calls a couple days after the course to ask if there have been any problems…usually verbal but sometimes e-mails*" (Level 1 course).

3.3.3.4. Self-efficacy and the value placed on training

Trainers were also asked in interview: how they would rate themselves with regard to being able to meet the needs of participants; and how much they felt their role as a trainer, and training in general, were valued by the LSCB. A four-point Likert scale was used which ranged from 'highly qualified/valued ' to 'could be more qualified/valued' to focus the discussion.

Self confidence

Most trainers (internal and external) delivering foundation and introductory-level courses felt 'highly' or 'well qualified' to undertake the work. Only one trainer, an external trainer delivering Level 1 courses felt only 'adequately' qualified. Trainers delivering Level 2 and above courses were more likely to report being 'well qualified'; there did not appear to be any differences between internal and external trainers.

Valuing trainers and training

The extent to which trainers felt that their *role as a trainer* was valued by the LSCB differed between internal and external trainers. Most internal trainers were not sure how much the LSCB valued training; one answered, "*I don't know, have no context to base this on*", while another commented, "*I wouldn't have the faintest idea as I never get feedback from them*". In contrast, many external trainers delivering courses at various levels felt that the role of trainers was 'highly' valued by the LSCB. Internal trainers were more likely than external trainers to feel that training in general was (only) 'well-valued' by the LSCB; external trainers were more likely to respond that training was 'highly valued', but one external trainer commented that "*it could be more valued, as there is no direct or indirect feedback from the LSCB*" (Level 1 course).

3.3.3.5. Perceived benefits of interagency training to service users

Trainers were asked to comment on the perceived benefits to parents, carers, and young people from interagency safeguarding training. As was reviewed in the Introduction, a distinction can be made between the outputs and outcomes.

Outputs

Policies and procedures

One of the key outputs identified by trainers was an increase in the level of course participant's knowledge of policies and procedures in safeguarding children. Trainers suggested that when staff were "*more alerted/aware of the signs of child abuse*" (External, Level 1 course), have "*relevant understanding of their legal mandate*" (External, Level 1 course), as well "*greater understanding of statutory/non-statutory guidance*" (External, Level 1 course), safeguarding children "*moves away from crisis management to prevention*" (Level 2/3 specialist course). One trainer asserted that, "*assisting professionals with their knowledge of risks and need criteria which should result in delivering a better plan for their services*" (Internal, Level 2 course).

Another trainer agreed that training lead to increased knowledge but was not sure how this translated into better outcomes for children and families. It could,

> "*change awareness around protocol and procedures for those attending training…but not sure exactly how it would benefit service users*" (Internal, Level 1).

Transferring knowledge into practice was essential, as one trainer put it, "*don't just gather info/guidance but need to analyse it as well…learning must be put into context*" (External, Level 1 course). Proper staff supervision also plays a key role, "*Staff knowledge and understanding has a huge impact on families but this must go part and parcel with good supervision as well*" (Level 2/3 specialist course).

Roles and responsibilities

A shared understanding of the roles and responsibilities of staff working in the safeguarding system was considered an important output, i.e. "*That everyone involved with the family is aware what each other's role/responsibilities are*" (External, Level 1 course) and that " *everyone is responsible for safeguarding children, i.e. a shared community responsibility*" (External, Level 1 course). One trainer commented that, "*Reinforcing the same messages is crucial not only for key workers but for service users as well*" (External, Level 1 course).

Trainers also believed that training increased the confidence of staff responsible for making safeguarding decisions. As one trainer claimed, "*training gives people from certain agencies confidence in what they are saying/doing*" (Internal, Level 1 course). Another added that staff now have "*clear points about making judgements about decisions which should lead to better safeguarding*" (External, Level 1 course).

One trainer summed up the outputs of training as "*More consistent messages from professionals involved in terms of thresholds, risk assessment and priorities for work*" (Internal, Level 1 course).

Outcomes

Trainers believed that the outcomes of interagency training would be positive for service users. Who should benefit from a shared and common understanding on the part of staff of the services available. "*Service users can be pointed in the right direction quite easily now*" (External, Level 1 course). Another trainer added that, *"a more informed/knowledgeable workforce should result in safeguarded children by resulting in more referrals*" (Internal, Level 2/3 specialist course).

Some trainers felt that dealing with misconceptions and misperceptions in the training course would help not only break down barriers which existed between professions but also between staff and service users. One trainer claimed that "*by agencies breaking down their own barriers helps breakdown barriers between themselves and the service users*" (External, Level 1 course).

The training courses, it was claimed, provided examples of how to communicate with service users through using "*common/non-threatening language, for example, speaking with families about child protection in a user-friendly manner and realising that you can do it in a supportive way*" (External, Level 1 course), which resulted in "*better communication with service users and their greater involvement in decision making*" (Internal, Level 1 course) as well as the "*development of appropriate service responses*" (Level 2/3 specialist course). However, as one trainer stated, "*Whatever service users' needs are, services have to be joined up*" (Internal, Level 1 course).

3.4. Discussion

The programmes of interagency training organised and provided under the auspices of the LSCBs are in most cases very substantial. There are many courses offered on a range of important topics. Most of those identified as important in *Working Together* were being covered, although there were only two courses specifically on the topic of child neglect.

These courses are short, the great majority being for one day only, although participants are permitted to a number each year. This means a member of staff working for one of the

partner agencies can develop and consolidate there learning in various aspects of safeguarding, assuming that they can be released to attend.

The courses are of course interprofessional as well as interagency programmes. Possibly because they are not called 'interprofessional education' or 'common learning' they have not been part of the major developments in interprofessional learning at postqualifying level in adult services (Carpenter and Dickinson, 2008). This is a pity, because an exchange between trainers/educators across adult and children's services could be very fruitful.

The courses are evidently led by skilled and experienced trainers using participative educational models. However, one important message is that they need more recognition and support than they are currently receiving.

3.5. References

Carpenter, J. and Dickinson, H. (2008) *Interprofessional Education and Training*, Bristol, Policy Press.

DfES (2005b) Common Core of Skills and Knowledge for the Children's Workforce, London, DfES.

Dept. of Health (1999) Working Together to Safeguard Children. London, Department of Health.

H.M. Government (2006) Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. London, DCSF.

4. Evaluating the Outcomes of Interagency Training Courses

4.1. Introduction

In the previous chapters we have explained the importance of interagency training in terms of enabling all staff in contact with children and young people to safeguard them from harm. We have described the organisation of training in the eight sites in which this study has taken place. We have analysed the content of training and explored the trainers' perspectives on its delivery. Now we come to the fundamental question, does it work?

4.1.1. Existing literature

We have seen in Chapter 1 that the existing literature does not help very much, if at all, in answering questions about the effectiveness of interagency or interprofessional training for safeguarding children. There was only one example found. However, it is worth attempting to draw some lessons from the approaches which have been used to measure outcomes of uni-disciplinary or single agency training as well. Four studies in the systematic review by Carter et al. (2006) attempted an objective evaluation of the impact of training.

In the only example of interagency training identified in the review, Cerezo and Pons-Salvador (2004) demonstrated a significant increase in the reporting of child abuse and neglect following the major programme in Spain. However, as we commented in Chapter 1, this study is of limited value because it cannot demonstrate the series of steps with might have led to this outcome. Even if we can demonstrate these steps, there are still problems in determining direct causality of training on learning (an output or outcome, depending on the nature of the research) resulting in increasing reporting of child abuse or referrals (more outputs), which lead to increased safeguarding of vulnerable children (an outcome).

The idea of using the apparently 'hard evidence' of numbers of new cases of abuse identified following a course is superficially attractive. But, it would not be possible to know whether the cases had been *correctly* identified, not least because we could not necessarily expect the professionals themselves to agree. The numbers of new cases in a geographical area is actually quite small and subject to what appears statistically to be random variation, (see Carpenter et al. (2007) for a failed attempt to identify the impacts of Sure Start programmes on child abuse in seven North East local authorities).

The numbers of referrals of children to social services is another possible outcome indicator; here fluctuations in the data over time are more obvious because the numbers are much greater. However, as Carpenter et al. (2007) discovered, the definition of a 'referral' varied between authorities, making it impossible to aggregate or compare data. In any case, children are referred for many other reasons than suspected abuse and neglect. Whilst it may be possible to identify some overt cases of abuse and neglect, in many other cases the boundaries (or thresholds) between issues 'child protection' and 'family support' are far from clear. Finally, how would it be possible to assert cause and effect? Changes in the numbers of referrals may reflect the introduction of a new service (like Sure Start), or a campaign by the press as well a training intervention, no matter how big.

There were three studies that tested factual *knowledge* before and after training: Palusci and McHugh, (1995), Socolar et al. (1998) and Weintraub et al. (2002). Of these only the first study demonstrated a conclusive improvement, but this is clearly an important outcome; after all, one of the reasons assumed for going on a course is that participants learn something.

Finally, there were two studies, by Henry et al (2002) and MacCleod et al (2003) which assessed subjective outcomes; these described increases in *self-reported knowledge* and

confidence. Note that these are correctly described as outcomes in the sense that knowledge and confidence were reported on a scale *before* the start of the course as well as afterwards.

4.1.2. Assessing learning outcomes

Much of the general literature on training evaluation has employed a framework originally developed by Kirkpatrick (1967). This identifies different levels of outcome beginning with 'learner's reactions', attitudes, knowledge and skills, and impact on behaviours. In this study we employed a primarily quantitative approach to the assessment of outcomes, seeking to measure them by means of self-completion questionnaires. This is not the only quantitative method which can be used to evaluate the learning outcomes of professional education (see Carpenter, 2005 for a review), but it is by far the most cost-effective. Further, since the central aim of the project was to establish a substantial evidence base for interagency training it was essential to use established methods and to collect a large amount of data from a wide range of courses. Consequently, we planned to use questionnaires to measure the following outcomes:

- Attitudes to interprofessional learning (Kirkpatrick 1: learners' reactions)
- Knowledge of the topic (e.g. the effects of parental substance misuse on children) and of how to work together to safeguard children (i.e. interagency policies and procedures)
- Attitudes to children and families in safeguarding situations and to interprofessional working
- Self-efficacy i.e. beliefs that you *can* work well and effectively (generally skills).

Self-efficacy is more than a self-perception of competency. It is an individual's assessment of his or her confidence in their ability to execute specific skills in a particular set of circumstances and thereby achieve a successful outcome (however defined). Furthermore, there is substantial empirical evidence accumulated in many fields over the last four decades that it is a powerful predictor of behaviour (Salas and Cannon-Bowers, 2001).

However, this approach assumes that suitably valid and reliable measures (scales) exist. In the case of safeguarding children, few do, and of these none were suitable, generally because they were not measuring the learning outcomes in which we were interested. In the following section, we consider any relevant measures. There was only one set of scales which were useful for our purposes. These had been developed to measure the outcomes of interprofessional education in health and social care and we were able to adapt them, as described in chapter 6 on working together with other professionals to safeguard children.

In the absence of suitable scales there was no alternative to developing our own. This is a time consuming procedure and is not generally to be recommended.

4.1.3. Procedure for the development of scales[6]

We describe the procedures adopted for each of the scales we developed in the following chapters.

Generally it involved:

- consultation with experts in the specific fields
- examination of any existing scales

[6] This procedure is described amusingly in relation to a measure of craving for chocolate. http://www.guardian.co.uk/education/2009/feb/24/improbable-research (accessed 24.2.09)

- generating a set of statements covering the outcomes in which we were interested: attitudes, knowledge and self-efficacy
- construction of a Likert-style questionnaire with above items
- inclusion of open knowledge questions
- piloting and revision of scales
- reliability testing and removal of items
- psychometric analysis of scales[7]

Questionnaires have been criticised because they may not be reliable in assessing attitudes – respondents may give socially desirable responses. However, they can reliably test knowledge (they can be framed so that the answers are "right" or "wrong") and, we have suggested, self-efficacy is a good predictor of subsequent behaviour. What they cannot do easily is to test whether the participant's learning has been implemented post-training.

4.1.4. Implementation of learning

One method of assessing whether or not a trainee put their learning into practice is to ask a potentially reliable informant, such as their manager. This is most usually done by interview and would be impossible for a large project such as this. We know of no examples of this use of questionnaires, probably because they would be extremely difficult to devise. Consequently, we aimed to collect some indicative data through follow-up interviews with a small sample of willing trainees and with parents or young people who were receiving help and support for the trainee at the time.

The limitations of this approach are fairly obvious: participants, both trainees and service users, would have to volunteer to take part in the interviews. Since very few of them are likely to do so (as was the case) they are probably an unrepresentative sub-sample of the groups as a whole. This means that it is impossible to generalise, but the findings themselves may be suggestive.

We concluded that it would not be possible to measure outcomes for children and young people, and their parents or carers. We discussed the problems of using referrals data and child protection registrations above. In any case, the goal of safeguarding should be that children and young people are kept safe. The demonstration that fewer are on a register does not mean that they are being protected. Other outcomes, such as "well-being" are very difficult to measure and, we have to agree not only the definition of well-being but how this has changed over what time period? Furthermore, there are many more influences on a child than the contact that he or she may have with a safeguarding professional. As MacDonald (2001) has noted, most professional responses to child abuse and neglect are composite in nature, involving a range of staff, services and interventions. How could we demonstrate that it was *this* professional's (the trainee's) intervention which had made a difference? There may have been extenuating circumstances which had nothing to do whatsoever with the safeguarding system. Finally, it is well worth remembering that the training intervention itself was, in most cases, *only one day*. It is possible to claim that training staff over a year or more in the use of relatively sophisticated and targeted psychosocial interventions *can* make a measurable difference to the mental health and social functioning of service users (e.g. Carpenter et al., 2007), but this is a very different case.

4.1.5. Measures adopted for the assessment of outcomes

The measures and approaches adopted for the study of the outcomes of the various courses

[7] Technical details of the statistical procedures used and the results of the analyses are available on request from the authors. They will be submitted to peer review journals in due course.

are summarised in Table 1 and discussed in detail in the individual chapters.

TABLE 1: KNOWLEDGE, SKILLS, ATTITUDES AND BEHAVIOUR: MEASURING LEARNING OUTCOMES (ADAPTED FROM CARPENTER, 2005)

DIMENSION		LEVELS OF TRAINING	MEASUREMENT
Attitudes to learning	Attitudes to interagency learning	2	Interprofessional Learning scale
Cognitive	Declarative (factual knowledge, e.g. of indicators of abuse, impact of domestic violence on children)	1, 2, 3	Knowledge tests 1. Child abuse scenarios (identifying types of abuse) 2. Factual/counterfactual items in questionnaires 3. Open question about factors which influence safeguarding.
	Procedural (knowledge organisation)	2	1. Child abuse scenarios (action test) 2. Self-report confidence in using procedures
Skills	Initial skill (interviewing)	2	Self-efficacy in communication
	Compilation of skills (planning, organising interventions)	3	Self-efficacy in specific tasks to work together in safeguarding
Affective	Attitudes to service users and to abuse Attitudes to other safeguarding professionals	1, 2	1. Attitudinal statements 2. Interprofessional Relationships scale
	Motivational outcomes, self-efficacy	1, 2, 3	Self-confidence ratings
Behaviour	Implementation of learning in practice	1, 2, 3	Self-selected task ("Dear Me" letter) and follow up[8]. Follow up interviews with participants
Impact	Outcomes for users and carers (partnership and engagement in child protection processes).	2, 3	Interviews with parents/carers and young people[9]

[8] This method proved unsuccessful, with a poor response rate (15%) and is not reported.
[9] It proved impossible to recruit a sample through the trainees.

4.2. Research design

This was an observational study of current practice. We wanted to know whether the training which was being provided was making a difference. We were not, in other words, designing and testing an educational intervention, with all that it implies in terms of having control over the process.

Consultation with training co-ordinators confirmed that the strongest design, a randomised controlled trial, would not be feasible because it would be ethically and practically unacceptable to randomise potential trainees to a no-training control condition as safeguarding children training is mandated by government. Nor was it considered acceptable or feasible to recruit participants to a course and to tell a randomly selected half of the applicants that they could complete a questionnaire and then wait three or four months before starting (i.e. a 'waiting list' control, as often used in psychotherapy research)[10].

The approach chosen was a repeated-measures design, employing a double baseline. Thus, successful applications to the course could be asked to complete the measure at the time they registered for the course (T0), generally six weeks before the start. They would complete it again at the beginning of the first day of the course and then again at the end of the course. Finally, there would be a follow-up assessment; we chose three months.

This design is based on the hypotheses that, in the absence of any training intervention, there would be no change, or only a small change, in mean total scale ratings between registration (T0) and the start of the course (T1); at the end of the course (T2), there would be an improvement in mean scores compared to T1 and this could be attributed to the training intervention; at follow up, three months later (T3), the improvement would have been sustained.

Because we were able to collect data from a number of sites in different parts of the country all providing largely similar courses we could assess the outcomes for each independently. If the effects were consistent, as predicted, it would be possible to claim that they were likely to be associated with the training intervention, rather than some other influence.

4.2.1. Samples

The courses included in the study were selected through consultation with the training coordinators. One consideration was that we should include courses which were running in a number of the sites. The second was to have a range of courses in terms of topic and level. A third was to select courses on topics of particular current concern, such as young people with harmful sexual behaviours, disabled children and female genital mutilation.

The final sample of courses and the numbers of respondents in the study are shown in Table 2.

[10] It would have been possible to have a much shorter gap, but this would have meant no useful period of follow-up, so it would not have been possible to gauge learning retention.

Table 2: Summary of courses offered and evaluated and respondents (2007-8)

	SITE A	SITE B	SITE C	SITE D	SITE E	SITE F	SITE G	SITE H	TOTAL
Courses offered in LSCB sites									
Foundation (1 day)	3	0	14	0	0	0	0	0	17
Level 1 (1 day)	12	13	11	1	10	0	0	5	52
Level 2 (1/2 day revision)	0	0	6	2	0	0	0	0	8
Level 2 (1 day)	16	0	5	27	10	56	18	7	123
Level 3 (2 day)	16	1	12	3	10	0	0	0	42
Level 3 (1 day)	0	20	16	0	5	8	40	4	93
Level 3 (2 day)	16	6	6	3		0	0	0	31
Total	**47**	**51**	**48**	**41**	**35**	**64**	**69**	**16**	**366**
Courses in evaluation project									
Foundation- Traditional	1	0	0	0	0	0	0	0	1
Level 1 Introduction to Child Protection	6	8	5	4	5	0	0	3	31
Level 2 Working Together to Safeguard Children	4	1	5	0	5	4	7	4	30
Safeguarding Disabled children	0	1	2	2	2	0	4	0	11
Domestic abuse and safeguarding children	1	2	4	2	1	4	5	2	21
Parents with mental health problems and safeguarding	1	1	2	0	2	0	2	0	8
Drug misusing parents and safeguarding	2	1	0	0	2	3	0	0	8
Female Genital Mutilation	1	2	0	0	0	0	0	0	3
Young People with Sexually harmful behaviour	2	2	0	1	0	2	4	0	11
Child Protection Conferences	0	0	3	0	1	0	0	0	4
Child Neglect	0	0	0	1	0	0	0	0	1
Total	**18**	**18**	**21**	**10**	**18**	**13**	**22**	**9**	**129**
Respondents (measures)									
Identifying and responding (CAS)	90	150	95	3	130	30	170	80	748
Interprofessional Working (IPW)	39	18	45	13	67	28	137	58	405
Safeguarding Disabled Children (DC)	n/a	17	45	21	39	n/a	71	n/a	193
Domestic Abuse (DA)	21	33	24	0	63	44	55	27	267
Drug Misusing Parents (DMP)	23	19		n/a	5	59	n/a	n/a	106
Parental Mental Health (PMH)	15	21	9	n/a	40	n/a	36	n/a	121
Young People with sexually harmful behaviour (AYPSAS)	43	31	n/a	8	23	50	42	n/a	197
Female Genital Mutilation (FGM)	16	36	n/a	n/a	n/a	n/a	n/a	n/a	52
Total	**247**	**325**	**218**	**45**	**367**	**211**	**511**	**165**	**2089**

4.2.2. Procedures

All LSCB interagency courses were advertised in a brochure distributed to staff through participating agencies. All intending participants were required to apply in advance to the LSCB Training Coordinator or the Training Administrator. Applications had to be supported by their line manager who was asked to confirm that staff would be released to participate in the training. In the event of a course being oversubscribed, the training coordinator in the participating agency was required to make a decision based on agency priorities as well as to ensure a good mix of participants for learning purposes.

Around six weeks before the start of the course, successful applicants were sent a letter or email confirming their registration for the course. The training administrator was asked to enclose with this a letter from the research team inviting participants to take part in the evaluation, together with an information sheet (see Appendix for further details). The information sheet explained the procedures for ensuring confidentiality and assured them that their participation in the evaluation was voluntary; if they chose not to participate this would have no impact of the training the training they were to receive. A demographic form and the T0 scale were included and they were asked to return this to the training administrator before the start of the course (see Appendix for further details). In order to permit the researchers to identify completed questionnaire from the same respondents over time, participants were asked to create a memorable personal code and insert this at the top of the scale questionnaire.

At the start of the course, all course participants were given the information sheet and the T1 scale. If they had not previously completed the demographic questionnaire, they were asked to do so. Completion of these forms took 10 to 15 minutes. The T3 questionnaire was distributed ten minutes before the scheduled end of the course and participants invited to complete it together with the LSCB's own evaluation form before leaving. Three months later, the training administrator posted or emailed the follow up (T3) form to participants. As an incentive, participants were informed that if they returned the completed T3 questionnaire to the training administrator and gave their contact details, they could request a certificate from the University of Bristol. This would verify their participation in the research and could be used as evidence of their continuing professional development (CPD).

4.2.3. Implementation of learning

Trainees (course participants).

Following completion of the last set of forms (T3), participants in the training courses on safeguarding disabled children were given the option of volunteering to be interviewed by one the project researchers. If they were willing to be interviewed by telephone, they were asked to self-identify and put their name and contact details on a detachable form which was included in the e-mailed/posted Time 3 package. A list of potential interviewees was compiled by the research staff. Prior to the telephone interview, each was sent a cover letter, which explained the research project in full, an information sheet, which included some commonly-asked questions and answers, as well as overview of the topic areas to be covered in the interview.

4.2.4. Ethical approval

The procedures described above, together with the letter of invitation to course participants, further information and frequently asked questions and answers were all reviewed and approved on 30th March 2007 by the Research Ethics Committee of the School for Policy Studies acting on behalf of the University of Bristol.

4.2.5. Analysis of change over time

Because there was a substantial amount of missing data, especially at T3 (3 month follow up), sample sizes for analysis were maximised by pairing respondents at successive time points (T0-T1; T1-T2; T2-T3). The mean scores for participants in each of the participating LSCBs at the different time points, together with the overall mean total scores were calculated. Note that in the following chapters if LSCB scores are not shown at all time points this is because data were not available. The site means provide supporting evidence of any statistical effects and enables a comparison of baseline (T0) scores and of the extent of changes in scores over time between sites. In other words, if the pattern is similar in all LSCBs, irrespective of baseline scores, the courses are having a similar effect on participants' scores.

Differences in mean total scores on the scale were assessed using the paired *t*-test. In addition to p-values (alpha 0.5), 95% confidence intervals for the mean differences and an estimate of the effect sizes are presented. The effect size is estimated using Cohen's *d* and an interpretation provided (e.g. "negligible", "strong"). The effect size is a more reliable indicator for making statistical inferences than simple *p*-values because it takes into account the size of the sample. A combination of a "strong" effect and a highly statistically significant p-value (<.001) provides strong statistical evidence of differences between scores with a sample.

Differences in mean scores on each item in the questionnaires were also analysed, this time using the Wilcoxon signed ranks test for nonparametric data. We employed this more conservative test because the distribution of scores on a single item was frequently skewed (e.g. when respondents generally agree or disagree quite strongly with an item).

4.2.6. Graphical presentations

Two kinds of charts are presented. The first is a simple line chart illustrating mean total scores in each site at each time point, plus the overall mean total score. Strictly speaking, the points should not be joined by a line because the cases at each time point are not the same. It would be correct to present these in the form of bar charts, however, this could mean up to nine bars at each of the four time point, i.e. 9 x 4 = 36 bars on the chart. The graphical representation would be unintelligible. The line charts however give an indication of the variation between sites so that patterns can be detected. It is important to note that the number of participants in each site varies considerably. The overall trend is of course illustrated in the "total" line.

The second chart is a box plot representing the distribution of the scores at each time point for the total sample combined. This is a form of a box plot, but much more informative. The line in the middle of the box represents the median (middle) value: 50% of participants scored above this line and 50% below. The boxes (top and bottom) represents 50% of the scores and the "whiskers" the top and bottom quartiles (25%). There are sometimes a few "outliers" which reflect extreme scores on either end of the scoring continuum.

4.2.7. Predictors of outcome

The potential effects on scores at the start of the course (T1) of differences between participants were explored using linear regression analysis. Potential predictor variables entered into the analysis were age, gender, ethnicity, profession, years since qualification, whether their attendance was required or voluntary, and the LSCB. Similarly, the effects of these predictor variables, plus T1 scores, on scores at T2 were also explored using the same method. These analyses control simultaneously for the influence of all other factors

and therefore permit an interpretation of the effects of, for example, profession on changes in knowledge and self-efficacy.

4.3. Discussion

At the conclusion of their systematic review, Carter et al. (2006) wrote: "The challenge of assessing the impact of interventions in medical education due to multiple and confounding variables is acknowledged. For this reason the concept of "best available medical education" or *BEME*[11] has evolved. It represents a pragmatic way forward in an area where double blinded, random control studies are not practical."[12]

The methodology used to assess the outcomes of the courses in this study is an example of BEME, or its equivalent. The research design is more robust than those previously employed in this area, which to date have used simple pre- and post-test designs. Only four other studies attempted a follow-up beyond the immediate post-training period: (Cerezo and Pons-Salvador, 2004; Palusci and McHugh, 1995; Socolar et al., 1998; and Burton et al. 2002). Further, we developed much more comprehensive measures of learning outcomes, including both subjective outcomes (e.g. attitudes) and objective ones (knowledge) as well as self-efficacy. As reported in the following chapters, we tested these measures carefully and found that most performed creditably.

However, we must acknowledge the limitations. First, we do not have a control or comparison group of professionals from different agencies who did not participate in interagency training courses. This limits the explanatory power of the research design because we cannot say for certain that the gains in self-reported knowledge and self-efficacy could not have been achieved equally well by another method of learning, such as a uni-disciplinary (single agency) course or reading assignments.

Second, the design assumes that there will be a reasonable response rate at all four time points. As we shall see in the chapters which follow, the response at T3 three month follow-up was often poor, so we cannot be very confident that learning was sustained.

Third, the results cannot 'prove' that interagency training 'works' to safeguard children; the world is more complicated than that, as we have tried to explain. What we can hope to do is to take some steps on the road by examining whether or not the educational outcomes are achieved.

Finally, we are keen to encourage LSCB training sub groups and training co-ordinators to engage in systematic evaluations of their courses. A toolkit, based on the experience of this project is provided in the Appendix.

4.4. References

Burton, D., Stanley, D. and Ireson, C. (2002) Child advocacy outreach: using telehealth to expand child sexual abuse services in rural Kentucky. *Journal of Telemedicine and Telecare*, 8: S2: 10–12.

Carpenter,J. (2005) *Evaluating the Outcomes of Social Work Education*. London: Social Care Institute of Excellence.

Carpenter, J., Brown, S. and Griffin, M. (2007) Prevention in integrated children's services: the impact of Sure Start on referrals to social services and child protection registrations. *Child Abuse Review*, 16: 17-31.

[11] http://www.bemecollaboration.org/ (accessed 24.02.09)
[12] See also (Hammick and Haig 2007).

Carpenter, J., Milne, D., Lombardo, C. and Dickinson, C. (2007) Process and outcomes of training in psychosocial interventions in mental health: a stepwise approach to evaluation. *Journal of Mental Health*, 16: 505-20.

Carter, Y., Bannon M., Limbert , C., Docherty, A. and Barlow, J. (2006**)** Improving child protection: a systematic review of training and procedural interventions, *Archives of Disease in Childhood*, 91: 740-43.

Cerezo A, and Pons-Salvador G. (2004) Improving Child Maltreatment detection systems: a large scale case study involving health, social services and school professionals. *Child Abuse and Neglect*, 28: 1153-69.

Hammick, M. and Haig, A. (2007) The Best Evidence Medical Education Collaboration: processes, products and principles, *Clinical Teacher*, 4: 42-5.

Henry, BM., Ueda, R., Shinjo, M, and Yoshikawa, C. (2003) Health education for nurses in Japan to combat child abuse. *Nursing and Health Sciences*, 5: 199-208.

MacDonald, G (2001) *Effective Interventions for Child Abuse and Neglect: An Evidence-Based Approach to Evaluating and Planning Interventions*. Chichester: John Wiley.

MacLeod, C., Dorman, O., Livingstone, A., McCormack, L., Lees, J., and Jenkins, M. (2003) Teaching junior doctors to recognise child abuse and neglect. *Medical Education*, 37: 1046.

Palusci, V. and McHugh, M. (1995) Interdisciplinary training in the evaluation of child sexual abuse. *Child Abuse and Neglect,* 19: 1031-8.

Socolar, R., Raines., B, Chen-Mok, M., Runyan, D., Green, C. and Paterno S. (1998) Intervention to improve physician documentation and knowledge of child sexual abuse: A randomised controlled trial. *Pediatrics*, 101: 817–24.

Salas, E. and Cannon-Bowers, J. (2001) The science of training: a decade review of progress, *Annual Review of Psychology*, 52: 471-99.

Weintraub, B., Lazzara, P., Fuchs, S. & Wiltsek, D. (2002) Child Maltreatment Awareness for Hospital Providers. *International Journal of Trauma Nursing*, 8: 81-3.

5. Identifying and Responding to Child Protection Concerns

5.1. Introduction

Safeguarding children and young people is the responsibility of all staff. *Working Together* (2006) identifies as a target group for training all those in "regular contact" with children and young people and with adults who are parents or carers. It points out that many people, both paid staff and volunteers are in a position to identify concerns about maltreatment. These include "…housing and hospital staff, youth workers, childminders, private foster carers, those working with children in residential and day care settings and those working in sport and leisure facilities in both a paid and unpaid capacity" (p. 94). This introductory training should be focused, it says, on how to work together to safeguard and promote the welfare of children (Sec. 4.19).

The responsibilities of staff and volunteers in relation to safeguarding are explained in practice guidance (HM Government, 2006) issued in support of the government's policy on children, *Every Child Matters*. This document focuses on "what to do if you have concerns about children" in order to safeguard them and promote their welfare (p.5). Of course, what is also essential is that causes of child protection concerns are identified.

5.1.1. Previous evaluations of training on child abuse

In Chapter 1, we described a systematic review of the literature by Carter et al., (2006). This review identified four before and after studies of the outcomes of training on the identification of child maltreatment concerns: Weintraub et al. (2002) and Henry et al. (2003) reported evaluations of awareness raising course for nurses in the US and Japan respectively and Palusci and McHugh (1995) and MacLeod et al. (2003) evaluated training for junior doctors in the US to recognise child abuse and neglect. However, of the three studies that tested knowledge before and after training, only Palusci and McHugh's (1995) study demonstrated a conclusive improvement.

5.1.2. Courses: Traditional

Seven out of the eight participating LSCBs were offering courses described as foundation or introductory courses on child abuse during the study period. These courses were open to any staff in the LSCB area, although those from private sector agencies, including private schools, which were not LSCB partners had to pay. The courses offered 15 to 25 places each.

The learning outcomes of the courses sampled were almost identical and are summarised in Box 1. These outcomes follow the recommendations in *Working Together* which are outlined above. These courses all lasted one day, i.e. seven hours, including lunch. Lunch was seen as a good opportunity for networking and informal exchanges between staff from different agencies.

Many of these courses made use of the DfES sponsored training pack *Safeguarding Children: a shared responsibility* (NSPCC, 2007) which contains training sessions, handouts and slides and video clips. The courses were highly interactive, as indicated in the analysis of content and methods presented in Chapter 4 (Table 2). They inevitably included small group discussion of case scenarios.

5.1.3. Courses: E-learning

Four of the LSCBs also provided e-learning courses. We had hoped to undertake a comparative evaluation of the outcomes of these courses in comparison with the traditional

face-to-face versions described above. The e-learning providers were keen to cooperate but unfortunately technical challenges proved too difficult to resolve in the time available.

BOX 1: LEARNING OBJECTIVES OF COURSES

- Investigate value issues around child protection
- Learn definitions of child abuse
- Recognize key signs and symptoms of abuse
- Understand impact of abuse upon children, families
- Understand local multi-agency child protection procedures and guidelines
- Describe how to make a referral to social services
- Gain awareness of the responsibilities of different agencies
- Recognize the different working relationships between agencies and the different professional roles within child protection

Summary of learning objectives: Provides opportunity for staff who have frontline responsibility for the protection and safeguarding of children. The purpose of course is to familiarize participants with a working knowledge of local child protection procedures and guidelines.

5.2. Methods

5.2.1. Procedures

The procedures used were as described in Chapter 4.

5.2.2. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

5.2.3. Child Abuse Scenarios (CAS)

All of the existing studies of knowledge for identifying child protection concerns mentioned above were carried out in hospitals in the US or Japan. Having examined them, we concluded that none were suitable because of the very different cultural and organisational contexts. Consequently, with the help of members of the training coordinators' group, we devised a new measure. This was based on the observation that all courses were using some form of case scenario group based exercise in the first session of their course.

The measure therefore comprised brief written presentations of typical potential causes for concern that participants were likely to encounter. Respondents were asked to (1) identify the type or types of abuse or neglect indicated, or to say that there was no abuse, and (2) to choose one of two possible actions, or say "no action". The final measure is included in the Appendix to this chapter. Preceding versions had been developed with the help of a Delphi group of eight national experts in child welfare who made successive ratings which were shared with the other group members in order to attain a consensus on the correct responses. Where the experts were unable to agreed, the scenario was dropped. In two instances (scenarios 1 and 6), the experts agreed that one of two responses was acceptable as a correct answer.

With regard to the most appropriate action to be taken, we consulted the training coordinators as well. It became apparent that the 'correct' answer could differ in different LSCB areas because of differing policies and procedures. Also, someone already working in

children's social services was unlikely to give the response 'refer to social services' which made scoring problematic.

The measure was piloted on three LSCB courses and revised with the elimination of two scenarios which participants clearly found confusing, as judged by their inconsistent responses.

5.2.3.1. Scoring: 'Type' Knowledge Test

Knowledge of the type of abuse was scored as follows. Respondents were given a score of 1 if they: reported emotional or neglect for Scenario 1; neglect for Scenario 2 and 3; physical abuse for Scenario 4 and Scenario 5; neglect for Scenario 6; physical abuse or neglect for Scenario 7; emotional abuse for Scenario 8; and, neglect for Scenario 9. Don't know was recoded into 'Incorrect type' and assigned a score of 0.The 'Type' Knowledge test has 9 items and possible scores could range from 0 to 9.

5.2.3.2. Scoring: 'Action' Knowledge Test

Knowledge of the appropriate action to take to safeguard children and young people was assessed as follows. Respondents were given a score of 1 if they felt that some form of action should be initiated (1 = Initiate a Common Assessment Framework (CAF) response or 2 = make a referral to social services), No action (3) = -1 points and for Don't Know (4) they were given 0 points. The 'Action' Knowledge test has 9 items and possible scores could range from -9 to +9.

5.2.4. Data analysis

Procedures for data analysis are described in Chapter 4.

5.3. Results

5.3.1. Participants

Demographic data from the forms completed by participants were available on just over 500 participants (out of nearly 750 taking part in the evaluation (69%) from seven LSCB sites (Table 1). We also analysed anonymised copies of the attendance sheets forwarded by the training administrators. These gave information about profession/occupation and gender on 725 (97%) of participants. Where there were discrepancies in the data from these two sources they are noted below.

Around one in four participants who completed the demographic form was a social worker, although nearly another third were present according to the attendance sheets. One in five were teachers and a similar proportion were nurses. There were small numbers of counsellors, probation officers, doctors and police officers. However that attendance sheets indicate that that there were twice as many probations officers and police present, suggesting that they also chose not to take part in the evaluation. Nearly one quarter of respondents were categorised as "other"; most of these described themselves as support workers, including family support workers. There were eleven who worked in the general field of youth services, seven worked in education or an education related post (e.g. education welfare), and three were foster carers. It is evident that these introductory level courses were attracting the wide range of professions and occupations sought.

The great majority of participants were white and female. There was a wide range of service experience represented. Thus, while one in five had been in service for a year or less, a third had been working for over ten years. However, four in ten had been in their current post for a year or less, which suggests that many course participants were taking the course because it was relevant to, or a requirement of their new job. In fact, over a third reported that their primary reason for being there was that they had been required to attend.

TABLE 1: COURSE PARTICIPANTS

		NUMBER	%
Site	A	90	12.0%
	B	150	20.1%
	C	95	12.7%
	E	130	17.4%
	F	30	4.0%
	G	170	22.7%
	H	80	10.7%
	Total	745	100.0%
Gender	Female	432	85.7%
	Male	72	14.3%
	Total	504	100.0%
Age	18-30	119	23.2%
	31-40	171	33.3%
	41-50	176	34.2%
	51+	48	9.3%
	Total	514	100.0%
Years in service	1 year or less	96	19.3%
	1-5 years	125	25.2%
	5-10 years	108	21.7%
	10 or more years	168	33.8%
	Total	497	100.0%
Years in post	1 year of less	198	40.0%
	1-5 years	204	41.2%
	5 or more years	93	18.8%
	Total	495	100.0%
Profession/occupation	Social work	108	24.7%
	Counselling/Psychologist	12	2.7%
	Probation	10	2.3%
	Teacher	86	19.7%
	Nurse/midwife	91	20.6%
	Doctor	11	2.5%
	Police	18	4.1%
	Other	102	23.3%
	Total	437	100.0%
Ethnicity	White	460	89.7%
	BME	53	10.3%
	Total	513	100.0%
First motive for attendance	Volunteered	320	65.2%
	Required	171	34.8%
	Total	491	100.0%

A series of chi-square tests of association established that 'nurse/midwife/doctors' and 'other professions' as well as white respondents were more likely to respond at both time points than were other respondents. In addition, participants in sites F and B were more likely to respond at both time points. There no other statistically significant differences in the proportions of respondents at T0 and T1 by age group, gender, years since professional qualification, years in present post, ethnicity and primary motive for attendance (volunteered

or required). This suggests that respondents at T0 were, in terms of their demographic characteristics, reasonably representative of course participants in general.

5.3.2. Outcomes: Type Knowledge scores

5.3.2.1. Changes in mean total Type Knowledge scores over time

Mean total 'Type' Knowledge scores for participants in each LSCB at each time point (where available) are shown in Figure 1. The total mean scores for all courses are also shown. The pattern of responses between registration, start and end of the course is consistent and clear and is confirmed by the statistical analysis (Table 2). Thus, there is no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("large" effect size), which was highly statistically significant. Poor response rates at T3 (n=36 matched respondents) prevented estimation of the extent to which learning outcomes were retained three months after the course finished.

FIGURE 1: TOTAL 'TYPE' KNOWLEDGE SCORES (MEANS) BY LSCB

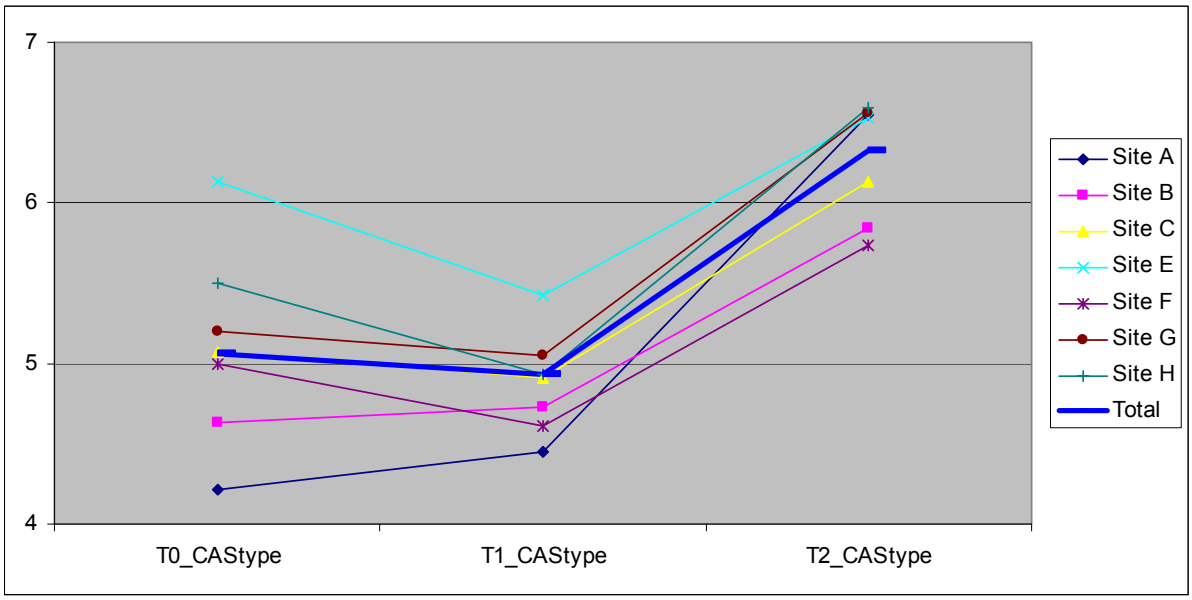
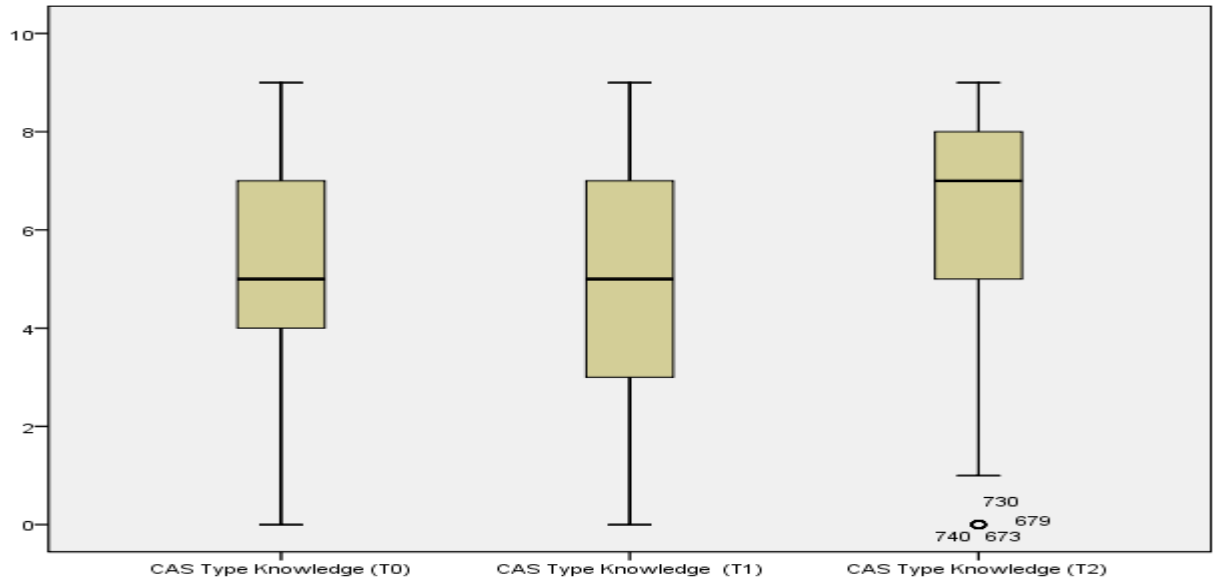


TABLE 2: CAS 'TYPE' KNOWLEDGE SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	137	5.10	2.23	5.43	2.34	0.33	2.28	0.04	0.61	136	0.024	0.14
T1 - T2	303	5.10	2.45	6.28	2.14	1.18	8.86	0.92	1.44	302	<0.001	0.51

The same overall pattern is shown in the box and whisker plots (Figure 2). The distribution of scores at T2 indicates a substantial improvement over T1 for around half of the participants. The median score was around 7/9 (78% correct), indicating that more than half did very well. However, the long "whisker" at the bottom for the T2 distribution indicates that a quarter of respondent were still scoring quite poorly, identifying the correct action in only 5/9 cases (56%).

FIGURE 2: DISTRIBUTION OF TOTAL 'TYPE' KNOWLEDGE SCORES (POSSIBLE RANGE 0 TO 9) AT SUCCESSIVE TIME POINTS



5.3.2.2. Changes in Type Knowledge item scores over time

An analysis of differences between mean test scores for each scenario at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 3 of the 9 score items (Table 3). This more detailed analysis shows that most scenarios were responded to correctly by most participants. The scenario which caused most difficulty, or perhaps controversy, was scenario 8. This case was considered by the expert Delphi panel to be possible emotional abuse with the recommended action being referral to children's social services. However, it is clear that most course participants did not take this position at the start of the course. At the end of the course, a few participants had apparently changed their minds, but the mean score remained very much lower than for the other scenarios.

TABLE 3: CAS 'TYPE' KNOWLEDGE TEST SCORES: PAIRED SAMPLES *T*-TEST

	T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Scenario 1	0.83	0.37	0.89	0.32	415	-2.621	0.009
Scenario 2	0.71	0.45	0.73	0.44	258	-0.717	0.473
Scenario 3	0.87	0.34	0.80	0.40	339	-2.556	0.011
Scenario 4	0.90	0.30	0.92	0.27	369	-1.000	0.317
Scenario 5	0.91	0.29	0.92	0.27	427	-0.866	0.386
Scenario 6	0.77	0.42	0.79	0.41	323	-0.563	0.574
Scenario 7	0.82	0.38	0.85	0.35	259	-1.000	0.317
Scenario 8	**0.43**	**0.50**	**0.54**	**0.50**	**288**	**-3.536**	**<0.001**
Scenario 9	0.85	0.36	0.90	0.30	388	-2.393	0.017

Predictors of Type Knowledge scores

Regression analysis of T1 'Type' Knowledge test scores showed that there were several significant predictors of test scores at T1 (see Table 4). In addition to the usual finding that these were predicted by scores at registration, it was apparent that being older (over 40 years of age) was associated with lower scores at the start of the course, all other factors having been controlled for. Conversely, nurses were inclined to have higher scores. Those who were required to attend the training were likely to show quite strong gains even *before* the start of the course. The regression model accounted for a substantial 65% of the variance.

TABLE 4: PREDICTORS OF 'TYPE' KNOWLEDGE TEST SCORES AT T1 (LINEAR REGRESSION ANALYSIS)

	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	0.45	0.85		0.52	0.602	-1.26	2.15
T0 Type Score	0.93	0.07	0.87	12.58	***<0.001***	0.78	1.08
Age							
31-40	-0.67	0.49	-0.14	-1.38	0.173	-1.64	0.30
41-50	-1.54	0.51	-0.32	-3.00	***0.004***	-2.57	-0.52
51+	-1.81	0.64	-0.25	-2.82	***0.006***	-3.10	-0.53
Male	0.60	0.46	0.09	1.29	0.201	-0.32	1.52
Profession							
Teacher	0.82	0.50	0.15	1.65	0.104	-0.17	1.81
Health	1.06	0.51	0.20	2.06	***0.043***	0.03	2.08
Community protection	0.51	0.73	0.06	0.70	0.488	-0.95	1.97
Other profession	0.51	0.50	0.09	1.01	0.316	-0.49	1.51
Attendance Required	1.37	0.38	0.27	3.56	***0.001***	0.60	2.13
Adjusted R Square	***0.65***						

What predicted high 'Type' knowledge scores at the end of the course (T2)? The regression analysis (see Table 5) identified that in addition to scores at the start of the course, being in Site E and profession were significant predictors of scores at T2. It also showed, again controlling for all other factors, that participants in Site E made somewhat smaller gains than participants in the other sites. However, the explanation for this is suggested in Figure 1 which shows that, on average, participants started off with higher scores, in other words, they had less to gain. At the end of the course, their mean total scores were relatively high. The other finding was that being a community protection officer (probation and police officers combined for the sake of the analysis because of small numbers) predicted a high score at T2. This suggests that they had, in general, learned more from the courses than other groups.

TABLE 5: PREDICTORS OF 'TYPE' KNOWLEDGE TEST SCORES AT T2 (LINEAR REGRESSION ANALYSIS)

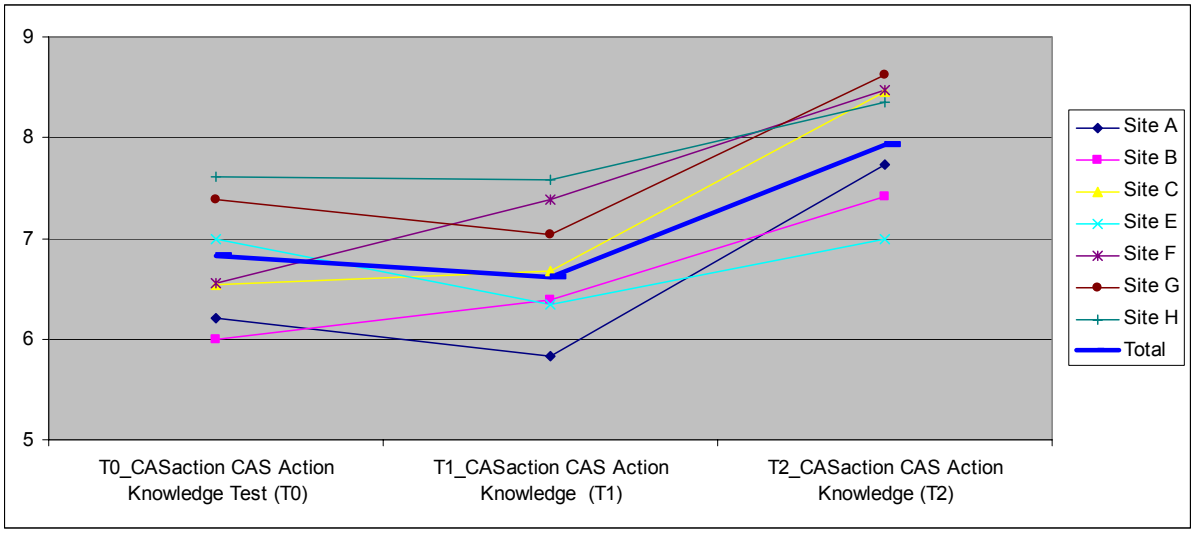
	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	4.68	0.62		7.60	***<0.001***	3.46	5.89
T1 Type Score	0.42	0.05	0.52	7.63	***<0.001***	0.31	0.53
LSCB							
Site B	-0.70	0.48	-0.15	-1.45	0.149	-1.65	0.25
Site C	-0.42	0.57	-0.06	-0.74	0.463	-1.56	0.71
Site E	-1.49	0.52	-0.30	-2.88	***0.005***	-2.52	-0.47
Site F	-0.84	0.79	-0.08	-1.07	0.288	-2.40	0.72
Site G	-0.84	0.52	-0.16	-1.62	0.108	-1.88	0.19
Site H	-0.02	0.54	0.00	-0.03	0.975	-1.09	1.06
Profession							
Teacher	0.59	0.40	0.12	1.46	0.147	-0.21	1.38
Health	0.15	0.41	0.03	0.37	0.710	-0.65	0.96
Community protection	1.25	0.60	0.17	2.07	***0.040***	0.06	2.43
Other profession	0.26	0.39	0.06	0.68	0.500	-0.51	1.03
Adjusted R Square	***0.27***						

5.3.3. Outcomes: Action Knowledge scores

5.3.3.1. Changes in mean total Action Knowledge scores over time

Mean total 'Action' Knowledge scores for participants in each LSCB at each time point (where available) are shown in Figure 3. The total mean scores for all courses are also shown. Care must be taken in interpreting the results from the individual sites. For example, the apparent increase in T0 to T1 in site F is dependent on only a handful of respondents. However the overall pattern of no improvement between registration and the start of the course, followed by a substantial increase at the end of the course is quite clear.

FIGURE 3: TOTAL 'ACTION' KNOWLEDGE SCORES (MEANS) BY LSCB



This is confirmed by the statistical analysis (Table 6). Thus, overall, there was no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is zero. Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("large" effect size), which was highly statistically significant.

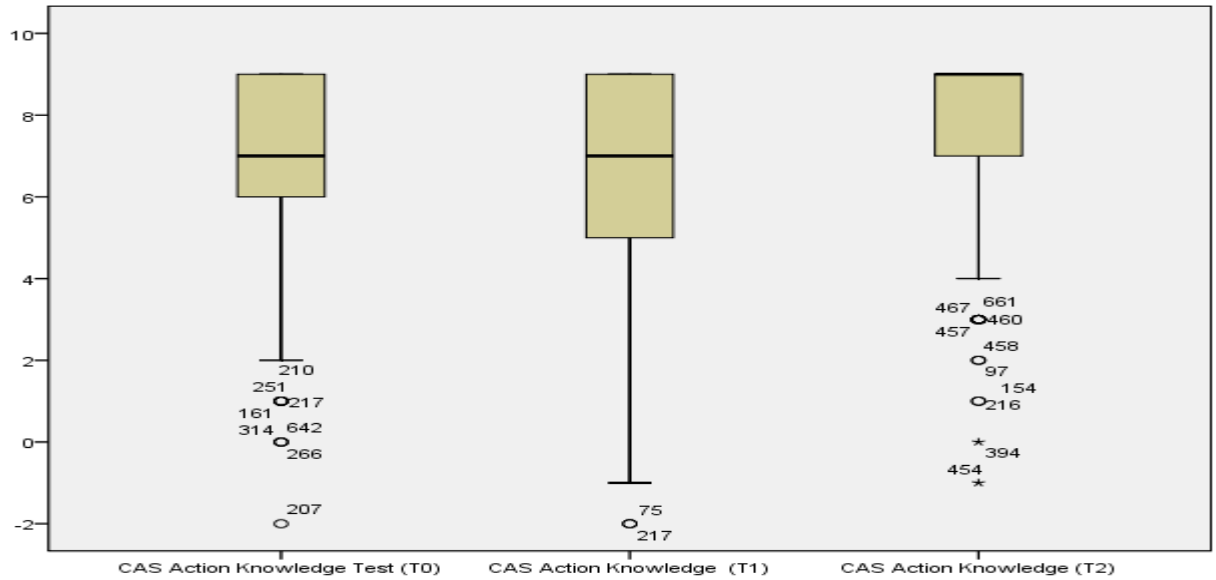
The maximum score on the scale is 9 points and so the chart illustrates that respondents in some sites were achieving close to the maximum score. In site E however, the end of course score somewhat lower than the corresponding scores in the other sites; the pattern is very different in site A which had an even lower mean score at T1 but which finished considerably higher at T2. Poor response rates at T3 (n=52 matched respondents) prevented estimation of the extent to which learning outcomes were retained three months after the course finished.

TABLE 6: CAS 'ACTION' KNOWLEDGE SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 – T1	137	6.85	2.34	6.85	2.51	0.00	0.00	-0.26	0.26	136	1.000	0.00
T1 – T2	303	6.68	2.54	7.80	1.88	1.12	8.06	0.85	1.39	302	<0.001	0.50

The same overall pattern is shown in the box and whisker plots (Figure 4). The distribution of scores at T2 indicates a substantial improvement over T1 for around three quarters of the participants. Indeed the median score at T2 was 9, indicating that half the participants answered every scenario correctly. The very long whisker at T1, representing a group with poor scores had shortened considerably at T2. It is noticeable that there are some outliers, with few scoring below zero at more than one time point.

FIGURE 4: DISTRIBUTION OF TOTAL 'ACTION' KNOWLEDGE SCORES (POSSIBLE RANGE -9 TO +9) AT SUCCESSIVE TIME POINTS



5.3.3.2. Outcomes: Changes in Action Knowledge item scores over time

An analysis of differences between mean test scores for each scenario at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on all the nine 9 scenarios (Table 7), however changes in item means were very small. The only point of interest is Scenario 8 where it is clear that most participants did not agree with the expert panel and thought that "no action" was the correct response.

TABLE 7: CAS 'ACTION' KNOWLEDGE TEST SCORES: PAIRED SAMPLES *T*-TEST

	T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Scenario 1	0.86	0.42	0.87	0.42	224	-6.272	<0.001
Scenario 2	0.64	0.67	0.67	0.62	220	-5.497	<0.001
Scenario 3	0.80	0.49	0.80	0.46	225	-2.807	0.005
Scenario 4	0.84	0.45	0.89	0.37	227	-2.695	0.007
Scenario 5	0.86	0.39	0.89	0.37	217	-2.974	0.003
Scenario 6	0.73	0.53	0.72	0.56	207	-3.909	<0.001
Scenario 7	0.87	0.41	0.84	0.43	212	-2.515	0.012
Scenario 8	0.23	0.81	0.32	0.82	193	-6.886	<0.001
Scenario 9	0.88	0.42	0.85	0.45	209	-4.057	<0.001

5.3.3.3. Predictors of Action Knowledge scores

Regression analysis of T1 'Action' Knowledge test scores showed that baseline knowledge of what action to take was a significant predictor of test scores at T1 (see Table 8). The analysis also shows that, taking all other factors into account, teachers and "other professions" more likely to improve their scores before coming on the course than the other occupation groups. The regression model accounted for 60% of the variance, which is quite high.

TABLE 8: PREDICTORS OF 'ACTION' KNOWLEDGE TEST SCORES AT T1 (LINEAR REGRESSION ANALYSIS)

	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	0.08	1.01		0.08	0.936	-1.92	2.08
T0 Action Score	0.84	0.08	0.81	10.86	***<0.001***	0.69	0.99
Profession							
Teacher	1.20	0.59	0.20	2.04	***0.045***	0.03	2.37
Health	0.68	0.60	0.12	1.12	0.267	-0.53	1.88
Community protection	1.07	0.87	0.11	1.24	0.219	-0.65	2.80
Other profession	1.47	0.59	0.24	2.49	***0.015***	0.29	2.65
Adjusted R Square	***0.60***						

What predicted high scores at the end of the course (T2)? The regression analysis identified that baseline scores at the start was a statistically significant predictor. In other words, controlling for all other potential predictors, the higher the mean total score at the start, the higher the score at the end. It also showed, again controlling for all other factors, that participants in Site E made somewhat smaller gains than participants in the other sites. The regression model accounted for 26% of the variance.

5.4. Discussion

The introductory courses in this sample were evidently attracting many of those "in regular contact with children" who were in the 'target audience' identified in *Working Together* (2006), including support workers as well as nurses and social workers. However, some groups were barely represented, including housing staff, child minders, librarians and leisure facilities staff. It may be that these staff are been trained on a single agency basis; possibly this is justified with the reason that they do not interact with social workers and nurses and other 'core' safeguarding professionals so much. However, it could also be that these staff are not prioritised as targets for these introductory courses and that their access to them is limited. It may be that they would be reached more effectively by e-learning.

In comparison to the level 2 and level 3 courses which feature in the following chapters of this report, these introductory courses featured staff with longer service experience; over half had more than five years experience whereas on the specialist courses almost all participants had under 5 years experience. A substantial minority were relatively new to their current post and it would seem that many were taking the course as a job requirement rather than voluntarily.

The 'child abuse scenarios' measure developed specifically to assess the outcomes of these courses performed satisfactorily for the most part and showed sensitivity to change in "type knowledge" (recognising abuse and neglect) and in "action knowledge" (knowing what to do), when used as a scale. One of the items in the measure did not perform as expected and should probably be replaced.

In general, as predicted by the evaluation hypothesis (see chapter 4), there were no statistically significant changes in mean total scores between registration (T0) and the start of the course (T1). However, from the start to the end (T2) there was very strong statistical evidence of improvements in participant's scores: the statistical significance of differences in mean total scores was very high and the effect size was very large. This suggests that we can attribute the improvement to the impacts of attending the course. However a note of caution is needed because the number of matched pairs at T0-T1 is only 45% of those at T2. It would be useful to follow up the profile of respondents who completed all four time points and to compare them with those who have completed two consecutive questionnaires (which was the criterion for inclusion in the paired means analysis). This would reveal whether those responding at the various time points differ from each other in important ways. For example, the response rate at T3 was extremely disappointing. It was easily the lowest of the courses evaluated in this project and so small as to be useless. The reasons for this very poor response are not clear. It may be that participants had less of an investment in the training than those on the other courses; for many it may be the only safeguarding course they take.

Nevertheless, the analyses showed that the great majority of participants taking these courses significantly increased their knowledge concerning the recognition of neglect and abuse in its various forms and also of what action to take. Substantially more participants gave more of the answers considered correct by the panel of experts at the end, compared to the beginning of the course. Further, the regression analyses indicated that, taking baseline scores into account, participants in most occupational groups benefited equally and those that were required to attend learned as much as these attending voluntarily.

While it is encouraging to have found quite strong evidence of positive outcomes (and we should remember that such evidence barely exists in the published research literature), this evaluation does not tell us whether the methods of teaching employed are any more or less effectively than other methods available.

We had hoped to be able to compare the outcomes of these face-to-face courses with those of people completing an on-line course. Unfortunately, this was not feasible in the time available for this study, but it is an evaluation which should be undertaken. Such an

evaluation should measure other outcomes considered to be important in safeguarding, especially interprofessional relationships and confidence and knowledge about working together. Proponents of interactive, interagency learning would claim that these outcomes could not be achieved by e-learning alone. Interagency working itself is the topic of the next chapter.

5.5. References

Carter, Y., Bannon M., Limbert , C., Docherty, A.**,** and Barlow, J. (2006**)** Improving child protection: a systematic review of training and procedural interventions, *Archives of Disease in Childhood*, 91:740-43.

Cerezo, A, and Pons-Salvador G. (2004) Improving Child Maltreatment detection systems: a large scale case study involving health, social services and school professionals*. Child Abuse and Neglect*, 28: 1153-69.

H.M. Government (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children.* London, DCSF.

H.M. Government (2006) *What to do if you're worried a child is being abused.* London, DfES.

Henry BM, Ueda R, Shinjo, M, and Yoshikawa C. (2003) Health education for nurses in Japan to combat child abuse. *Nursing and Health Sciences*, 5: 199-208.

MacLeod C, Dorman O, Livingstone A, McCormack, Lees J, and Jenkins M. (2003) Teaching junior doctors to recognise child abuse and neglect. *Medical Education*, 37: 1046.

NSPCC (2007) *Safeguarding Children. A Shared responsibility.* CD Rom. London, NSPCC.

Palusci, V. and McHugh, M. (1995) Interdisciplinary training in the evaluation of child sexual abuse. *Child Abuse and Neglect,* 19: 1031-8.

Weintraub, B., Lazzara, P., Fuchs, S. and Wiltsek, D. (2002) Child maltreatment awareness for hospital providers. *International Journal of Trauma Nursing*, 8: 81-3.

5.6. Appendix: Child Abuse Scenarios

Scenario 1: Levi is nine years old he lives with his mum and dad. Both parents drink regularly, recently their relationship has become conflictual which has resulted in physical abuse of one another. Levi was observed walking along the street with his mother, he was in tears and she appeared to be staggering.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Emotional or Neglect* No abuse □

Scenario 2: Jade is an eighteen month old child who has some developmental delay. The health visitor has noticed a bald patch on the back of her head. She is worried and feels that her development is delayed because she isn`t stimulated sufficiently.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Neglect* No abuse □

Scenario 3: Tracey is single parent who works as a teacher. She has to leave home at 7.30 every morning to get a lift to school. As a result she leaves her two boys in the house by themselves, Graham is nine and Brian is six. They are alone for an hour before they take themselves to school.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Neglect* No abuse □

Scenario 4: Imran is a thirteen year old who presents challenging behaviour and places considerable stress on his parents. He regularly attacks them. He arrives at school with a bruised eye, claiming that his father punched him. When his father is interviewed, he claims that he was defending himself from Imran.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Physical abuse* No abuse □

Scenario 5: Heather is fifteen. She has had a steady boyfriend for two years. Yesterday Heathers father came home unexpectedly during the day and found her in bed with her boyfriend. The boyfriend was thrown out and Heather was given what her father called “a good hiding”. She has several large bruises, although she was fully clothed when her father hit her.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Physical abuse* No abuse □

Scenario 6: Jane aged 13 and dual heritage lives alone with her mother. Her mother is a solicitor who works long hours, as a result Jane is often left to prepare her own meals and chooses to stay out late, sometimes not returning home in the evenings.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Neglect* No abuse □

Scenario 7: Sheila (24) and Des (38) are parents of Jodie, aged 14 months. Both parents have moderate learning disabilities. Whilst the parents express their deep love for their daughter, there have been a number of injuries sustained in the recent past due to inappropriate handling of the child. Support from the family`s health visitor has been beneficial and has resulted in significant but short term improvements in parenting standards. Recently, the parents have been told by their social worker that if they do not "buck up their ideas", Jodie will be removed. In the course of a home visit, the health visitor observes Jodie being force fed.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Physical abuse or Neglect* No abuse □

Scenario 8: John is fifteen years old. His father has recently discovered that John is having a sexual relationship with a long standing friend, James, who is seventeen. When confronted by his father, John tells his father that he is gay. John`s father now refuses to talk to John, has grounded him indefinitely and has forbidden him any kind of contact with friends.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Emotional abuse*. No abuse □

Scenario 9: Simon is ten years old and the eldest of five children. He appears much smaller than his peers. His clothing is often older and tattier than other children. You are told by his teacher that they suspect Simon has been taking food from other pupils lunch boxes which are stored in the hall. You are also informed that there are rumours in the community that both parents are using and dealing in drugs. His parents have never turned up to parents evening in all the years he has been at the school.

1. Initiate Common Assessment Framework (CAF)
2. Make a referral to social services
3. No action
4. Do not know

Primary type of abuse: *Correct answer: Neglect* No abuse □

6. Interprofessional Working for Safeguarding Children

6.1. Introduction

In this chapter we consider the outcomes of generic courses on interprofessional and interagency working to safeguard children. These courses were at 'Level 2', that is, they were designed for those who work regularly with children and young people, and with adults who are carers, and those who may be asked to contribute to assessments of children in need. This group should have a "…fuller understanding of how to work together to identify and assess concerns and to plan, undertake and review interventions (Working Together, 2006, 4.19)

The literature reviewed in Chapter 1 identified only one course which evaluated the outcomes on an interagency programme and, as noted, the outcomes of the courses themselves were not directly assessed.

6.1.1. Courses

All the eight participating sites were offering Level 2 interprofessional working courses; in two sites the courses had a specific focus on child neglect and child protection conferences respectively.

Two of the LSCBs offered one day courses and four offered the course over two days. Both types of course lasted seven hours including lunch, which was seen as a good opportunity for networking and informal exchanges between staff from different agencies.

One of these courses features in the analysis of content and methods in relation to the *Common Core* which is presented in Chapter 3 (see Table 2). This description indicates the highly interactive nature of these courses which aim to use the participants' existing knowledge and experiences as an important ingredient in the learning. The explicit assumption is that by learning together through discussion and problem solving that participants will be able to work together more effectively.

The learning outcomes of the courses sampled were very similar, apart from the particular emphases noted above. They are summarised in Box 1. It can be seen that they reflect the Working Together (2006) guidelines closely.

BOX 1: LEARNING OBJECTIVES OF COURSES

- Have a sound understanding of principles and processes for effective collaborative interagency work
- Understand the contribution made by other key agencies to safeguarding children
- Understand how prejudices and stereotypes around different jobs affect interagency working in relation to child protection
- Develop interagency working relationships
- Understand legal and organizational frameworks
- Understand the balance between vulnerability and resilience and its link to the assessment process
- Address the role of conferences as a multi-agency process

Summary of learning objectives: Provides opportunity for participants who have already received basic child protection training to improve understanding and knowledge of their own and other's responsibilities. Provides opportunity to explore with colleagues from other agencies challenges related to working together.

6.2. Methods

The procedures used were as described in Chapter 4.

6.2.1. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

There are various standardised measures which have been used to assess the outcomes of interprofessional education and training. These have recently been reviewed by Carpenter and Dickinson (2008). For the purposes of this evaluation, three scales developed by Pollard and her colleagues at the University of the West of England were chosen. These scales were designed to assess:

1. Attitudes to interprofessional learning
2. Interprofessional interaction
3. Interprofessional relationships

The scales had been used in a longitudinal study of a large programme of pre-qualifying interprofessional education involving a wide range of health and social care students, including nursing, social work and medical students. Pollard *et al.* (2004, 2005, 2006) reported the psychometric properties of the scale, including the internal consistency, test-retest reliability and factor structure of the scales as being very satisfactory. Because the scales were designed for a student group and were generic in content, the scales were adapted, with the permission of the authors, to make them more focussed. An example of an adapted scale item was as follows. Thus,

> "My skills in communicating with patients/clients would be improved though learning with students from other health and social care professions"

was adapted to:

> "My skills in communicating with families would be improved though learning with other professionals who engage in work to safeguard children".

The statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree"). Eight of the 26 statements were designed for reverse scoring in order to reduce response bias.

The adapted scales, combined in a single questionnaire, were piloted on one of the courses provided by an LSCB. The internal reliabilities of the adapted scales were assessed using Cronbach's alpha and all of the original 26 statements were retained for the analyses. The 26-item version of the scale, separated into learning (9 items), interaction (9 items) and relationships scales (8 items) used in the study are presented in Tables 3, 5, and 8 below. The reverse-scored items are indicated.

6.2.2. Data analysis

Procedures for data analysis are described in Chapter 4.

6.3. Results

6.3.1. Participants

Demographic data were available on 297 course participants (out of 405 taking part in the evaluation) (73%) from all LSCB sites (Table 1). The numbers of courses participating per areas was uneven. There were seven courses in site G but only one in Sites B and D (Child Protection Conference and Child Neglect as noted earlier). As with most other Level two courses in this study, the great majority of participants were white women. However, the years in service was more spread than that in other courses; four in ten participants had ten or more years in service; a similar percentage have been in their posts for less than a year. Professional representation was mainly distributed across social services and health, but teachers also had a good presence at roughly 20 per cent. Doctors, counsellors and the police were underrepresented. While a majority of participants had volunteered to attend, one in three had been required to do so, a considerably higher proportion than for most of the other courses in this study.

TABLE 1: COURSE PARTICIPANTS

		NUMBER	%
Site	A	39	9.6%
	B	18	4.4%
	C	45	11.1%
	D	13	3.2%
	E	67	16.5%
	F	28	6.9%
	G	137	33.8%
	H	58	14.3%
	Total	405	100.0%
Gender	Female	240	82.5%
	Male	51	17.5%
	Total	291	100.0%
Age	18-30	62	20.9%
	31-40	98	33.0%
	41-50	95	32.0%
	51+	42	14.1%
	Total	297	100.0%
Years in service	1 year of less	40	13.7%
	1-5 years	69	23.5%
	5-10 years	64	21.8%
	10 or more years	120	41.0%
	Total	293	100.0%
Years in post	1 year of less	120	41.4%
	1-5 years	108	37.2%
	5 or more years	62	21.4%
	Total	290	100.0%
Profession/occupation	Social work	69	26.0%
	Counselling/Psychologist	9	3.4%
	Probation	19	7.2%
	Teacher	50	18.9%
	Nurse/midwife	60	22.7%

		NUMBER	%
	Doctor	8	3.0%
	Police	9	3.4%
	Other	41	15.5%
	Total	265	100.0%
Ethnicity	White	267	90.5%
	BME	28	9.5%
	Total	295	100.0%
First motive	Volunteered	190	70.1%
	Required	81	29.9%
	Total	271	100.0%

Note: Doctor disaggregated from Nurse/midwife/doctor for this chapter.

A series of chi-square tests of association established that women were rather more likely than men to respond at both time points. There no other statistically significant differences in the proportions of respondents at T0 and T1 by age group, training site, years since professional qualification, years in present post, ethnicity and primary motive for attendance (volunteered or required).

6.3.2. Psychometrics of Learning, Interaction and Relationship Scales

The internal reliability of the Learning scale as assessed by Cronbach's alpha at T0, T1, T2 was around 0.90, which is highly reliable for research of this nature. It was slightly lower for Interaction and Relationship scales, grouping around the 0.80 mark, which again is very satisfactory.

Confirmatory principal component analysis of the three interprofessional working scales suggested that each of the scales comprised between one to three components. These factors were interpreted as confirming the stated aims of the scales: attitudes to learning on the course, interaction with colleagues, and working relationships with staff in other agencies.

6.3.3. Outcomes: Learning scale

The first scale measured participants' attitudes towards learning with professionals in other agencies in relation to working together to safeguard children.

6.3.3.1. Changes in mean total scores over time

Mean total learning score for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 1. The total mean scores for all courses are also shown. For courses in one of the sites (B) there was an apparent increase in ratings between registration and T1. However, numbers were very small (18) and this difference may be spurious. Considering the courses overall, there was a small, but statistically non-significant decrease scores between T0 and T1, as shown in Table 2.

At the end of the course, participants were even more positive about interprofessional learning than they had been at the beginning. This finding was statistically significant ("medium" effect size).

Poor response rates at T3 (n=57 or 22% of matched respondents) prevented estimation of the extent to which changes in learning scale outcomes were retained three months after the course finished.

FIGURE 1: TOTAL LEARNING SCORES (MEANS) BY LSCB

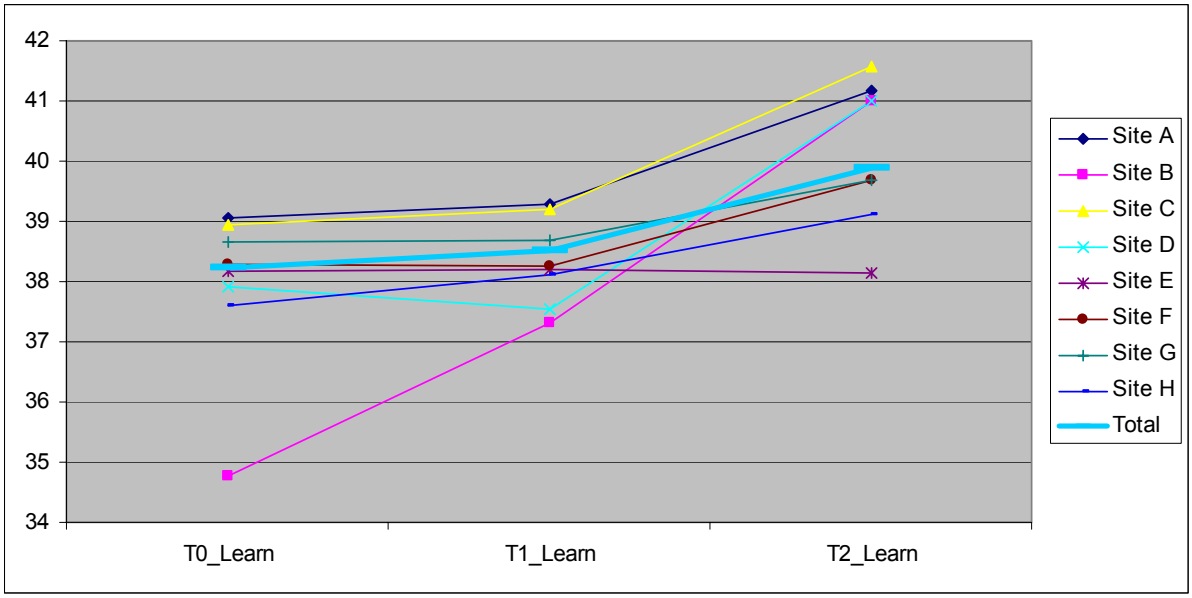
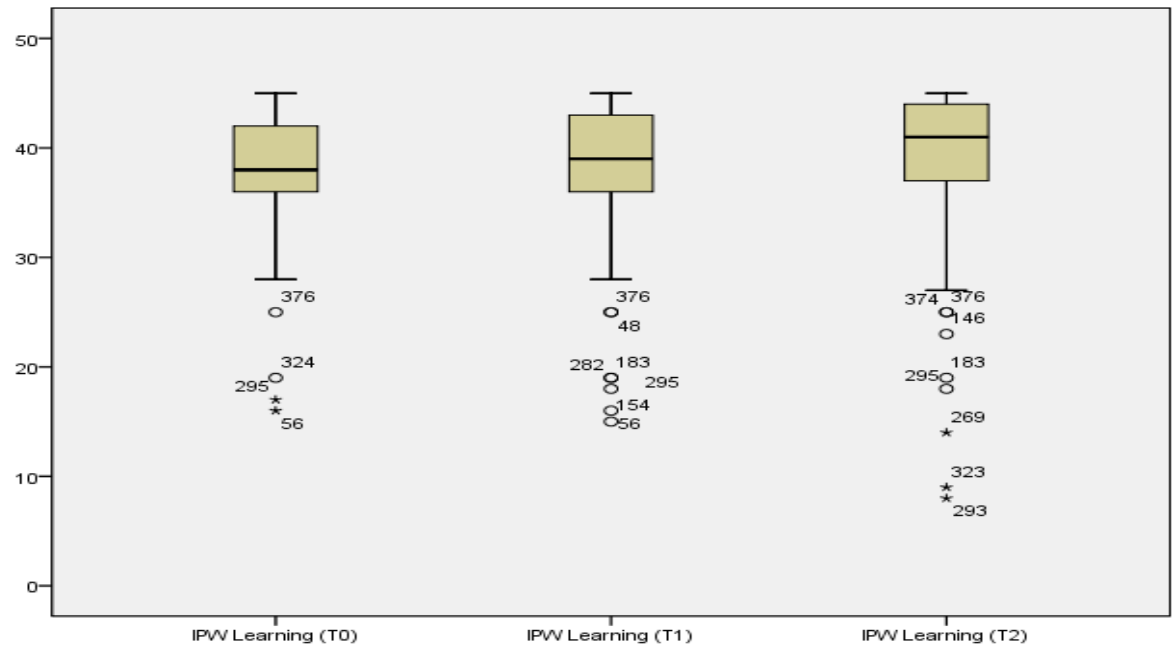


TABLE 2: LEARNING SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	132	38.29	5.27	37.57	5.29	-0.72	-1.92	-1.46	0.02	131	0.057	0.14
T1 - T2	260	38.44	5.18	40.13	5.41	1.69	4.86	1.00	2.37	259	***p<0.001***	0.32

FIGURE 2: DISTRIBUTION OF TOTAL 'LEARNING' SCORES (POSSIBLE RANGE 9–45) AT SUCCESSIVE TIME POINT



The same overall pattern is shown in the box and whisker plot (Figure 2). However, this reveals that the median rating was higher at time 2 (end of the course) than at time 1 (start of the course). This indicates that the majority of respondents were at least as positive as they had been at the end of the course but that a minority with negative views had pulled down the mean. It is worth noting that there are a few outliers. Since these are at the bottom of the scale, they represent a very small minority of participants (around 0.04%) who had presumably had a poor experience on the course.

.**Changes in item scores over time**

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 8 of the 9 items (Table 3). It is important to note that the respondents were overwhelmingly positive about the interprofessional dimension to the interagency courses at the start of the course with each scale item being rated over 4 on the five point scale (equivalent to "agree"). At the end of the course the same rating were 4.4/5 or above indicating "strongly agree". They believe it was a positive experience, that their skills in interprofessional communication had been improved and that it was likely to improve services for service users.

TABLE 3: LEARNING SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	My skills in communicating with families would be improved though learning with other professionals who engage in work to safeguard children	4.3	0.76	4.5	0.75	253	-4.400	<.001
Q2	My skills in communicating with other professionals would be improved through attending interagency safeguarding trainings	4.3	0.73	4.5	0.74	259	-4.224	<.001
Q3	I would prefer to learn only with peers from my own profession	4.2	0.93	4.4	0.98	254	-1.866	.062
Q4	Learning with course participants from other professions is likely to facilitate subsequent working professional relationships	4.3	0.82	4.5	0.70	255	-2.570	.010
Q5	Learning with course participants from other professions would be more beneficial to improving my teamwork skills than learning only with my peers	4.1	0.92	4.4	0.79	258	-5.091	<.001
Q6	Collaborative learning would be a positive experience for all professionals who engage in work to safeguard children	4.4	0.77	4.6	0.68	258	-4.258	<.001
Q7	Interagency training is likely to help to overcome stereotypes that are held about the different professions	4.2	0.82	4.4	0.84	259	-3.912	<.001
Q8	I would enjoy the opportunity to learn with course participants from other safeguarding children professions	4.4	0.71	4.6	0.72	258	-3.547	<.001
Q9	Learning with course participants from other safeguarding children professions is likely to improve the service for patient/service user	4.4	0.80	4.5	0.76	259	-2.599	.009

Reverse scored: 3

6.3.3.2. Predictors of interprofessional learning scores

Regression analysis was used to explore the predictors of baseline learning scores at the start of the courses. This showed that learning score at T0 and being in the teaching profession were the only significant predictors of T1 scores, but each having the opposite effect. This indicates that teachers in general, at the start of the course were slightly less positive about the prospect of interprofessional learning than they had been at the beginning. Otherwise, taking all these variables and their interactions into account, there were no other statistically significant effects on T1 scores associated with any demographic factors or the LSCB in which the courses took place. The regression model accounted for 44% of the variance.

What predicted high learning scores at the end of the course (T2)? The regression analysis identified that baseline scores at the start were the only statistically significant predictor ($p<0.001$). In other words, controlling for all other potential predictors, the higher the mean total score at the start, the higher the score at the end. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. No demographic variables, including profession and experience had any effect on changes in scores and neither did "required", as opposed to voluntary attendance. This regression model accounted for only 19% of the variance.

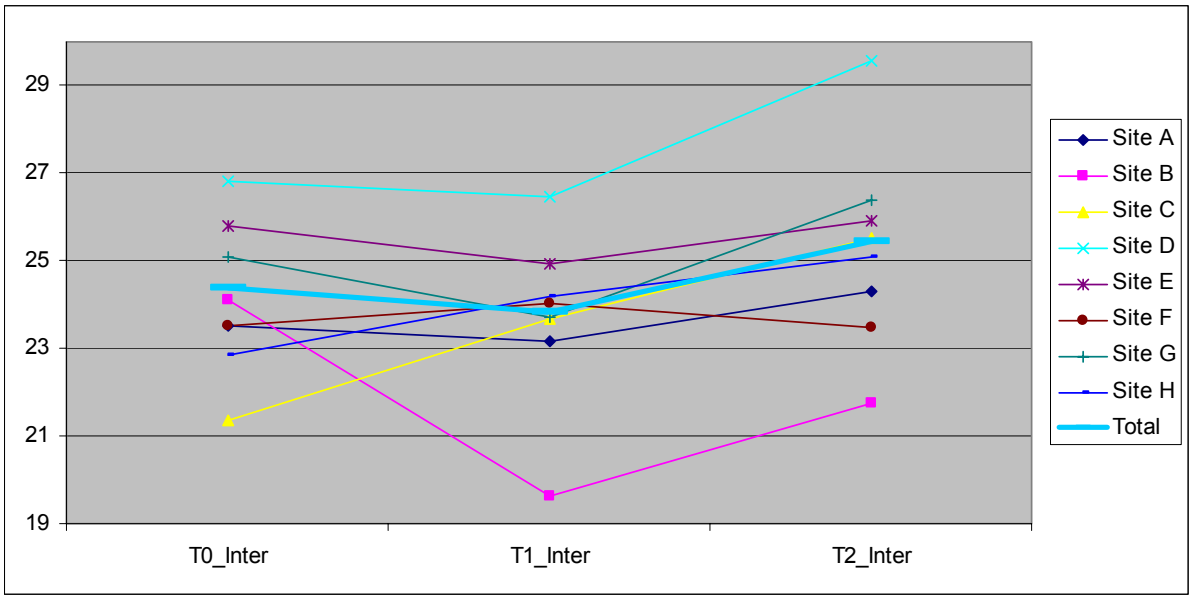
6.3.4. Outcomes: Interaction scale

The second scale measured participants' perceptions on interprofessional interaction in relation to working together to safeguard children.

6.3.4.1. Changes in mean total scores over time

Mean total learning score for participants in each LSCB at each time point (where available) are shown in Figure 3. Although there are some exceptions (Site F, for example), we found that interaction scores improved between the start and end of the course.

FIGURE 3: TOTAL INTERACTION SCORES (MEANS) BY LSCB



Overall, there was no significant change in mean total scores between registration and start of the course (Table 4) and the effect size is interpreted as “negligible”. Between the start (T1) and end (T2) of the course, there was an improvement in mean total scores (“medium” effect size), which was also highly statistically significant.

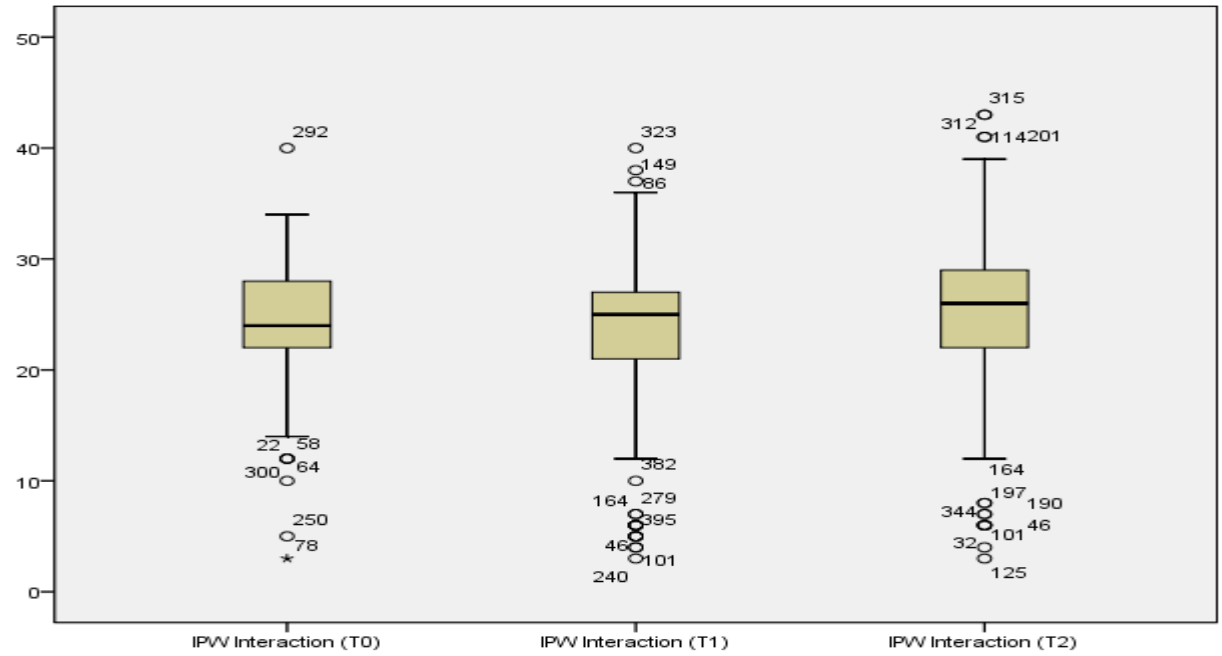
Poor response rates at T3 (n=55 matched respondents) prevented estimation of the extent to which changes in interaction scale outcomes were retained three months after the course finished.

TABLE 4: INTERACTION SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	131	24.49	4.68	24.53	5.29	0.04	0.10	-0.72	0.80	130	0.921	0.01
T1 - T2	260	23.62	6.32	25.47	6.55	1.84	4.83	1.09	2.59	259	***<0.001***	0.29

The box and whisker plot (Figure 4) reveals that there was actually a very wide spread of opinions about interprofessional interaction in safeguarding. The mid point on this scale is 18 and the plot suggests that around 20% of the respondents had negative views. The few outliers had quite strongly negative views.

FIGURE 4: DISTRIBUTION OF TOTAL ‘INTERACTION’ SCORES (POSSIBLE RANGE 9–45) AT SUCCESSIVE TIME POINTS



6.3.4.2. Changes in item scores over time

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 7 of the 9 items (Table 5).

TABLE 5: INTERACTION SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q10	Different professionals who engage in work to safeguard children have stereotyped views of each other	2.6	0.81	2.8	0.98	258	-2.943	.003
Q11	The lines of communication between all professionals who engage in work to safeguard children are open	2.8	0.94	3.1	0.96	257	-4.907	<.001
Q12	There is a status hierarchy in safeguarding work that affects relationships between professionals	2.8	0.84	2.8	0.99	241	-.194	.846
Q13	Different professionals who engage in work to safeguard children are biased in their views of each other	2.9	0.80	3.0	0.90	242	-2.108	.035
Q14	All members of safeguarding children professions have equal respect for each discipline	2.9	0.89	3.1	0.94	242	-3.551	<.001
Q15	It is easy to communicate openly with people from other safeguarding children disciplines	3.2	0.92	3.6	0.94	241	-6.669	<.001
Q16	Not all relationships between professionals who engage in work to safeguard children are equal	2.6	0.85	2.7	0.99	240	-2.082	.037
Q17	Professionals who engage in work to safeguard children do not always communicate openly with one another	2.4	0.85	2.5	0.90	241	-1.069	.285
Q18	Different professionals who engage in work to safeguard children are not always cooperative with one another	2.5	0.80	2.7	0.98	240	-2.989	0.003

Reverse scored: 10, 12, 13, 16, 17

Examination of these individual scale items shows that, in general respondents were unsure, or equally divided, on whether there was a 'status hierarchy' in safeguarding work and on whether they had biased views of each other. However, there was a marked improvement in the ease of communicating with each other.

6.3.4.3. Predictors of interaction scale scores

Regression analysis was also used to explore the predictors of baseline interaction scale scores at the start of the courses (Table 6). Here, in addition to interaction score at T0, the profession of the course participant and reason for being at the training course played a key role in predicting T1 interaction scores. For example, teachers, health service staff and other professions in general were all significantly more like to be more positive about interprofessional interaction by the time they started the course. Those 'required' to attend the course were more likely to report higher scores at the start of course. The regression model accounted for 53% of the variance.

TABLE 6: SIGNIFICANT PREDICTORS OF INTERACTION SCALE AT T1 (LINEAR REGRESSION ANALYSIS)

	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	5.38	2.68		2.01	***.048***	0.04	10.72
T0 Interaction Score	0.60	0.10	0.52	6.29	***<.001***	0.41	0.80
Profession							
Teacher	3.75	1.44	0.26	2.61	***.011***	0.88	6.61
Health	3.43	1.32	0.29	2.61	***.011***	0.81	6.05
Community protection	0.61	1.66	0.04	0.36	.717	-2.70	3.92
Other profession	4.78	1.64	0.29	2.92	***.005***	1.52	8.05
Attendance Required	1.93	0.93	0.16	2.08	***.041***	0.08	3.78
Adjusted R Square	***0.53***						

What predicted high interaction scale scores at the end of the course (T2)? The regression analysis identified that baseline interaction scores at the start (p = 0.001 and being in the health profession (p = 0.32) were the only statistically significant predictors. Controlling for all other potential predictors, the higher the mean total score at the start and being a nurse/GP/other healthcare professional, the higher the score at the end. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. No other demographic variables, including years of experience had any effect on changes in scores and neither did being "required", as opposed to voluntary attendance. This regression model accounted for 36% of the variance.

6.3.5. Outcomes: Relationship scale

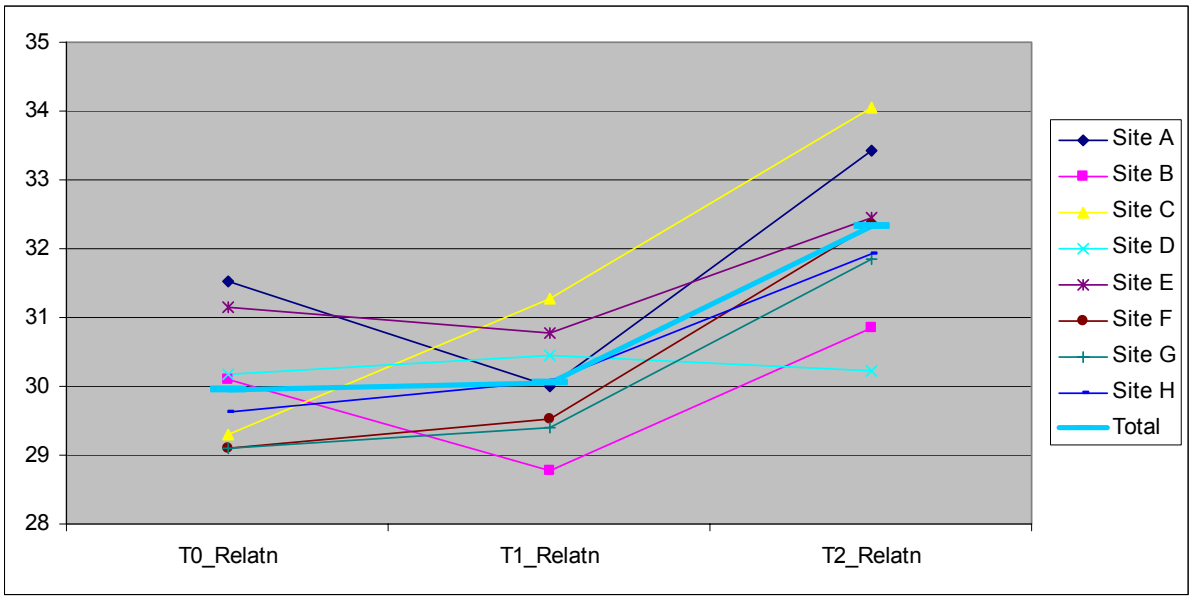
This scale measures attitudes to working relationships with other professions as well as your own profession in the context of safeguarding children.

6.3.5.1. Changes in mean total scores over time

Mean total relationship score for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 5. The total mean scores for all courses are also shown. This shows a large increase in scores from the start to the end of the course, although this varied by LSCB.

Poor response rates at T3 (n=52 matched respondents) prevented estimation of the extent to which changes in relationship scale outcomes were retained three months after the course finished.

FIGURE 5: TOTAL RELATIONSHIP SCORES (MEANS) BY LSCB



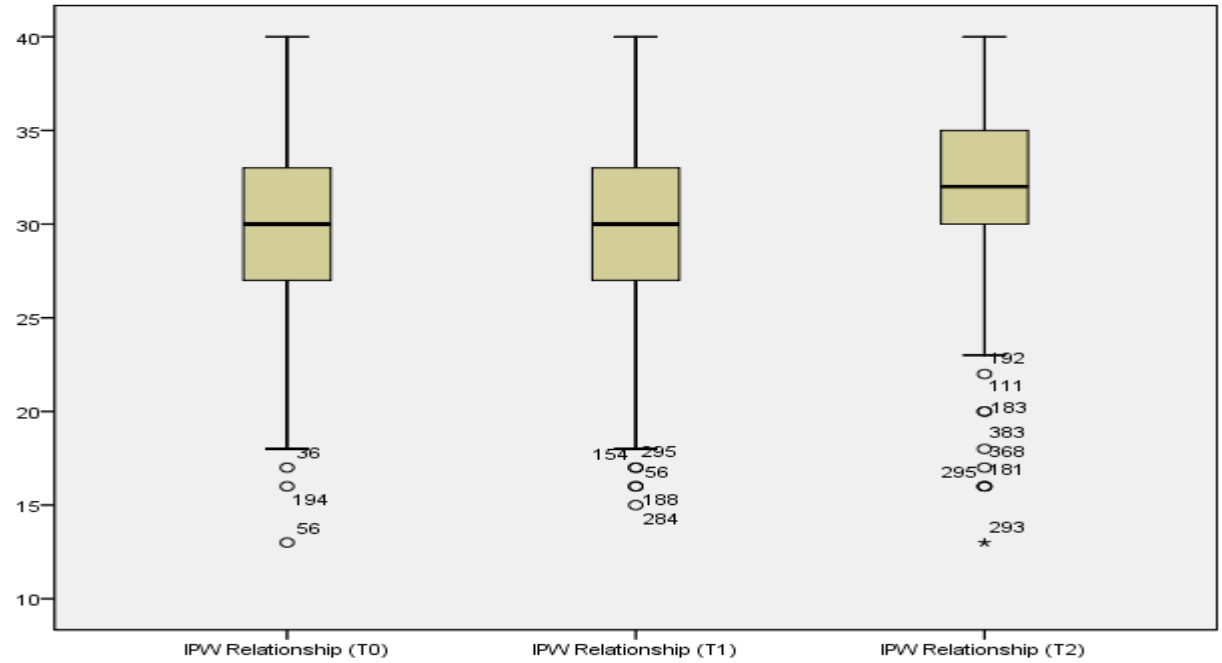
There was no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as "negligible" (see Table 7). Between the start (T1) and end (T2) of the course, there was a substantial improvement in mean total scores ("large" effect size), which was highly statistically significant. The improvement in overall mean total was maintained at follow-up (T3) although the response rate as a proportion of those responding at T2 was only 21%.

TABLE 7: RELATIONSHIP SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	126	30.18	4.67	30.13	4.30	-0.06	-0.18	-0.65	0.54	125	0.854	0.01
T1 - T2	243	29.95	4.39	32.63	4.31	2.68	9.69	2.14	3.23	242	***<.001***	0.62

The same overall pattern is shown in the box and whisker plot (Figure 6). The distribution at T2 is different to that at T1 confirming this significant change between the start and the end of the course.

FIGURE 6: DISTRIBUTION OF TOTAL 'RELATIONSHIP' SCORES (POSSIBLE RANGE 8-40) AT SUCCESSIVE TIME POINTS



6.3.5.2. Changes in item scores over time

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on all of the 8 items (Table 8). The items which are of particular interest are those pertaining to relationships with other professionals involved in safeguarding children. Here it can been see (Q21) that there were large improvements in their perceived understanding of the roles of different professionals who engage in work to safeguard children and in their confidence and comfort in working with them.

TABLE 8: RELATIONSHIP SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q19	I have an equal relationship with peers from my own professional discipline	4.0	0.93	4.2	0.88	237	-3.621	<.001
Q20	I am confident in my relationships with my peers from my own professional discipline	4.3	0.79	4.5	0.61	242	-4.154	<.001
Q21	I have a good understanding of the roles of different professionals who engage in work to safeguard children	3.4	0.92	4.1	0.70	240	-8.682	<.001
Q22	I am confident in my relationships with people from other safeguarding children disciplines	3.5	0.88	4.0	0.73	243	-7.965	<.001
Q23	I am comfortable working with people from other safeguarding children disciplines	3.8	0.81	4.2	0.68	242	-7.291	<.001
Q24	I feel that I am respected by people from other safeguarding children disciplines	3.4	0.86	3.7	0.86	243	-6.462	<.001
Q25	I lack confidence when I work with people from other safeguarding children disciplines	3.5	1.08	3.7	1.10	241	-2.399	.016
Q26	I am comfortable working with people from my own professional discipline	4.3	0.78	4.4	0.74	235	-2.695	.007

Reverse scored: 25

6.3.5.3. Predictors of interprofessional relationship scores

Regression analysis was also used to explore the predictors of baseline interaction scale scores at the start of the courses. Here, we find that only score at T0 played a key role in predicting T1 relationship scores ($p < 0.001$). In other words, taking all these variables and their interactions into account, there were no significant effects on T1 scores associated with any demographic factors, profession, or the LSCB in which the courses too place. The regression model accounted for 48% of the variance.

What predicted high relationship scale scores at the end of the course (T2)? The regression analysis identified that baseline relationship scores at the start, age group of the respondent, and profession of the course participant were statistically significant predictors (see Table 9 below). In other words, controlling for all other potential predictors, the higher the mean total score at the start or being a teacher, the higher the score at the end, whereas being 41-50 years of age predicted a lower relationship score at the end of the course. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results for almost all the participants. No other demographic variables, including years of experience had any effect on changes in scores and neither did "required", as opposed to voluntary attendance. This regression model accounted for 24% of the variance.

TABLE 9: SIGNIFICANT PREDICTORS OF RELATIONSHIP SCALE AT T2 (LINEAR REGRESSION ANALYSIS)

	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	17.46	2.67		6.55	***<.001***	12.18	22.73
T1 Relationship	0.54	0.08	0.52	6.74	***<.001***	0.38	0.70
Age							
31-40	-0.63	0.99	-0.06	-0.64	.521	-2.59	1.32
41-50	-1.92	0.94	-0.20	-2.03	***.044***	-3.78	-0.05
51+	-2.19	1.28	-0.17	-1.71	.089	-4.71	0.34
Male	0.23	0.86	0.02	0.27	.790	-1.47	1.93
Profession							
Teacher	2.43	1.10	0.21	2.21	***.029***	0.25	4.60
Health	0.72	1.02	0.07	0.70	.484	-1.31	2.75
Community protection	1.07	1.35	0.07	0.79	.429	-1.60	3.75
Other profession	1.46	1.09	0.12	1.33	.185	-0.71	3.62
Adjusted R Square	***0.24***						

6.4. Discussion

Working Together (2006) identifies those who work regularly with children and young people, and with adults who are carers, and who may be asked to contribute to assessments of children in need. They include "...GPs, hospital and community health staff, family and children's centre workers, teachers, education welfare officers, social workers, mental health and learning disability staff and probation officers" (p.95). Social workers, including family support workers, teachers and nurses were all strongly represented on the level 2 courses in our sample and so, in proportion to their overall numbers in the services, were probation officers. There were however very few doctors which must be a matter of concern. GPs and other doctors are very likely to encounter children who have been, or who are at risk of being abused and neglected. Can we have confidence that they are sufficiently knowledgeable

about current interagency safeguarding policies and procedures? The other group noticeably conspicuous by its relative absence is the police.

There is strong statistical evidence to support the continued promotion of these courses. Participants were overwhelmingly positive about the interprofessional dimension to the interagency courses at the start, and even more so, at the end of the courses. They believed it was a positive experience, that their skills in interprofessional communication had been improved and that it was likely to improve services for service users.

Responses to the interprofessional interaction scale showed an overall improvement, and an improvement in most scale items, including the very important issue of confidence in interprofessional communication. There were items which registered no change for participants and where they gave divided or non-committal responses. However, because the courses themselves highlighted problems in interagency and interprofessional interaction, particularly with reference to the numerous official enquiries which have taken place over the years, it is understandable that responses reflected issues of bias and status hierarchy which negatively impacted on interprofessional working. Further, in spite of these slightly equivocal findings, the participants showed large improvements in their self-reported understanding of the roles of different professionals who engage in work to safeguard children and in their confidence and comfort in working with these colleagues.

But were these improvements sustained? Here the evidence is weaker. There was a poor response to the T3 three month follow-up, which amounted to a little over one in five of the respondents at T2. So we can say little in terms of sustained outcomes over time for the three interprofessional working scales. Nevertheless, the overall findings from the evaluation of these courses are very encouraging. So too is the demonstration through the regression analysis that participants in all the different LSCBs courses benefited. Interestingly, the length of course did not make a difference to the scores, all other variables being taken into account. This suggests that one-day courses are equally effective as two day courses and, since they must cost less to provide and attend, implies that they are much more cost-effective. However, a word of caution is relevant here: this evaluation is only as good as its measures. It is possible that the measures do not capture all the learning, especially the depth of learning, that longer courses might engender. What is clear is that these courses were equally beneficial to all professional groups and to professionals of all age groups, both genders and with different levels of experience and irrespective of whether they had volunteered or been required to attend. LSCBs can therefore, on the basis of this evidence, commission and promote these courses to all comers with considerable confidence.

6.5. References

Pollard,K., Miers,M. and Gilchrist,M. (2004) Collaborative learning for collaborative working? Initial findings from a longitudinal study of health and social care students. *Health and Social Care in the Community,* 12: 346-58.

Pollard,K., Miers,M. and Gilchrist,M. (2005) Second year scepticism: pre-qualifying health and social care students' midpoint self-assessment, attitudes and perceptions concerning interprofessional learning and working. *Journal of Interprofessional Care,* 19: 251-68.

Pollard,K., Miers,M., Gilchrist,M. and Sayers,A. (2006) A comparison of interprofessional perceptions and working relationships among health and social care students: the results of a 3-year intervention. *Health and Social Care in the Community,* 14: 541-552.

7. Safeguarding Children and Domestic Abuse

7.1. Introduction

Working Together to Safeguard Children suggests that exposure to domestic violence can have serious effects on the children's development and emotional wellbeing (HM Government 2006, Sec. and 11.45). A considerable body of research shows that children who grow up in families where domestic violence occur, show signs of physical, behavioural, emotional, and long term developmental problems (Humphreys 1999; Humphreys and Stanley, 2006; Calder, 2004; McGee, 2000; Cleaver et al. 2008; Devaney 2008). It is therefore appropriate to regard such children as children who should be safeguarded.

Domestic violence can have an impact in many ways:

- It can pose a threat to an unborn child, because assaults on pregnant women frequently involve punches or kicks directed at the abdomen.
- Older children may also suffer blows during episodes of violence.
- Children may be greatly distressed by witnessing the physical and emotional suffering of a parent. Children's exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress.
- Physical assaults and psychological abuse suffered by adult victims of domestic violence can have a negative impact on their ability to look after their children.
- The negative impact of domestic violence is exacerbated when the violence is combined with drug or substance misuse; children witness the violence; children are drawn into the violence or are pressurised into concealing the assaults (HM Government 2006, Sec. and 9.15).

Commissioning guidance for Directors of Children's Services and LSCBs (LGA, ADSS, CAFCASS and Women's Aid (2005)) focuses on meeting the needs of children affected by domestic abuse within the planning of integrated children's services. The document provides a framework intended to ensure that the needs that children experience in relation to domestic violence are identified and addressed. It links evidence from research with best practice and draw attention to specialist services to which children require access. The guidance assists authorities to assure themselves that their services and responses satisfy the target of Every Child Matters Outcomes Framework: children affected by domestic violence are identified, protected and supported (HM Government 2006, Sec. 11.50).

7.1.1. Brief review of the literature.

A large body of research shows that domestic abuse is a highly prevalent and widespread social problem (Humphreys and Stanley 2006). The findings of the British Crime Survey (Walby and Allen 2004) indicated that at least 75,000 children in England and Wales were living in families where domestic abuse occurred. The findings also indicated that although domestic abuse affects all sections of society, the overwhelming majority of incidents involved a women victim and a male perpetrator. The presence of children in the household was associated with almost double the risk of domestic abuse for women (Walby and Allen 2004). It is also well documented that pregnancy is a time of increased risk of physical or sexual violence. In this respect, violence during pregnancy represents the most serious forms of abuse against women and their children (BMA 2007).

Much of the literature on the incidence of domestic abuse deals with the various risks and various forms of domestic abuse. While many studies emphasize the dangers for children

exposed to domestic violence (e.g. Abrahams 1994), the literature also suggest that there is also a wide variation in the ways children witness or hear violence.

According to a recent literature review provided for the Scottish Government 'Failing to acknowledge the diverse forms of violence in families and communities may limit professionals' capacity to safeguard children' (Humphreys, Houghton and Ellis 2008, p. 8). Similarly, the division between direct and indirect forms of domestic abuse of children is not necessarily an effective mean of assessing the real risk and severity of abuse (p.14).

A comprehensive body of literature deals with the severe impact of domestic abuse on children's health and well-being (see for example Humphreys 1999; Humphreys and Stanley, 2006; Calder, 2004; McGee, 2000, Cleaver et al. 2008; Devaney 2008). This research suggests that there is a clear link between the presence of domestic violence, distress, depression, anxiety, poor educational achievement (Hester *et al*. 2000, Humphreys and Mullender 2002).

As the *Directions* written for the Scottish Government indicate there are some inconsistencies in research evidence about the impact of living with domestic abuse (Humphreys, Houghton and Ellis 2008 p.10). While many studies suggest that directly abused children are more likely to suffer from severe and negative impacts of assaults on their health, other research has found little difference between children witnessing domestic abuse, being involved in the violence and being the target of violence (Mertin and Mohr 2002 p.5). A meta-analysis of 118 published studies carried out by Kitzmann *et al*. (2003) found that the psychosocial outcomes of children witnessing domestic abuse assessed on various developmental and behavioural factors were significantly poorer than of those children not witnessing abuse; the outcomes for children witnessing abuse were similar to those children who were subject to direct physical abuse.

Studies not only emphasize that children can be affected in many different ways by living with domestic violence. The impact of domestic violence shows a broad variation according to the stages of the children's social, biological and neurological development or their age (Martin 2002). Other important factors that can moderate the vulnerability of abused children include the level of family and community support these children receive, the mental health of their parents, the general impact of domestic violence on the parenting capacity of parents and the extent to which their emotional or physical needs have been neglected (Mullender *et al*. 2002, Brandon and Lewis, 1996, Hughes *et al*. 2001). As the reviewers point out, it is important to resist pathologising all children living with domestic abuse. There are children who manage in abusive situation and many children completely recover from the effects of domestic violence once they are in a safe and violence free environment (Humphreys, Houghton and Ellis 2008 p.13-14).

7.1.2. The importance of interagency working and training.

A research report published by DCSF (Cleaver *et al*. 2008) concluded that services for domestic abuse are not routinely involved at any stage of the child protection process. Services for domestic violence were represented in only five percent of cases at initial child protection conference despite the fact that some form of domestic violence occurred in nearly three quarters of cases. According to this research, the involvement of services for domestic abuse was evident in fewer than one in ten protection plans. Although agencies working on issues related to domestic violence were more involved in the provision of services, collaboration was still low. Following an initial assessment, only a fifth of cases where there was evidence of domestic abuse were referred to a service provider specialising in domestic abuse. Interviews with social workers suggested a number of reasons for this lack of involvement: judging involvement as irrelevant or unnecessary (because the violent partner had left; shifting responsibility to another domestic violence service provider such as

the police; a lack of resources within children's social care; and a lack of sufficient local services (p. 7-8).

Working Together stresses that local Domestic Violence Forums and LSCBs should jointly contribute to the assessment of the domestic violence case, the involved children's needs, the adequacy of local arrangements to meet those needs, and the implications for local services. At the same time, it is also essential to develop joint protocols, safe information-sharing arrangements and interagency training (2006, Sec. 11.48).

The DCSF report (Cleaver *et al*. 2008) also argued that 'Providing plans, procedures and joint protocols will not in themselves bring about the required changes in practice. Practitioners need training on the underlying principles and how to implement the procedures and protocols.' (p. 11). The report indicated that the extent to which managers of local authorities claimed to grasp the impact of domestic violence on children's development was closely associated with the domestic abuse training provided by their authority.

Working Together (2006) asserted that an awareness of the needs and experiences of children exposed to domestic violence and, by implication, multi-agency responses to those needs should be addressed at all levels of training for safeguarding. Issues relating to domestic abuse should be incorporated into basic, introductory safeguarding training for all those in contact with children (Level 1); in addition, specific training courses on domestic abuse should be run for practitioners who work regularly with these children and who have a particular responsibility for their safeguarding (Sec. 4.19).

The DCSF report also stressed the importance of interagency training in the field of domestic violence. The authors proposed that 'This format can promote an understanding of the roles and responsibilities of professional working indifferent organisations, their different thresholds for services, the legal frameworks within which they work, and issues surrounding confidentiality and information sharing. It will also provide opportunities to develop inter-agency networks, increase levels of trust, and provide insights into the philosophy and work of each other's organisations.' (Cleaver *et al*. 2008, p. 16.).

7.1.3. Previous evaluations

There have been a number of papers advocating training on children and domestic violence (e.g. Mullender 2004; Buckley, Holt and Whelan 2007) but the only published evaluation of the outcomes of training for staff in direct contact with children was published in the USA a few year ago (Saunders and Anderson 2000). The evaluators used a pre-post design to evaluate a two-day programme for staff in a family support agency. They reported that, at the end of the course participants were more likely to say that they would provide assessment and brief interventions, hold the abuser responsible, substantiate emotional abuse of a child, and empathise with victims. Respondents reported less likelihood of holding the victim responsible for stopping the violence, telling the woman she must end the relationship. Unfortunately, participation in the evaluation was poor: out of over 300 attendees, matched t1-t2 responses were only available for 36 participants.

Warburton *et al*. (2006) used a pre- and post-training questionnaire to assess knowledge and attitudes of a dental team in Manchester about domestic abuse before and after a two-hour awareness raising session entitled '*A Smack in the Mouth*'. The authors found that there was a significant increase in dental professionals' recognition of the importance of their involvement in the identification of abuse. The training also improved their self-reported comfort in asking about abuse; they were less afraid of offending their patients and less likely to blame the victims when asking about abuse. Thus, before training only five percent correctly thought that patients would not object to being asked about abuse, while 63% of respondents post-training thought the same thing. There was a significant improvement in

knowledge and the respondents' perceived self-efficacy.

7.1.4. Courses

All the eight participating LSCBs were offering specialist courses on domestic abuse during the study period. These courses were open to any staff who had a frontline responsibility for the protection and safeguarding of children or young people. Often domestic abuse issues formed a significant proportion of the role. The courses offered 15 to 20 places each.

The learning outcomes of the courses sampled were almost identical and are summarised in Box 1. These outcomes follow the recommendations in *Working Together* which are outlined above. Six of the LSCBs offered one day courses lasting seven hours, including lunch. Lunch was seen as a good opportunity for networking and informal exchanges between staff from different agencies. These courses typically combined lectures based on research on needs and presentation of good practice guidelines; videos of children and their carers; presentation and discussion of interagency roles and procedures; exploration of personal and organisational attitudes; case studies of safeguarding; role plays and practical communication exercises. The other two LSCBs (LSCB C and LSCB D) provided courses lasting one and a half days on two consecutive days. The domestic abuse course run by LCSB D was not included in the evaluation.

BOX 1: LEARNING OBJECTIVES OF COURSES

- Review definitions of domestic abuse
- Being able to reflect on domestic abuse incidence both locally and nationally
- Investigate the assessment process and good practice guidance in relation to domestic abuse
- Develop ability to assess risk in relation to children who are in families where domestic abuse is prevalent
- Gain greater understanding of the interagency approach to working with families who have experienced domestic abuse
- Develop ideas in order to improve own practice
- Identify ways to keep themselves safe.

Summary of learning objectives: Provide participants with an understanding of domestic abuse and the possible impact on the developmental outcomes for children. Understand own and other agencies' contribution to safeguard children exposed to domestic abuse.

7.2. Methods

7.2.1. Procedures

The procedures used were as described in Chapter 4.

7.2.2. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

A search of the literature identified a questionnaire (Warburton et al. 2006, reviewed above) that has been adapted from questionnaires used in previous studies (Cann *et al.* 2001, McCauley *et al*. 2003, Maurio *et al*. 2000). We adapted sections of the scale and, after consultation with two experts on domestic violence, we edited some and compiled other set of statements with reference to the stated learning objectives of the courses. These included self-efficacy/confidence statements such as, "I feel comfortable asking clients about

domestic abuse"; statements designed to assess knowledge, e.g. "Babies under one will hardly be affected in their health when they witness domestic violence"; and statements designed to grasp attitudes such as, "The 'victim' has often done something to bring about abuse in the relationship". The statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree"). Eleven of the 28 statements were designed for reverse scoring in order to reduce response bias.

7.2.3. Data analysis

Procedures for data analysis are described in Chapter 4.

7.3. Results

7.3.1. Participants

Demographic data were available on 164 course participants (out of 267 taking part in the evaluation (61%) from seven LSCB sites (Table 1 overleaf). The numbers of courses participating per areas was uneven. There were four courses in site G but only one each in Sites A and F. As with most other Level two courses in this study, the great majority of participants were white women and had one to five years service experience. None of the participants had over five years experience. Professional representation was mainly distributed across social services and health; just ten teachers education was also present with ten percent. Four in ten were social workers or family support workers. Almost all were voluntary participants; fewer than ten percent of the participants had been required to attend.

A series of chi-square tests of association established that respondents in the oldest age group (51+ years) were more likely than those in the younger age groups to respond at both time points, whereas as those 31-40 and 41-50 were more likely to not respond at either time point. There no other statistically significant differences in the proportions of respondents at T0 and T1 by gender, years since professional qualification, years in present post, ethnicity and primary motive for attendance (volunteered or required).

7.3.2. Psychometrics of the Scale

The internal reliability of the scale as assessed by Cronbach's alpha at T0, T1 and T2 was around 0.66, which is acceptable for exploratory research of this nature, although it dropped to 0.59 for the 26 participants at T3.

Principal component analysis, the scree plots and analysis of item loading suggested that the scale comprised five reliable factors. The factors were interpreted as indicating attitudes to domestic abuse, attitudes to victims, self-confidence, knowledge and personal responses.

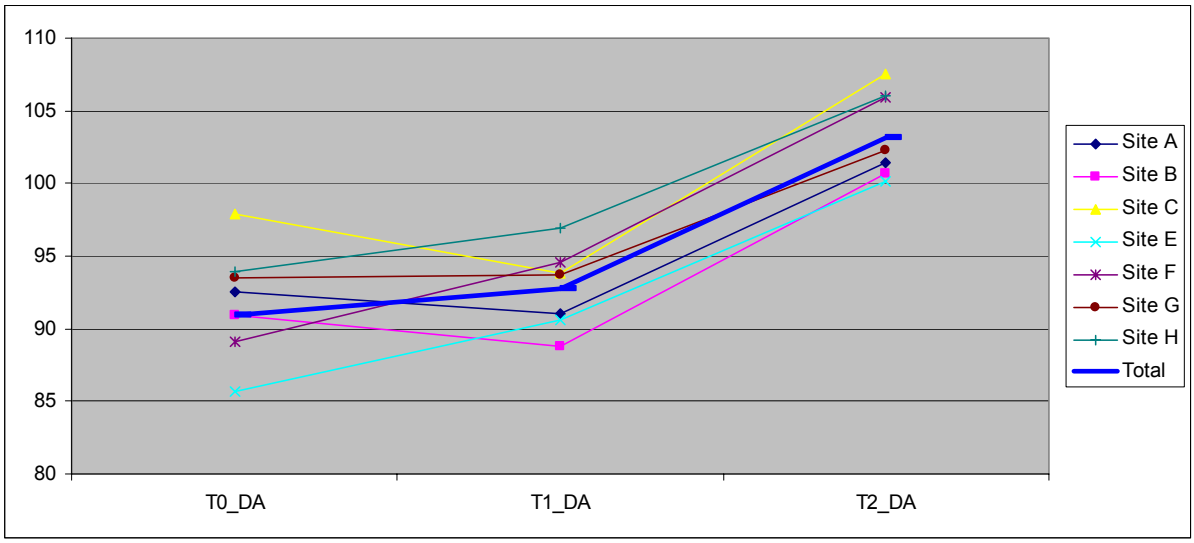
TABLE 1: COURSE PARTICIPANTS

		NUMBER	%
Site	A	16	9.8%
	B	26	15.8%
	C	17	10.4%
	E	34	20.7%
	F	13	7.9%
	G	41	25%
	H	17	10.4%
	Total	164	100.0%
Gender	Female	145	91.2%
	Male	14	8.8%
	Total	159	100.0%
Age	18-30	31	18.9%
	31-40	50	30.5%
	41-50	42	25.6%
	51+	41	25.0%
	Total	164	100.0%
Years in service	1 year or less	16	10.1%
	1-5 years	142	89.9%
	5-10 years	0	
	10 or more years	0	
	Total	158	100.0%
Years in post	1 year of less	60	37.7%
	1-5 years	99	62.3%
	5 or more years	0	
	Total	159	100.0%
Profession/occupation	Social work	55	40.7%
	Counselling/Psychologist	5	3.7%
	Probation	3	2.2%
	Teacher	10	7.4%
	Nurse/midwife/doctor	41	30.4%
	Police	1	.7%
	Other	20	14.8%
	Total	135	100.0%
Ethnicity	White	151	92.1%
	BME	13	7.9%
	Total	164	100.0%
First motive for attendance	Volunteered	147	90.2%
	Required	16	9.8%
	Total	163	100.0%

7.3.3. Outcomes: Changes in mean total scores over time

Mean total scores for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 1. The total mean scores for all courses are also shown. Overall, there are increased in domestic abuse learning outcomes between the start and the end of the course.

FIGURE 1: TOTAL SCORES (MEANS) BY LSCB



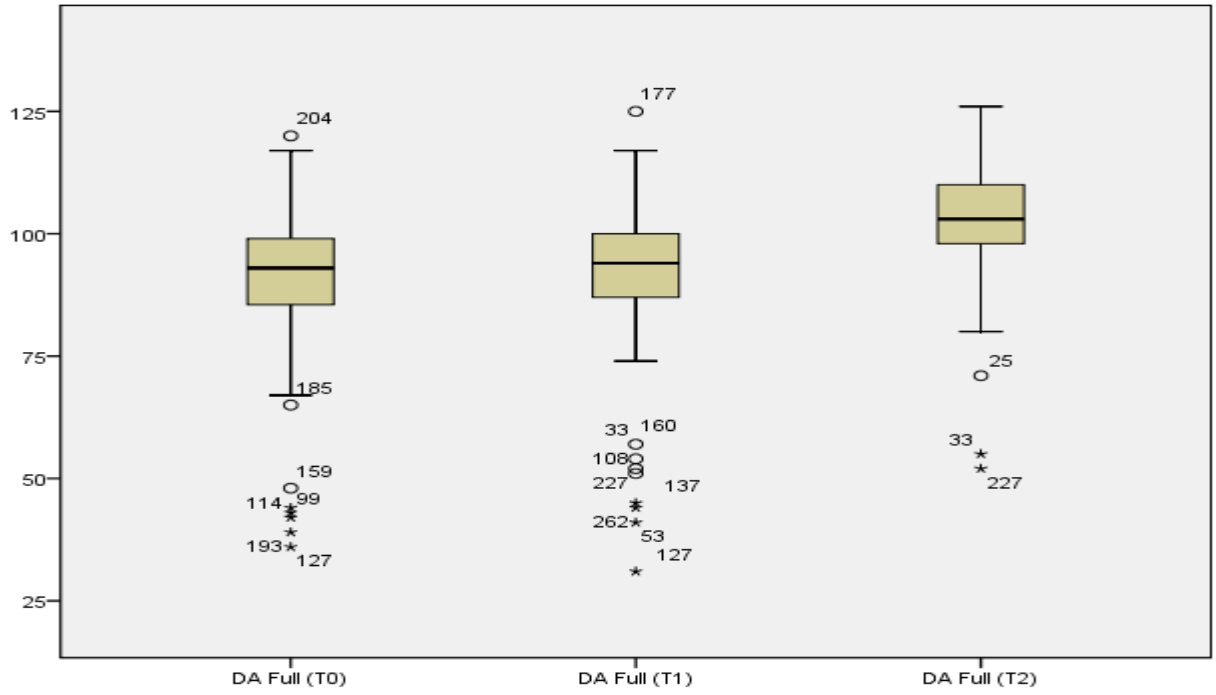
It is evident that there is a very similar pattern in all sites and this is confirmed by the statistical analysis (Table 2). Thus, there is no significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("very large" effect size), which was highly statistically significant. We were unable to determine whether this improvement was sustained at the three month follow-up due to poor response rates (n= 26 or 15% matched respondents).

TABLE 2: DOMESTIC ABUSE SCALE SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	98	91.76	12.91	93.34	12.13	1.58	1.48	-0.53	3.70	97	0.141	0.13
T1 - T2	177	93.12	11.94	103.44	11.42	10.31	11.17	8.49	12.13	176	**<0.001**	0.89

The same overall pattern is shown in the box and whisker plots (Figure 2). The distribution of scores at T2 indicates a substantial improvement over T1 for three quarters of the participants. There are a few outliers; one participant (ID=33) scored very poorly at both time points.

FIGURE 2: DISTRIBUTION OF TOTAL SCORES (POSSIBLE RANGE 28–140) AT SUCCESSIVE TIME POINTS



7.3.4. Outcomes: Changes in item scores over time

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 21 of the 28 items (Table 3).

There were highly statistically significant changes in the degree to which participants felt comfortable asking clients about domestic abuse; they were much less likely to consider this demeaning or to fear offending them. Participants were very significantly more likely to acknowledge that it is their responsibility to ask a woman if she is experiencing domestic abuse. They felt much more confident that they could correctly identify a woman who was being abused and were more likely to recognize that domestic abuse may be associated with any physical complaints they saw in their practice. Participants also reported feeling significantly more confident about talking to perpetrators.

At the end of the course, participants were very significantly more likely to acknowledge the direct link between child abuse and domestic violence and to recognise that children witnessing incidents of domestic violence are at great risk of significant harm. Participants were more likely to know that the postpartum period is the time of greatest risk for domestic violence. They reported very significantly more confidence in talking to children about their experiences of domestic abuse.

In terms of local policies and procedures, there were very significant improvements in participants' reported understanding of local information sharing policies for domestic abuse and in their confidence that they could make appropriate referrals for abused clients. At the end of the course they were very significantly more likely to believe that there were strategies they could use to help victims of domestic abuse change their situation

TABLE 3: DOMESTIC ABUSE SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
1	I feel comfortable asking clients about domestic abuse	3.4	1.00	4.1	0.77	175	-7.895	<0.001
2	I have clients whose personalities cause them to be abused	3.7	1.10	3.9	1.14	175	-2.052	<0.04
3	Abused women should leave their partners	3.5	0.89	3.3	1.09	173	-1.924	0.54
4	It is not my place to interfere with how a couple chooses to resolve conflicts	3.7	0.96	3.9	1.07	173	-2.511	<0.012
5	Separation will not put women and children at greater risk of further abuse	3.4	1.05	3.7	1.36	170	-2.457	<0.014
6	There are strategies I can use to help 'victims' of domestic abuse change their situation	3.7	0.87	4.3	0.67	177	-6.672	<0.001
7	I understand how my own experiences may influence my capacity and willingness to engage with issues of domestic abuse	3.8	0.90	4.1	0.82	176	-4.551	<0.001
8	Women experiencing abuse are deeply ashamed	3.4	0.94	3.8	1.01	176	-3.913	<0.001
9	Mothers in abusive relationships cannot be expected to have their children's welfare as their top priority	3.5	1.06	3.4	1.25	176	-1.608	0.11
10	I feel confident in talking to perpetrators about domestic abuse	2.9	1.15	3.4	1.12	177	-4.442	<0.001
11	Domestic abuse may be associated with just about any physical complaint I see in my practice	3.0	1.00	3.5	1.14	174	-5.57	<0.001
12	I have a good understanding of local information sharing policies for domestic abuse	3.0	1.05	3.9	1.01	176	-7.297	<0.001
13	Babies under one will hardly be affected in their health when they witness domestic violence	4.2	1.04	4.4	0.98	177	-2.289	<0.05
14	Abused women should leave their partners, whatever the circumstances	3.0	0.99	3.1	1.24	172	-0.383	0.22
15	In assessment of risk to a child, you should take into account differences in cultural norms in the acceptability of violence	3.8	1.12	3.9	1.32	171	-0.617	0.54
16	It is my responsibility to ask a woman if she is experiencing domestic abuse	3.5	0.94	4.0	1.01	171	-5.912	<0.001
17	Children of women who are abused are likely to grow up to be abusers or victims of domestic violence themselves	2.8	1.00	2.8	1.20	167	-0.688	0.49
18	I feel confident that I can make an appropriate referral for abused clients	3.6	0.98	4.2	0.91	168	-6.427	<0.001
19	A woman should expect to be re-abused if she decides not to take appropriate action after being offered help/advice	2.4	1.14	2.7	1.36	171	-2.696	<0.007
20	It is demeaning to clients to question them about abuse	3.5	0.93	3.9	1.12	169	-4.008	<0.001
21	The postpartum period is the time of greatest risk for domestic violence	3.2	0.90	3.8	1.24	165	-5.504	<0.001

22	There is no direct link between child abuse and domestic violence	3.8	0.88	4.3	1.07	171	-5.271	<0.001
23	I am afraid of offending my clients if I ask about abuse	3.6	1.11	4.1	1.09	171	-5.056	<0.001
24	The 'victim' has often done something to bring about abuse in the relationship	4.1	1.08	4.3	1.05	170	-1.25	0.21
25	I would personally feel confident that I could correctly identify a woman with experience of domestic abuse	2.8	0.95	3.4	0.95	170	-5.945	<0.001
26	I feel confident in talking to children about their experiences of domestic abuse	3.3	1.08	3.8	0.94	171	-5.864	<0.001
27	Children witnessing incidents of domestic violence are at great risk of significant harm	4.0	1.02	4.3	0.98	169	-3.408	0.001
28	Children recover quickly when they are no longer subject to exposure to domestic violence	2.5	1.02	2.6	1.27	165	-0.987	0.32

Reverse scored: 2, 4, 5, 9, 13, 15, 17, 20, 22, 23, 24.

Both at the beginning and end of the course participants strongly disagreed with the assertion that "the 'victim' has often done something to bring about abuse in the relationship." In other respects, their attitudes had changed very significantly: they were much less likely to think that women experiencing abuse are deeply ashamed or to endorse the view that a woman should expect to be re-abused if she decides not to take appropriate action after being offered help or advice. Further, they considered that they had a greater understanding of how their own experiences might influence their capacity and willingness to engage with issues of domestic abuse.

There were some areas in which no statistically significant changes were detected. For example, at the start of the course they were, on average, somewhat inclined to believe that mothers in abusive relationships cannot be expected to have their children's welfare as their top priority; at the end of the course they have not changed this position.

In general, respondents could not decide whether or not they agreed or disagreed with the statement that "Abused women should leave their partners, whatever the circumstances" and the course did not clarify their position on this matter. Similarly, there was a degree of uncertainty about whether or not children of women who are abused were likely to grow up to be abusers or victims of domestic violence themselves and the course did not clarify this for them. They were inclined to disagree that children recover quickly when they are no longer subject to exposure to domestic violence, but in general they were not very confident and again had not made up their minds by the end.

In general participants were inclined to agree that, when assessing the degree of risk to a child, practitioners should take into account differences in cultural norms in the acceptability of violence. This would be dangerous practice, of course, if by this they meant that they would be more tolerant of violence in certain ethnic groups. Their average position on this did not change at the end of the programme.

7.3.5. Predictors

Regression analysis was used to explore the predictors of baseline scores at the start of the courses. This showed that only score at T0 was a significant predictor of T1 scores. In other words, taking all these variables and their interactions into account, there were no significant effects on T1 scores associated with any demographic factors, profession, or the LSCB in which the courses too place. The regression model accounted for 20% of the variance.

What predicted high scores at the end of the course (T2)? Again, the regression analysis identified that baseline scores at the start were the only statistically significant predictor. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. No demographic variables, including profession and experience had any effect on changes in scores and neither did "required", as opposed to voluntary attendance. This regression model accounted for 21% of the variance.

7.4. Discussion

It is evident that these courses on domestic abuse attracted a disproportionate number of women; men were very poorly represented, which must be a matter of concern. Male professionals are just as likely to encounter women who have been abused as their female colleagues and are as likely to benefit from interagency training. The great majority of participants were social workers, family support worker and nurses, which begs the question about the GPs and other doctors who are probably those most likely to encounter abused women with children. Can we have confidence that they are sufficiently knowledgeable about their attitudes, the knowledge of the effects of domestic abuse on children and of current interagency safeguarding policies and procedures? The other group noticeably conspicuous by its absence is the police. Only two police officers attended the training.

In common with most of the other courses studied in this project, all participants were relatively recently qualified. Professionals who have been in services for five years or longer did not attend any of the courses in any of the LSCBs. Either they are not being offered interagency training, or they do not feel the need for it. This situation is concerning: not only has knowledge of the effects of domestic violence on children advanced over the last few years, but also local policies and procedures have developed. As outlined in the introduction, the revised edition of *Working Together* (2006) paid considerable attention to domestic abuse and safeguarding.

For those professionals who participated in the training courses and the evaluation, there were clear benefits. Even though we might expect a largely volunteer group made up of a majority of female social workers and nurses to be quite knowledgeable about domestic abuse and to have appropriate attitudes, there was strong evidence of positive change which can be attributed to the courses.

As predicted by the evaluation design (see chapter 4), there were no significant effects between registration (T0) and the start of the course (T1). However, from the start to the end (T2) there was very strong statistical evidence of improvements in participant's scores: the statistical significance of differences in mean total scores was very high and the effect size was very large.

Examination of the individual scale items showed highly statistically significant improvements in attitude, confidence and knowledge in the great majority of items. However, this detailed analysis revealed that participants were in general still uncertain on a number of important issues, for example whether abused women should leave their partners, whatever the circumstances, and were lacking in certain knowledge, for example whether or not children of women who are abused were likely to grow up to be abusers or victims of domestic violence themselves, and whether children recovered quickly when they are no longer subject to exposure to domestic violence. More worryingly, participants in general tended to think that when assessing the degree of risk to a child, practitioners should take into account differences in cultural norms in the acceptability of violence. As noted above, this would be dangerous practice.

In short, there was strong evidence that the overall outcomes of training, "to provide participants with an understanding of domestic abuse and the possible impact on the

developmental outcomes for children. Understand own and other agencies' contribution to safeguard children exposed to domestic abuse" (Box 1) were being achieved.

But was this learning sustained? Here the evidence is weaker. There was a poor response to the T3 three month follow-up questionnaire. This amounted to 15% of paired T1-T2 sample (177 pairs). So, while the T2-T3 analysis showed anecdotal evidence that improvements in knowledge and self-efficacy had indeed been retained, we can only say that this was true for the 26 trainees (15%) who chose to respond. It may not have been the case for the remainder.

Nevertheless, we consider that the overall findings from the evaluation of these courses are very encouraging. So too is the demonstration through the regression analysis that participants in all the different LSCBs courses benefited (as indicated also in the graphical evidence, Fig. 2). Interestingly, the length of course did not make a difference to the scores, all other variables being taken into account. This suggests that one-day courses are equally effective as two day courses and, since they must cost less to provide and attend, implies that they are much more cost-effective. However, a word of caution is relevant here: this evaluation is only as good as its measures. It is possible that the measures do not capture all the learning, especially the depth of learning, that longer courses might engender. We cannot say. What is clear is that these courses were equally beneficial to all professional groups and to professionals of all age groups, both genders and with different levels of experience and irrespective of whether they had volunteered or been required to attend. LSCB can therefore, on the basis of this evidence, commission and promote these courses to all comers with considerable confidence.

7.5. References

Abrahams, C. (1994) *Hidden Victims: Children and Domestic Violence*, London: NCH Action for Children.

Bacchus L, Aston G, Torres Vitolas C, Jordan P, and Murray S.F. (2007) *A theory-based evaluation of a multi-agency domestic violence service at Guy's & St Thomas' NHS Foundation Trust*. London: King's College London. Available from http://www.kcl.ac.uk/schools/nursing/research/violence (accessed 18.02.09)

BMA (2007) *Domestic Abuse* – A report from the BMA Board of Science, BMA: London. http://www.bma.org.uk/images/PDFDomesticAbuse_tcm41-147013.pdf (accesses 26.01.09).

Brandon, M. and Lewis, A. (1996) 'Significant Harm and Children's Experiences of Domestic Violence', *Child and Family Social Work*, 1, (1). pp.33-42.

Buckley, H. Holt, S. and Whelan, S. (2007) Listen to me! Children's experiences of domestic violence, *Child Abuse Review*, 16, 296-310.

Calder, M. (2004) *Children Living with Domestic Violence*. Russel House: Lyme Regis.

Cann, K. Withnell, S. Shakespeare, J. Doll, H. and Thomas, J. (2001) Domestic violence: A Comparative survey of levels of detection, knowledge, and attitudes in healthcare workers. *Public Health*, 115, pp. 89-95.

Cleaver, H. Nicholson, D. Tarr, S. Cleaver, D. and Holloway, R. (2008) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. Executive Summary, DCSF.

The Crown Prosecution Service (2008) *Evaluation of the national domestic violence training programme 2005-2008*. Available at: http://www.cps.gov.uk/publications/equality/evaluation_of_national_domestic_violence_training_programme.html (accessed 24.01.09)

Hester, M. Pearson, C. Harwin, N. (2000) *Making an Impact: Children and Domestic Violence, A Reader*. Jessica Kingsley Publications: London.

Hughes, H. Graham-Bermann, S. and Gruber, G. (2001) 'Resilience in Children Exposed to Domestic Violence' in Graham-Bermann, S. and Edleson, J. (eds) *Domestic Violence in the Lives of Children: The Future of Research, Intervention and Social Policy*, Washington DC: American Psychological Society.

HM Government (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*.

Humphreys, C. (1999) Avoidance and confrontation: social work practice in relation to domestic violence and child abuse, *Child and Family Social Work*, 4, 77-87.

Humphreys, C. and Mullender, A. (2002) *Children and Domestic Violence: A Research Overview of the Impact on Children*. Dartington: Devon.

Humphreys, C.and Stanley, N. eds. (2006) *Domestic Violence and Child Protection*. Jessica Kingsley, London.

Humphreys, C., Houghton, C. and Ellis, J. (2008) *Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice*. Edinburgh: The Scottish Government.

Kitzmann, K. Gaylord, N. Holt, A. and Kenny, E. (2003) Child Witnesses to Domestic Violence: a Meta-Analytic Review', J*ournal of Consulting Clinical Psychology*, 71, pp. 339-352.

LGA, ADSS, CAFCASS and Women's Aid (2005 October) *A Vision for Services for Children and Young People Affected by Domestic Violence – guidance to local commissioners of children's service*.

Martin, S. G. (2002) Children Exposed to Domestic Violence: Psychological Considerations for Health Care Practitioners. *Holistic Nursing Practice* 16, pp. 7-15.

Maiuro, R. D. Vitaliano, P. P. Sugg, N. K. Thompson, D. C. Rivara, F. and Thompson R. S. (2000) Development of a healthcare provider survey for domestic violence: psychometric properties. *American Journal of Preventive Medicine*, 19: 254-252.

McCauley, J. Jenckes, M. and McNutt, L. (2003) L-ASSERT: the effectiveness of a continuing medical education video on knowledge and attitudes about interpersonal violence. *Academic Medicine*, 78, pp. 518-524.

Mertin, P and Mohr, P. (2002) 'Incidence and Correlates of Post-Trauma Symptoms in Children from Backgrounds of Domestic Violence', *Violence and Victims*, 17.

McGee, C. (2000) *Childhood Experiences of Domestic Violence*. Jessica Kingsley, London.

Mullender, A., Kelly, L. Hague, G. Malos, E. and Iman, U. (2002) *Children's Perspectives on Domestic Violence*, London: Routledge.

Patterson, G. T. (2004) Evaluating the Effects of Child Abuse Training on the Attitudes, Knowledge, and Skills of Police Recruits. *Research on Social Work Practice*, 14, 4, 273-280.

Saunders, D. G. and Anderson, D. (2000) Evaluation of a Domestic Violence Training for Child Protection Workers and Supervisors: Initial Results. *Children and Youth Service Review*, 22, 5, pp. 373-395.

Walby, S. and Allen, J. (2004) *Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey*, London: Home Office Research Study 276, Home Office Research, Development and Statistics Directorate.

Warburton, A. L. Hanif, B. Rowsel, C. and Coulthard P. (2006) Changes in the levels of knowledge and attitudes of dental hospital staff about domestic violence following attendance at an awareness raising seminar, *British Dental Journal*, 201, 10: 653-659.

8. Outcomes of Interagency Training for Safeguarding Disabled Children

8.1. Introduction

Working Together to Safeguard Children (HM Government 2006, Sec. 11.27) suggests that disabled children are at increased risk of abuse and, further, that having multiple impairments increases the risk of both abuse and neglect. The reasons for this increased vulnerability are suggested as being that they:

- have fewer outside contacts than other children
- receive intimate personal care, possibly from a number of carers, which may both increase the risk of exposure to abusive behaviour and make it more difficult to set and maintain physical boundaries
- have an impaired capacity to resist or avoid abuse
- have communication difficulties that may make it difficult to tell others what is happening
- be inhibited about complaining because of a fear of losing services
- be especially vulnerable to bullying and intimidation and/or be more vulnerable than other children to abuse by their peers (HM Government 2006, Sec. 11.27).

Standard 8 of the National Service Framework for Children, Young People and Maternity Services requires that LSCBs ensure that all disabled children are safeguarded from emotional, physical and sexual abuse and neglect; and that the specific needs of disabled children are addressed in safeguarding children protocols.

8.1.1. Brief review of the literature

Much of the literature on the incidence of abuse amongst disabled children is based on the analysis of abused populations. For example, Morris (1999) analysed the composition of the child protection register in an English county councils and found that, although disabled children made up only 2% of the local child population, they accounted for 10% of children on the register. However, studies which draw on samples of abused children, or disabled children are subject to sample bias and for more accurate estimates we should turn to whole population-based studies.

A systematic review by Govindshenoy and Spencer (2006) identified four good quality studies. Sidebotham and Heron 2003 studied nearly 120,000 children in West Sussex; Spencer et al . (2005) drew on the prospective Avon Longitudinal Study of over 14,000 children in South west England. There were two other studies, (Brown et al. 1998 and Vizcarra et al. 2001) which were based on much smaller randomly selected samples from defined populations in New York State and Chile, respectively. The English studies are particularly relevant here.

The Avon study found, after controlling for potentially confounding variables such as socio-economic status and maternal age, a two-fold increased risk of child abuse amongst children whose parents had reported concern about development delay before the child had reached 30 months. 'Risk of abuse' was defined as being on the child protection register.

The more extensive study, by Spencer et al., (2005) reported estimates of the odds ratios for risk of abuse for a range of impairments. They concluded that there was no evidence of an association between either childhood autism or sensory impairments and abuse. However, children with cerebral palsy where three times more likely to be physically abused and 2.7 times more likely to be neglected than non-disabled children. Children with learning difficulties had a four times higher risk of abuse in general and a six times greater risk of sexual abuse than non-disabled children. Speech and language problems were also

significantly associated with all forms of abuse except sexual abuse. Children assessed as having a conduct disorder were around seven times more likely to be at risk of abuse in general, and eleven times more likely in the case of emotional abuse. Emotional problems such as anxiety and depression were also strongly associated with emotional abuse. As the reviewers point out, however, we cannot conclude that psychological problems predispose children to abuse; it may be that dysfunctional parenting and other family factors which contribute to psychological and emotional problems may also culminate in abuse.

Govindshenoy and Spencer (2006) considered that overall the evidence base was weak and concluded their review by suggesting that practitioners should avoid the assumption that children with *any* [emphasis added] form of disability are more vulnerable to abuse and/or neglect than non-disabled children. "Although they should remain alert to the possibility of abuse and neglect as they should with all children, there is currently insufficient high quality evidence to justify the assumption of increased risk with the possible exception of children with psychological, emotional and learning disabilities." (p.557). In the light of these observations, it seems fair to conclude that a more cautious and nuanced understanding of the possible associations between abuse and impairments would be appropriate than previous more simplistic accounts. Nevertheless, the particular circumstances of disabled children deserve especial attention when considering how they might be safeguarded from abuse.

8.1.2. The importance of interagency working and training

A resource guide published by DfES (2006) asserted that, "In spite of this greater vulnerability [of disabled children to abuse], there is also evidence that current safeguarding systems do not adequately protect disabled children from harm." Citing reviews by Kennedy (2002) and Edwards and Richardson (2003), the authors suggested a number of reasons for this. These included the possibility that practitioners who are not familiar with disabled children may misinterpret indicators of abuse or neglect, particularly behavioural indicators, as being related to impairment; conversely, practitioners in specialist services for disabled children may not be trained in safeguarding children. The guide's authors also considered that many professionals do not think of disabled children are 'credible witnesses' and that they believe that police are unlikely to investigate allegations of abuse. Further, they contended that professionals, particularly social workers, are reluctant to confront carers, partly because it would be difficult to find an alternative placement for the child. Finally, they noted that disabled children are likely to be in contact with a number of different services. This creates the potential for disabled children's safeguarding to fall between the gaps and means that the sharing of information and coordination of responses is especially important.

Working Together (2006, Sec. 11.30) advocated special attention to the communication needs of some disabled children in child protection investigations so that the children's perceptions of events and his or her wishes be ascertained (see also Oosterhoon and Kendrick, 2001). The guidelines stress that agency staff should not make assumptions about a child's (in)ability to provide credible evidence and that they should strive to support these children in dealing with the courts, if necessary.

The authors of the DfES resource guide argued that an awareness of the needs and experiences of disabled children and, by implication, multi-agency responses to those needs should be addressed at all levels of training for safeguarding (DfES, 2006). Thus, they consider that particular issues relating to disabled children should be incorporated into basis safeguarding training for all those in contact with children; and, in addition, specific training courses on the safeguarding of disabled children should be run for practitioners who work regularly with these children and who have a particular responsibility for their safeguarding. However, although there have been a number of papers advocating training about safeguarding for disabled children (Ellis and Hendry, 1998;

Oosterhoon and Kendrick, 2001) there do not appear to be any previously published evaluations of training on this topic.

8.1.3. Previous evaluations

A comprehensive search prior to the initiation of the evaluation project did not yield any comparable evaluations.

8.1.4. Courses

The DfES Resource guide recommended that specialist training courses should be concerned with: "…challenging attitudes towards disabled children and abuse or neglect; increasing knowledge of the needs and circumstances of disabled children, and of the nature of their vulnerability to abuse or neglect; increasing knowledge of relevant legislation, guidance and procedures and their application to disabled children; and acquiring skills to communicate with disabled children, and to carry out assessments of their needs, and enquiries and investigations of abuse or neglect" (DfES 2006 5.4).

Five of the participating LSCBs were offering specialist (Level 3) courses during the study period. These courses were open to any staff who regularly worked with children, young people and their families, including disabled children and offered an average of 20 places each.

The learning outcomes of the courses sampled were almost identical and are these are summarised in Box 1. It can be seen that they reflect the DfES guidelines closely.

Box 1: Learning Objectives of courses

- Identify factors which contribute to increased risk for disabled children
- Raise awareness - within child protection frameworks - of the needs and difficulties that disabled children face
- Explore good practice in relation to the safeguarding of disabled children
- Learn about methods of communicating effectively with disabled children
- Discuss strategies to empower disabled children
- Challenge prejudices and practices that add to the vulnerability of disabled children
- Understand local interagency procedures for safeguarding disabled children

Summary of learning objectives: Promote effective interagency child protection practice with disabled children by developing participants' knowledge and skills. Raise an awareness of the needs and difficulties that are experienced by disabled children.

Four of the LSCBs offered one day courses lasting seven hours, including lunch, which was seen as a good opportunity for networking and informal exchanges between staff from different agencies. These courses typically combined lectures based on research on needs and presentation of good practice guidelines; videos of children and their carers; presentation and discussion of interagency procedures; exploration of personal and organisational attitudes; case studies of safeguarding; and practical communication exercises. The other LSCB (LSCB D) provided the course over two days, six weeks apart. This course had a special emphasis on learning communication skills for working with disabled children.

8.2. Methods

8.2.1. Procedures

The procedures for the evaluation of the courses are as described in Chapter 4.

For this set of courses only, participants at T3 were asked to indicate whether they would be willing to participate in a follow-up telephone interview with a researcher and, if so, to forward their contact details via the training co-ordinator.

8.2.2. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

A search of the literature failed to identify any published measures of professionals' knowledge and self-efficacy in relation to safeguarding disabled children; consequently a self-report questionnaire was developed specifically for this study. A set of statements was compiled with reference to the stated learning objectives of the courses. These included self-efficacy statements such as, "I can explain the relevant legislation about disabled children and abuse", statements designed to assess knowledge, e.g. "Physically disabled children and young people are over 4 times more likely to be abused than their non-disabled peers." The statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree").

The draft questionnaire was piloted with a class of 24 professional social workers undertaking a postqualifying course in child care social work. The internal reliability of the draft scale was assessed using Cronbach's alpha and two of the original sixteen statements were subsequently excluded because responses to these were inconsistent. Test-retest reliability was assessed by comparing ratings made at the beginning and end of the class (which was on disabled children in general); there were no statistically significant changes in responses in any of the items and overall scores at both time points were highly correlated. The 14-item version of the scale used in the study is presented in Table 3. The reverse-scored items are indicated. In addition, respondents were asked to list up to five reasons which disabled children might be more vulnerable to abuse or neglect.

The semi-structured interview schedule was designed to explore respondents' views on the outcomes of learning at the various levels defined by Kirkpatrick (1967). These were: changes in attitudes and perceptions towards disabled children and their carers and towards other safeguarding professionals; the acquisition of knowledge and skills in relation to safeguarding disabled children; changes in their own practice and in organisational responses; and any benefits for disabled children and families which they associated with their attendance on the course.

8.2.3. Data analysis

Procedures for quantitative data analysis are described in Chapter 4.

The telephone interviews were analysed thematically, such as in identifying the different forms of knowledge gained in terms of concepts, processes and principles. They were also analysed in relation to the factors which appeared to have led to different outcomes, for example, in the extent to which participants had been able to apply knowledge gained on the course.

8.3. Results

8.3.1. Participants

Demographic data were available on 135 course participants from 5 LSCB areas (Table 1).

TABLE 1: COURSE PARTICIPANTS

		NUMBER	%
	B	17	8.8%
	C	45	23.3%
	D	21	10.9%
	E	39	20.2%
	G	71	36.8%
	Total	193	100.0%
Gender	Female	117	88.1%
	Male	18	11.9%
	Total	135	100.0%
Age	18-30	22	16.3%
	31-40	33	24.4%
	41-50	55	40.7%
	51+	25	18.5%
	Total	135	100.0%
Years in service	1 year or less	7	5.3%
	1-5 years	126	94.7%
	5-10 years	0	
	10 or more years	0	
	Total	133	100.0%
Years in post	1 year or less	34	24.8%
	1-5 years	101	75.2%
	5 or more years	0	
	Total	135	100.0%
Profession/occupation	Social work	25	18.5%
	Family Support Worker	11	8.1%
	Doctor	1	1.0%
	Teacher	12	8.8%
	Nurse	18	13.3%
	Police	3	2.3%
	Foster carer	8	5.9%
	Occupational therapist	5	3.7%
	Nursery nurse	5	3.7%
	Admin/support staff	15	11.1%
	Other	37	27.4%
	Total	101	100.0%
Ethnicity	White	132	97.7%
	BME	3	2.3%
	Total	135	100.0%
First motive for attendance	Volunteered	100	75.8%
	Required	32	24.2%
	Total	132	100.0%

Two LSCBs ran more than one course and participants in these areas accounted for over half the total. Professional representation was widely distributed across social services,

education and health; a quarter of the participants were social workers or family support workers. As with most other level two courses in this study, the great majority were white women and had one to five years service experience. In comparison to other courses, a relatively high proportion, one in four, had been required to attend.

There no other statistically significant differences in the proportions of respondents at T0 and T1 by age group, gender, years since professional qualification, years in present post, ethnicity and primary motive for attendance (volunteered or required).

8.3.2. Psychometrics of the Scale

The internal reliability of the scale as assessed by Cronbach's alpha varied between 0.59 at T1, which is marginal, to 0.79 at T3, which is good.

Principal components analysis identified four factors. The first factor was clearly related to *self-efficacy* in relation to procedures and processes; the second was associated with *knowledge* items; the third with *confidence in practice* and a fourth factor with *attitudes* to disabled children and abuse. Together, these factors accounted for 60.5% of the variance. This four factor solution was supported by graphical evidence found in the scree plot. Results from the PCA at the other time points were quite similar. This shows that the scale was performing very satisfactorily.

8.3.3. The analysis of changes in mean total scores over time

Mean total scores for participants in each LSCB at each time point are shown in Figure 1. Because the matched samples between T2 and T3 meet the inclusion criteria in Chapter 4, three month follow-up scores are presented and commented upon. The total means scores for all courses are also shown. It is evident that there is a very similar pattern in all sites and this is confirmed by the statistical analysis (Table 2). Thus, there is no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("very large" effect size), which was highly statistically significant. This improvement was maintained at follow-up (T3).

FIGURE 1: TOTAL SCORES (MEANS) BY LSCB

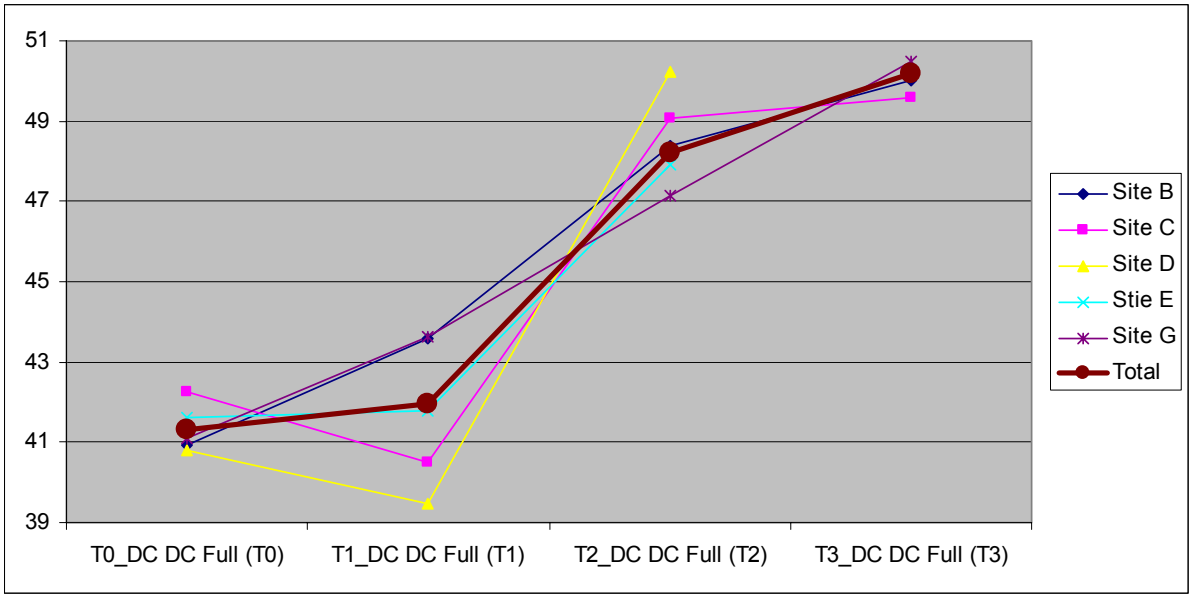
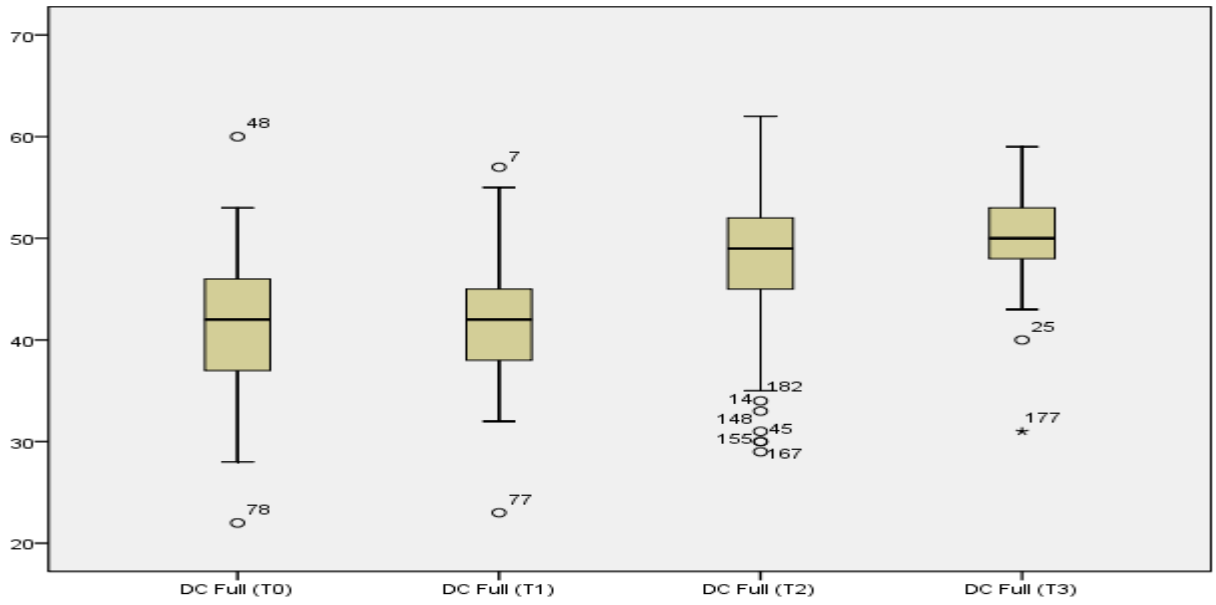


TABLE 2: SAFEGUARDING DISABLED CHILDREN SCALE TOTAL SCORES: PAIRED SAMPLES T-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	34	41.15	7.08	42.03	6.29	0.88	0.93	-1.04	2.80	33	.357	0.13
T1 - T2	90	42.22	5.53	48.01	5.64	5.79	8.86	4.49	7.09	89	< .0001	1.04
T2 - T3	29	49.45	5.38	50.28	5.59	0.83	8.86	-1.54	3.19	28	.480	0.15

The same overall pattern is shown in the box and whisker plots (Figure 2). Here it is evident that the range of scores at T2 is quite large, with some high scores (top quartile) matched by some relatively low scores (bottom quartile) and a small number of low scoring outliers.

Figure 2: Distribution of total scores (possible range 14 – 70) at successive time points



An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 12 of the 14 items (Table 3 below). Participants at the finish of the course (T2) reported greater confidence in their ability to describe the potential circumstances which make disabled children vulnerable to abuse. There were very significantly more likely to recognise that disabled children may not understand that they have been abused. However, contrary to expectations, respondents disagreed with the statement that "Compared to non-disabled children, disabled children who say they have been abused are less likely to believed by adults." In fact this statement is quite well supported in the literature (Kelly, 1992; Osterhoorn and Kendrick, 2001). However, closer inspection of the scale's reliability analysis suggests that this revere-scored item was less reliable than others; respondents may have been confused.

TABLE 3: DISABLED CHILDREN SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	I feel confident in my ability to communicate effectively with disabled children about abuse	2.9	1.01	3.7	0.94	88	-6.189	<0.001
Q2	Physically disabled children and young people are over 4 times more likely to be abused than their non-disabled peers	2.1	0.90	1.8	0.88	87	-3.711	<0.001
Q3	I can explain the relevant legislation about disabled children and abuse	2.6	0.91	3.7	1.00	88	-6.589	<0.001
Q4	Disabled children may not understand that they have been abused	3.9	1.04	4.2	0.99	89	-2.872	0.004
Q5	I have a good understanding of local interagency procedures on safeguarding disabled children	3.2	0.98	3.9	0.99	89	-5.392	<0.001
Q6	Compared to non-disabled children, disabled children who say they have been abused are less likely to believed by adults	2.6	1.03	2.2	1.12	90	-3.004	0.003
Q7	Children with sensory impairments are no more likely to be abused than non-disabled children	2.7	0.92	2.8	1.32	88	-0.092	0.927
Q8	I am clear on my roles and responsibilities when abuse of a disabled child is alleged or suspected	3.9	0.94	4.3	0.80	90	-4.205	<0.001
Q9	I am confident that I know how to use thresholds for triggering assessments of disabled children in suspected cases of abuse	3.0	1.04	3.8	0.96	89	-5.201	<0.001
Q10	I am afraid of offending parents if I ask about abuse in relation to their disabled child	3.4	1.19	3.7	1.13	88	-2.351	0.019
Q11	Children with conduct disorders are the most likely group to experience physical and sexual abuse	3.0	0.70	3.0	0.93	89	-0.1	0.920
Q12	I would personally feel confident that I could correctly identify a disabled child who had been abused	2.6	0.92	3.3	0.83	86	-5.212	<0.001
Q13	I can give examples of ways of empowering disabled children who may have been abused	3.0	0.91	3.9	0.74	89	-6.169	<0.001
Q14	I can describe the potential circumstances which make disabled children vulnerable to abuse	3.5	0.79	4.3	0.73	88	-5.629	<0.001

Reversed scoring: 2, 6, 10

At the end of the courses, participants reported feeling very significantly more confident that they could correctly identify a disabled child who had been abused and significantly less afraid of the prospect of offending their parents if they asked about it. They were also felt very significantly more confident about their ability to communicate effectively with a disabled child about abuse and that they could give examples of ways of empowering disabled children who may have been abused.

Participants reported very significant increases in their understanding of local interagency procedures on safeguarding disabled children and in clarity concerning their own roles and responsibilities when abuse of a disabled child is alleged or suspected. This was supported by a highly significant increase in their confidence in being able to explain the relevant legislation. Participants were very significantly more confident in using thresholds for triggering assessments of disabled children in suspected cases of abuse.

While it is true that physically disabled children and young people are more likely to be abused than their non-disabled peers, the statement that this is four times more likely is a deliberate overestimate (Govindshenoy and Spencer, 2006). Respondents in general were correct in thinking this to be the case and were significantly more confident in this knowledge at the end of the course. However, there were two items on which there had been no improvements in knowledge about the likelihood of children with different impairments being abused. In general, participants did not know that children with conduct disorders are the most likely group to experience physical and sexual abuse or that children with sensory impairments are no more likely to be abused than non-disabled children.

8.3.4. Open-ended question

Content analysis of responses to the final open question, which asked participants to identify reasons why disabled children might be more vulnerable to abuse and neglect, supported the participants' self-reported confidence about their knowledge. By far the most common answer was communication deficiencies such that disabled children were unable to tell others who might protect them; also abusers may think that no one would find out about the abuse and children may be unable to get away from situations with which they were uncomfortable. Other suggestions were that some disabled children would not understand what is wrong and that they often had lots of carers with whom they had intimate contact through a need with personal care.

Overall, whereas at the start of the course, answers were often more to do with the disabled children and their carers themselves (individual factors), by the end of the course participants were able in addition to identify wider institutional and societal factors as well such as a lack of interprofessional cooperation and poor interprofessional communication. They were also more likely to cite institutional sympathy for parents, for example, not wanting to challenge parents or carers and making the assumption that nobody would abuse a disabled child.

8.3.5. Predictors

The regression analysis of scores at the start of the courses showed that none of the potential predictor variables were significant at the 5% level, although score at registration was marginal. In other words, taking all these variables and their interactions into account, there were no significant effects on T1 scores associated with any demographic factors, profession, or the LSCB in which the courses too place. The regression model accounted for 31% of the variance.

What predicted scores at the end of the course (T2)? Analyses revealed that scores at the start of the course were the only statistically significant predictor. In other words, controlling for all other potential predictors, the higher the mean total score at the start, the higher the score at the end. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. No demographic variables, including profession and experience had any effect and neither did "required", as opposed to voluntary attendance. Taken together, the predictors accounted for 22% of the variance.

8.3.6. Follow up interviews

Three course participants agreed to take part in a semi-structured interview between four and six months after the end of the Safeguarding Disabled Children training course in which they participated. The interviews took between 45 and 60 minutes in total and covered several areas in relation to the training such as How decisions about CPD, course choice/attendance are made? What they learned? If they have had the opportunity to use the skills gained in the course? And the benefits to services users?

Each of the respondents stated that they thought it would help their knowledge and performance in their current position in some way.

> *"Since had no direct experience thought it would help my knowledge and ultimately performance"* (Participant, Site C)

> *"Think it would help my performance in my current position by improving my skills"* (Participant, Site B)

In relation to the acquisition of new knowledge and skills, respondents identified a range of areas in safeguarding disabled children which were improved through their participation in interagency training.

The training appears to have increased knowledge of the concepts of safeguarding disabled children.

> *"I didn't realise how much more vulnerable disabled children are"* (Participant, Site B)

> *"Raised awareness of different types of abuse..and now more alert to the signs of potential abuse"* (Participant, Site C)

There was mixed response to increased knowledge of the processes in safeguarding disabled children. One of the respondents did not feel it helped to increase their procedural knowledge, while one other said that it had. There was also some sense that the procedures for safeguarding all children are the same, regardless of level of physical/mental ability.

> *"As far as I am aware the processes are the same for every child, regardless of disability, so no, not really"* (Participant, Site C)

In terms of the principles of safeguarding disabled children, there was agreement that the specialist course did not add to their basic knowledge or understanding, but that there was some added value in getting a better understanding of the principles of specific procedures in the safeguarding children system, for example, Child Protection Conferences.

> *"Already knew about basic principles from Level 1 CP training"* (Participant, Site C)

> *"Learned more about child care conferences and 'strategy discussions' and how they are initiated"* (Participant, Site C)

> *"We are quite aware of principles, but did signpost us to specific aspects of legislation we need to refer to"* (Participant, Site B)

When asked which specific skills they acquired in the training, respondents' answers ranged from confirmation of what they already know to identifying signs of potential abuse.

"Less likely to take things on face value…more confidence in being able to tackle potential CP issues" (Participant, Site C)

"Keeping both an open-eye and open-mind as well as fostering more professional distance where action must be taken" (Participant, Site C)

"Good tips gotten through the course about how to assess potential SG issues" (Participant, Site B)

"Cemented a lot of things I was already trying to do, e.g. parents know their families' needs the best…confirmed a lot of this" (Participant, Site B)

When asked if they have had the opportunity to use the skills gained in the course, two of the respondents had not because of a lack of clientele, and the other one stated that it has helped them to introduce their families to new support services and people. As far as the actual and potential benefits to service users is concerned, each respondent stated that the training has and will help them ultimately in safeguarding disabled children, which will have positive outcomes for disabled children and their families/carers.

"Service users gain from the fact that we develop networks which can be called upon for help…increased access to services for parents" (Participant, Site B)

"We are very good in this area but training has helped us be aware of different perceptions and how to communicate with professionals in a different way knowing that there are differences in perceptions" (Participant, Site B)

"Don't know really right now but my knowledge has increased as has my confidence…but in the longer term it will, ie. when I do have such clients" (Participant, Site C)

8.4. Discussion

These courses on safeguarding disabled children were successful in attracting a varied membership from the range of LSCB partner agencies, including health, social services and education. Nearly a quarter had been required to attend, a relatively high proportion when compared to other courses in the study.

The great majority of attendees had been in service for between one and five years, which suggests that these level 2 courses were considered very suitable for relatively recently qualified staff beyond their induction year. Once again, it is noticeable that professionals who have been in services for five years or longer did not attend any of the courses. We cannot say whether this is because they are not being offered the opportunity to update their skills and knowledge in interagency working or whether they do not feel the need for it. It is surprising given their very likely contact with disabled children who may also have been abused, that only one doctor is recorded as having attended. We have to question whether doctors are sufficiently well informed about current interagency procedures in relation to these children including, for example, thresholds for triggering assessment.

The Safeguarding Disabled Children scale developed especially for this study performed quite satisfactorily in terms of its internal reliability. Exploratory principle components analysis provided good evidence of its validity in measuring discrete factors associated with self-efficacy and knowledge. Further refinement of this scale through the collection of data from larger samples for further psychometric analysis would be justified.

As predicted by the evaluation design (see chapter 4), there were no significant effects between registration (T0) and the start of the course (T1). However, from the start to the end (T2) there was very strong statistical evidence of improvements in participants' scores:

the statistical significance of differences in mean total scores was very high and the effect size was very large.

Examination of the individual scale items showed highly statistically significant improvements on almost all items, including knowledge of interagency policies and procedures and self-efficacy in identifying and working with abused disabled children. Participants were also more knowledgeable about the reasons why disabled children might be vulnerable to abuse, as attested by their post-course responses to the open questions as well as scale rating. In one important area, knowledge of the relatively high incidence of abuse for children and young people with conduct disorders, there was no improvement. This is possibly because as far as the training courses are concerned, such children are not included in the disabled group.

It is safe to conclude there was strong evidence that the overall outcomes of training, "To promote effective interagency child protection practice with disabled children by developing participants' knowledge and skills and by raising awareness of the needs and difficulties that are experienced by disabled children" (Box 1) were being achieved. Evidence from the follow up interviews supported this conclusion; we found that through their participation in training, participants felt more knowledgeable about the specific concepts, processes and principles of safeguarding children, but also that they acquired new skills which they currently use or plan to use in the future. Respondents to the interviews suggested that the increased knowledge and skills gained from the course will result in safeguarding disabled children and promoting their well being.

But was this learning sustained? The response rate to the T3 three month follow-up questionnaire was quite reasonable, at 32% of those completing the pre- and post-course measures. Mean total scores at follow-up were marginally, but not significantly, higher than end of course score. This indicates that the learning was indeed sustained.

In conclusion, the overall findings from the evaluation of these courses are very encouraging. Further, the regression analysis demonstrated that participants in all the different LSCBs courses benefited (as indicated also in the graphical evidence, Figure 1). Once again, the length of course did not make a difference to the scores, all other variables being taken into account. This suggests that one-day courses are equally effective as two day courses and, since they must cost less to provide and attend, implies that they are much moiré cost-effective. However, it is very possible that the measures do not capture all the learning gained on the longer courses. Thus, the scale contains only one question specifically on the ability to communicate effectively with disabled children; this was the main focus of some of the two day courses.

We conclude once more that these courses were equally beneficial to all professional groups and to professionals of all age groups, both genders and with different levels of experience and irrespective of whether they had volunteered or been required to attend.

8.5. References

Brown, J., Cohen, P., Johnson, J. G. and Salzingerr, S. (1998) A longitudinal analysis of risk factors for child maltreatment: findings of a 17 year prospective study of officially recorded and self reported child abuse and neglect. *Child Abuse and Neglect*, 22: 1065–78.

Department for Education and Skills (2006) Safeguarding Disabled Children: A Resource for Local Safeguarding Children Boards. London, DEfS. Available from http://www.everychildmatters.gov.uk/ (accessed 24.11.08).

Edwards, H. and Richardson, K. (2003) 'The child protection system and disabled children' in Morris, J. *"It doesn't happen to disabled children" Child protection and disabled children* – Report of the National Working Group on Child Protection and Disability, NSPCC.

Ellis, R, and Hendry, E. B. (1998). Do we all know the score? *Child Abuse Review*, 7: 360–3.

Govindshenoy, M and Spencer, N. (2006) Abuse of the disabled child: a systematic review of population-based studies *Child: care, health and development*, 33(5): 552–558.

Kelly L. (1992). Can't hear or won't hear?—the evidential experience of children with disabilities. *Child Abuse Review,* 1: 188-90.

Kennedy, M. (2002) 'Disability and child abuse' in Wilson, K and James, A. (eds.) *The Child Protection Handbook*, New York, Balliere and Tindall.

Morris, J. (1999) Disabled children, child protection systems and the Children Act, *Child Abuse Review*, 8: 91-108.

Oosterhoon, R. and Kendrick, A. (2001) No sign of harm: issues for disabled children communicating about abuse, *Child Abuse Review* 10: 243–53.

Sidebotham, P., Heron, J. and ALPSAC Study Team (2003) Child maltreatment in the children of the nineties: the role of the child. *Child Abuse and Neglect*, 27: 337–52.

Spencer, N., Devereux, E., Wallace, A., Sundrum, R., Shenoy, M., Bacchus, C. and Logan, S. (2005) Disabling conditions and registration for child abuse and neglect: a population based study. *Pediatrics*, 116: 609–13.

9. Parental Mental Illness and Safeguarding Children

9.1 Introduction

Woking Together (2006, 9.16) draws attention specifically to the potential impacts on a child's development of living with a parent with mental illness. The guidance takes care to point out that mental illness in a parent or carer does not necessarily have an adverse impact, but argues that it is necessary for professionals to assess its implications for any children in the family. The Royal College of Psychiatrists (2004, p.19) emphasised that the "The majority of adults with mental health problems do not abuse their children or intentionally or otherwise neglect them. However, all forms of mental disorder in a parent (or in a parent's partner) increase the risk of abuse and neglect of the child."

9.1.1. Brief review of the literature

The *Working Together* guidance cites a study by Falkov (1996) of one hundred reviews of child deaths where abuse and neglect had been a factor in the death; this study concluded that there was clear evidence of parental mental illness in one-third of the cases examined. Of course there are many forms of mental illness, some potentially more dangerous than others. Thus, the guidance notes that some conditions may blunt parents' affect, or cause them to behave towards their children in bizarre or violent ways. In some of these cases, for example where a child becomes the focus of paranoid delusions, he or she may be at risk of severe injury and death. A parent who is severely depressed may very well neglect their children's physical and emotional needs as well as their own. On the other hand, a period of mental illness may be relatively mild and or transitory and in the context of supportive family relationships, have little or no long term effects on the child. There is a substantial literature on this topic, helpfully reviewed by Berg-Nielsen et al. (2002) and Smith (2004) from a psychiatric and social work perspective respectively.

There may also be indirect effects on children of having a parent of carer with mental illness. Thus, persistent mental illness may markedly restrict children's friendships and social activities. Some children may assume the responsibility of caring for their parent in ways which are not appropriate to their age. Consequently, as the guidance points out, some may become excessively worried and anxious. Nevertheless Aldridge and Becker (2003) concluded from their study of children looking after mother with severe depression and bipolar disorder that outcomes were frequently positive.

Hetherington and Baistow (2001) have suggested that there are increasing numbers of children having a mentally ill parent in most European countries and that they feature disproportionately in the case loads of child welfare professionals, health visitors and social workers. They concluded from their comparative study that cooperation between agencies depended greatly on the make-up of professional service teams and the extent of genericism in the work force. They noted that multidisciplinary teams were more common in mental health than in child welfare and that the model of single discipline children and families teams found in England was unusual. In addition, they reported that across the participating countries mental health professionals generally felt unsure of themselves in working with children, while child welfare professionals felt that they lacked knowledge of mental illness.

Working Together explains that adult mental health services have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. It notes that this may be as a result of their work with a parents experiencing mental illness or at the request of children's social care services to provide an assessment of an adult perceived to represent a potential or actual risk to a child or young person. Adult mental heath staff, including psychiatrists, psychiatric nurses, occupational therapists and other should be aware of the risk of neglect and emotional abuse as well as physical and sexual

abuse. The guidance emphasises that they should follow the local child protection procedures and that consultation, supervision and training should be available. It further states that:

Close collaboration and liaison between adult mental health services and children's social services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm (2.94).

9.1.2. The importance of interagency working and training

Stanley et al. (2003) studied the barriers to providing effective services to families where parents had a mental illness. Their survey of five hundred staff from a wide range of health and social care professions identified communication problems particularly between child care workers and both adult psychiatrists and GPs. Confidentiality of patient/client information was considered often to be a stumbling block. The Royal College of Psychiatrists observed that, "Confidentiality is a potentially contentious issue in a context in which information about patients needs to be shared to ensure the protection of a child". (2004, p.5). This is apparently the case even though the previous version of *Working Together to Safeguard Children* (1999) as well as the current version states that the law permits the disclosure of confidential information without consent in some circumstances for the safety and welfare of a child; the problem seems to lie in the interpretation of "some".

The researchers asked the different professional groups about the extent to which they aligned themselves with parents or children, and whether they saw themselves as advocating on behalf of particular family members. Almost all (90%) of respondents believed that it was their role to advocate on behalf of particular family members, the exceptions were the police and GPs. Health visitors and child and adolescent mental health staff were unanimous in their belief that advocating on behalf of a particular family member was part of their role. The majority of child-care social workers considered that their role was to advocate on behalf of children. By contrast, the majority of adult psychiatrists and mental health social workers would advocate for an adult family member. It is not surprising therefore if conflicts arise between professionals in the care and treatment of families where one member has a mental illness and where a child in considered to be in need. Under the auspices of first ACPCs and subsequently LSCBs, interagency training has been developed to bridge the gap between children's and adult services.

9.1.3. Previous evaluations

There does not however appear to be any published evaluations of the outcomes of such training.

9.1.4. Courses

Five of the eight participating LSCBs were offering specialist courses on parental mental health during the study period. Two of the sites (C and D) ran these courses over two days. These courses were open to any staff who had a frontline responsibility for the protection and safeguarding of children or young people. Often domestic abuse issues formed a significant proportion of the role. The courses offered 15 to 20 places each.

One LSCB described a typical two-day course in the following terms:

> Participants will work together to gain an increased awareness of adult mental ill health and how this may affect a parent/carer's ability to care for their children. Trainers will highlight the need to work in partnership to promote the safety and well

being of children and young people who live with adults who experience mental ill health. Particular emphasis will be put on working together between children's services and adult mental health services.

The learning objectives of the courses are summarised in Box 1.

BOX 1: LEARNING OBJECTIVES

- State the signs and symptoms of adult mental ill health
- Investigate the effects of parental mental health problems on child development
- Develop and understanding of legislation, guidance and procedures in relation to mental health and children
- Facilitate improved interagency practice
- Reflect on local practice and procedures in relation to those children at risk of significant harm

Summary of learning objectives: Investigate the definitions of mental illness and to identify possible developmental outcomes for those children living in families where mental illness exists.

9.2 Methods

9.2.1 Procedures

Procedures were as described in Chapter 4.

9.2.2 . Measures

A self-report questionnaire was developed specifically for this study. A set of statements was compiled with reference to the stated learning objectives of the courses. These included self-efficacy statements such as, "I feel confident in my ability to communicate effectively with parents with severe mental illness about potential or actual child abuse"; statements designed to assess knowledge of the impact of parental mental illness on children, e.g. "Depressed mothers are more likely to be critical and rejecting of their children than non-depressed mothers" (compiled with reference to Berg-Nielsen et al., 2002 and Smith, 2004) ; and others to assess the extent to which professionals felt responsible for advocating the needs of their patients/clients (derived from Stanley et al., 2003).

The statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree"). Seven of the fifteen initial statements were designed for reverse scoring in order to reduce response bias (see Table 2).

The draft questionnaire was piloted with 15 professionals at the start of a one day interagency course run in one of the participating LSCBs. The internal reliability of the draft scale was assessed using Cronbach's alpha and six of the original fifteen statements were excluded because responses to these were inconsistent. Test-retest reliability was assessed with a small group of interagency trainers by comparing ratings made at the beginning and end of a one day workshop as part of the evaluation project. Scores at both time points were highly correlated. The 15-item version of the scale used in the study is presented in Table 2. The reverse-scored and excluded items are indicated.

Further psychometric analysis at the time of general data analysis revealed that the internal reliability of the scale was very poor, but could be improved considerably with the removal of further items. It was apparent that these items concerned knowledge of the impact of

parental mental illness on children. So, pragmatically, we removed these items and used them to construct a separate test of knowledge.

9.2.2.1 . Knowledge test

The Knowledge Score (PMHk) was derived from seven items from the original scale. Respondents received a score of 1 if they agreed with a correct statement, 0 if they neither agreed/nor disagreed, and -1 if they disagreed. This resulted in a new scale, the scores of which could range from -7 (all answers incorrect) to +7 (all answers correct). The knowledge test, correct answers and source are shown in Table 5 (end of the chapter).

Finally, respondents were asked to identify some reasons why children and young people of parents with mental illness may be at particular risk of abuse.

9.2.3 . Data analysis

Data were analysed according to the procedures described in Chapter 4.

9.3 . Results

9.3.1 . Participants

Demographic data were available on 95 course participants from five LSCB areas (Table 1). Three LSCBs ran more than one course and participants in these areas accounted for over two-thirds of total course participants. As with most other level two courses in this study, the great majority of participants were white women and had one to five years service experience. In comparison to other courses, a very high proportion (over 90 per cent), had volunteered to attend.

TABLE 1: COURSE PARTICIPANTS

		Number	%
Site	A	15	12.4%
	B	21	17.4%
	C	9	7.4%
	E	40	33.1%
	G	36	29.8%
	Total	121	100.0%
Gender	Female	86	92.5%
	Male	7	7.5%
	Total	93	100.0%
Age	18-30	13	13.8%
	31-40	24	25.5%
	41-50	46	48.9%
	51+	11	11.7%
	Total	94	100.0%
Years in service	1 year of less	16	17.0%
	1-5 years	78	83.0%
	5-10 years	0	
	10 or more years	0	
	Total	94	100.0%
Years in post	1 year of less	38	40.0%

		Number	%
	1-5 years	57	60.0%
	5 or more years	0	
	Total	95	100.0%
Profession/occupation	Social work	43	51.2%
	Counselling/Psychologist	0	
	Probation	2	2.4%
	Teacher	1	1.2%
	Nurse	26	31.0%
	Doctor	1	1.2%
	Police	1	1.2%
	Other	10	11.9%
	Total	84	100.0%
Ethnicity	White	90	94.7%
	BME	5	5.3%
	Total	95	100.0%
First motive	Volunteered	85	94.4%
	Required	5	5.6%
	Total	90	100.0%

Approximately two thirds of the participants were working for children's services. These included social workers employed by voluntary organisations such as the NSPCC as well those working in child and adolescent mental health services (CAMHS) and for the local authority in childcare and disability teams. There were four CAMHS nurses, one teacher and three nursery nurses working in children's centres and day nurseries and two education welfare officers. There was only one doctor, a paediatric registrar. Of the third of participants working in adult services, over a half were social workers, two were probation officers and the remainder were psychiatric nurses. There were no psychiatrists or psychologists, and only one police officer attended.

A series of chi-square tests of association established that participants with 1-5 years in service were more likely to respond at both time points. Otherwise there were no other statistically significant differences in the proportions of respondents at T0 and T1 by age group, gender, years in present post, ethnicity and primary motive for attendance.

9.3.2 . Psychometric Properties of the Reduced Scale

The internal reliability of the reduced (9 item) scale as assessed by Cronbach's alpha was 0.45 at T0, 0.53 at T1, and 0.55 at T2. Assessed reliability decreases with the number of items in the scale and the number of respondents. In this case, respondents were much fewer at T0. Reliability at T1 and T2 may therefore be judged as marginal, but poor at T0. The findings from the analysis of total scale scores should therefore be judged cautiously.

Principle components analysis on 102 cases at T2 identified three factors. The first factor was related to self-efficacy in relation to procedures and processes; the second with professional orientation or attitude; and the third with knowledge.

9.3.3 . Reporting the Findings

Given the difficulties with the original scale and the subsequent development of a reduced scale and a knowledge test, we have changed the order of presentation for this chapter. First we shall report an analysis of paired responses on questionnaire items at the beginning

(T1) and end of the course (T2). This is followed by the analysis of the reduced attitudinal scale at the first three time points and, finally by the knowledge test.

9.3.4 . Questionnaire Item Scores

An analysis of differences between mean scores for each scale (reduced attitudinal scale and knowledge score) item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 7 of the 15 items (see Table 2).

At the end of the courses, respondents in general expressed significantly greater confidence than at the beginning in their ability to communicate effectively with parents with severe mental illness about potential or actual child abuse; they continued to feel unafraid of upsetting vulnerable parents in this context. There were highly significant improvements in their self-reported clarity concerning roles and responsibilities and also on local interagency procedures on safeguarding children whose parents have mental illness. They were, on average, uncertain about whether or not interagency working in this area faced insurmountable obstacles of confidentiality of information and their opinions on this matter did not change. Similarly, they were in general disinclined to take a position on the desirability of advocating specifically for their client, or on whether or not they expected other professionals to do this.

At the end of the courses, participants were very significantly more confident that they could describe the reasons why children and young people of parents with mental illness are at particular risk of abuse. However, their responses to the questionnaire items were inconsistent. Thus while they were, correctly, more inclined to agree that depressed mothers are more likely to be withdrawn and listless than non-depressed mothers, they remained unsure about the evidence on persistent emotional and behavioural disturbance in children. They were also uncertain whether depressed mothers are comparatively more likely to be critical and rejecting of their children, although they tended, correctly to agree. Their opinions on the alleged remoteness of mothers with schizophrenia were incorrect. They also tended, incorrectly, to disagree with the statement that mothers with poorer mental health are very much more likely than mothers with better mental health to physically punish their children frequently. However, they were significantly more likely, correctly, to believe that the age of the child will largely determine their resilience to disruptions in parenting behaviour associated with mental illness.

TABLE 2: PARENTAL MENTAL HEALTH SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

	ITEM	T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	I feel confident in my ability to communicate effectively with parents with severe mental illness about potential or actual child abuse	2.9	0.93	3.7	0.81	85	-6.136	<0.001
Q2	At least half of all children whose parents have a psychiatric illness have persistent emotional and behavioural disturbance	2.9	0.76	2.8	0.99	85	-0.539	0.590
Q3	Interagency working with families with children where parents have a mental illness is bedevilled by insurmountable obstacles of confidentiality of information	3.0	0.94	3.0	1.11	83	-0.114	0.909
Q4	Depressed mothers are more likely to be critical and rejecting of their	3.1	1.05	3.2	1.05	82	-0.353	0.724

	ITEM	T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
	children than non-depressed mothers							
Q5	Depressed mothers are more likely to be withdrawn and listless than non-depressed mothers	3.5	0.89	3.9	0.83	85	-3.290	<0.001
Q6	I am clear on my roles and responsibilities when parents with mental illness are suspected of abuse or neglect	3.8	0.99	4.3	0.62	85	-4.155	<0.001
Q7	An accurate psychiatric diagnosis of the parent is the most important factor in assessing the risk of child abuse	3.3	1.02	3.1	1.14	83	-2.309	0.021
Q8	In interagency working with families with children where parents have a mental illness, my most important role is to advocate specifically on behalf of “my” client.	2.9	1.11	3.0	1.15	81	-1.260	0.207
Q9	I expect mental health and adult social care professionals to advocate for the parents and child care workers to advocate for the child	2.9	1.06	3.0	1.19	85	-0.221	0.825
Q10	I have a good understanding of local interagency procedures on safeguarding children whose parents have mental illness	3.2	0.83	3.8	0.69	83	-4.813	<0.001
Q11	I am afraid of upsetting vulnerable parents with mental illness if I ask about abuse in relation to their children	3.4	1.01	3.6	1.05	83	-1.392	0.164
Q12	In general, mothers with schizophrenia are more remote, insensitive, intrusive and self absorbed than mothers with depression and anxiety	3.3	0.71	3.3	0.83	82	-0.246	0.806
Q13	Mothers with poorer mental health are very much more likely than mothers with better mental health to physically punish their children frequently	2.7	0.98	2.6	0.98	82	-0.411	0.681
Q14	The age of the child will largely determine their vulnerability or resilience to disruptions in parenting behaviour associated with mental illness	2.9	0.97	3.5	1.05	83	-4.063	<0.001
Q15	I can describe the reasons why children and young people of parents with mental illness be at particular risk of abuse.	3.1	0.81	4.1	0.66	80	-6.381	<0.001

Reversed scoring: 2, 3, 7, 8, 9, 11, 12
Reduced attitudinal scale: 1, 5, 6, 7, 8, 9, 10, 11, 15
Knowledge scale: 2, 3, 4, 5, 12, 13, 14

9.3.5 . Outcomes: Changes in mean total scores over time

9.3.5.1 . Reduced attitudinal scale

Mean total reduced attitudinal scale scores for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 1. The total means scores for all courses are also shown. It is evident that there is a very similar pattern in all sites is confirmed by the statistical analysis (Table 3). Thus, there is no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("very large" effect size), which was highly statistically significant. Poor response rates at T3 (n=13) prevented analysis which would show the extent to which these improvements were maintained three months after the training programme.

FIGURE 1: TOTAL SCORES (MEANS) BY LSCB: REDUCED ATTITUDINAL SCALE

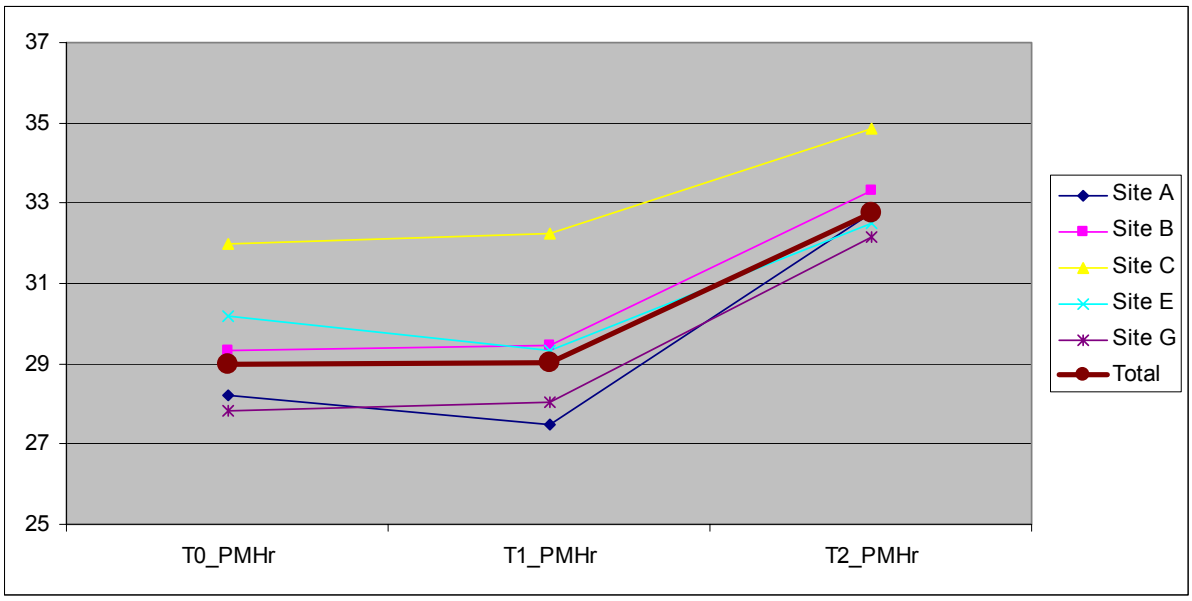


TABLE 3: PARENTAL MENTAL HEALTH AND SAFEGUARDING CHILDREN SCALE TOTAL SCORES: PAIRED SAMPLES T-TEST REDUCED ATTITUDINAL SCALE (PMHR)

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	29	28.79	3.91	28.28	3.98	-0.52	-1.53	-1.21	0.18	28	0.138	0.13
T1 - T2	74	29.26	3.98	32.91	3.74	3.65	8.38	2.78	4.52	73	<.001	0.95

9.3.5.2 . Knowledge score

Mean total knowledge scores for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 2. The total mean score for all sites combined is also shown. It is evident that there is a very similar pattern in all sites and this is confirmed by the statistical analysis (Table 4). However, here we find that there are statistically significant differences in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "very large effect" but that between the start (T1) and end (T2) of the course, there was a substantial *decrease* in

scores ("very large" effect size), which was highly statistically significant. It was difficult to confirm this trend at the three month follow-up as well due to the small number of paired samples between T2 and T3 (N=13).

FIGURE 2. TOTAL SCORES (MEANS) BY LSCB KNOWLEDGE SCORE (PMHK)

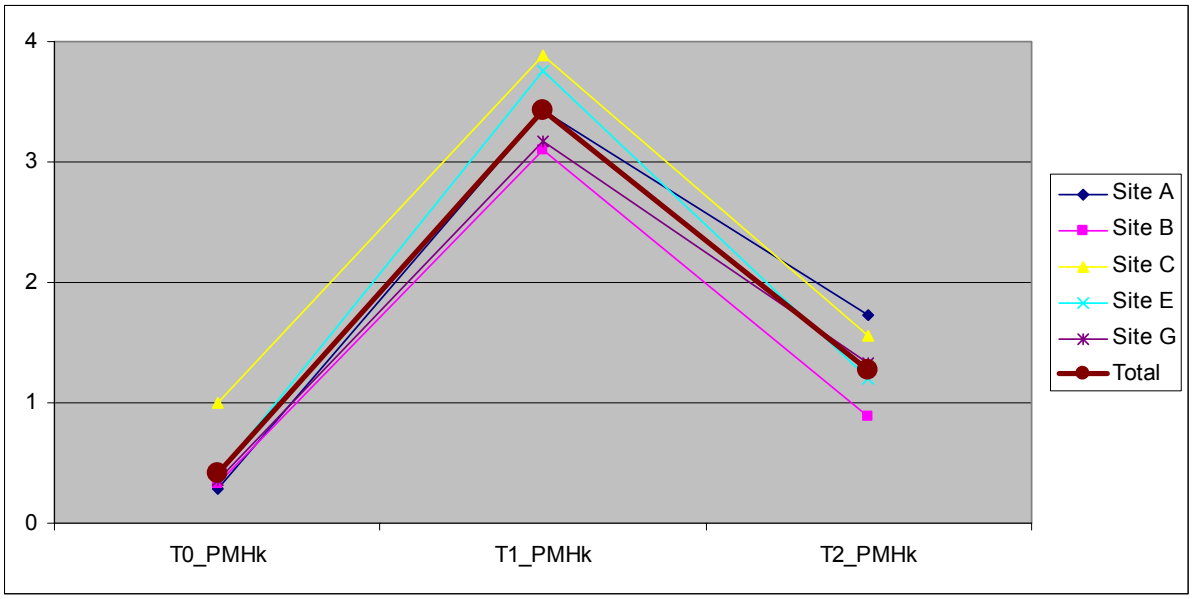


TABLE 4: PARENTAL MENTAL HEALTH AND SAFEGUARDING CHILDREN SCALE TOTAL SCORES: PAIRED SAMPLES T-TEST KNOWLEDGE SCORE (PMHK)

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	34	0.47	2.03	3.44	1.83	2.97	11.98	2.47	3.48	33	<.001	1.56
T1 - T2	75	3.37	1.72	1.15	1.81	-2.23	-9.66	-2.69	-1.77	74	<.001	1.27

9.3.6 . Knowledge score open-ended question

Responses to the final open question which asked participants to "Identify some of the reasons why children and young people of parents with mental illness may be at particular risk of abuse" were subject to content analysis and responses at the start and end of the course were compared. At the start, the most common correct answers were:

1. Parent unable to carry out caring/parenting duties
2. Child taking the role of carer
3. Parents under medication
4. Isolation
5. Disengagement
6. Instability, unpredictable behaviour
7. Children exposed to many people/carers
8. Low self-esteem
9. Social exclusion, stigmatization

Typically respondents identified only one or two correct answers at Registration (T0) and Start of the Course (T1), while 3-4 correct answers was more typical at the End of the

Course (T2). In addition, there were many 0s scored ("don't knows") both at start and at the end of the training course. At the end of training, interprofessional aspects came into play in the responses; thus, in addition to above answers, the following institutional and societal dimensions were mentioned:

- Lack of support, lack of information
- Lack of communication between agencies/services
- Not known to services, parents may not be diagnosed.

Again, this clearly indicates that one of the most important learning outcomes of these short courses is raised awareness on importance of interprofessional/interagency work.

9.3 Discussion

Given that a particular aim of these courses was to improve joint working between children's services and adult mental health services, it is disappointing that relatively few participants were attracted from the latter services. Further, most of these were social workers who, because social workers receive a generic training, could be expected already to have an understanding of safeguarding children and to be more confident in working with families with children and adolescents. The literature suggests that doctors, GPs as well as psychiatrists, and child and family social workers need to improve their collaboration and to clarify their mutual understanding of patient/client confidentiality in the context of safeguarding children.

The finding that doctors and, to a lesser extent adult psychiatric nurses were not participating in interagency training indicates a missed opportunity. One possible explanation is that the length and content or level of existing courses is not attractive to adult mental health professionals. The emphasis on learning basic information about mental illness would presumably be seen as a waste of time; further, some of these courses were two days in length (in two LSCB sites), which is a long time to take out of a clinical practice, especially as the courses are not accredited for continuing professional development for doctors. Half day or lunchtime programmes focussed on the specific issue of confidentiality and recent research findings on the interaction between parental mental illness and child development and risk of abuse and neglect might be more attractive. We suggest that LSCBs training groups review this issue.

The courses were however successful in attracting a good range of staff working in children's services, including child and adolescent mental health services (but again not doctors), children's centres, day nurseries and voluntary organisations.

As explained above, we had difficulties with the scale developed to assess the outcomes of learning. The initial version proved to be internally unreliable and, although reliability was improved with removal of items relating to knowledge, the revised version remained quite inconsistent. This is partly because the reduced scale was too short (only 9 items) and further work is required to produce a robust measure. Nevertheless, the reduced scale shows some promise, having an interpretable factor structure and the addition of further, similar items would be the first step to improving the measure.

The reduced scale nonetheless produced similar findings to the other course evaluations reported in this study: from the start to the end of the courses, participants' self-efficacy in terms of communicating with parents about abuse increased, as did their confidence in relation to safeguarding policies and procedures. There was a poor response to the T3 three month follow-up questionnaires, amounting to only 17% of paired T1-T2 sample.

There was however no change in the questionnaire items concerning advocacy and patient/client confidentiality designed to assess any impacts on interagency and interprofessional working. It seems likely that the absence of adult mental health

professionals with potentially different view points meant that opportunities to learn through an exchange of opinions were not available.

The most puzzling finding from this evaluation concerns participants' knowledge of the impact of adult mental illness on children. It was these knowledge items which were largely the cause of the poor internal reliability of the original scale. The analysis of the knowledge test, which employed a different scoring system, produced a curious set of results: knowledge scores increased from a low mean total score at registration to a more satisfactory score at the start of the course. Because the response rate at registration was much lower than at T1, this finding may be explained by a greater number of more knowledgeable participants completing the questionnaire at T1. This explanation is supported by the finding from the regression analysis that it was those categorised as 'other professions', i.e. those outside the usual social work and health professionals who had the lowest baseline scores.

However, at the end of the courses, the knowledge scores had actually decreased. This is not so easy to explain. One simple possibility is that the course content in relation to the effects of parental mental illness was not up to date and/or incorrect. But if this were so, one would expect there to be some variation between the outcomes of courses run by the different LSCBs; some trainers being more up to date than others, for example. However, both graphical evidence and the regression analysis showed this not to be the case.

A more complex explanation for the decrease in knowledge scores is first, that it is possible that little detailed research based information was actually presented on the courses, insufficient to answer the questionnaire items correctly. Second, it is possible that the orientation of the course content was generally to de-stigmatise parents with mental illness and to give 'positive messages' about their resourcefulness and potential to function well as parents, with appropriate support. These two factors could interact. Thus, the questionnaire items may have been perceived as being framed within a more negative psychiatric discourse and, in the absence of a clear research briefing, the participants therefore tended to reject responses which they felt were stigmatising. This issue needs further study: if participants come out of a course with less accurate knowledge of some important aspects of safeguarding this is a matter of obvious concern.

9.4 References

Aldridge J, and Becker S. (2003) *Children Caring for Parents with Mental Illness: Perspectives of Young Carers, Parents and Professionals*. Bristol, Policy Press.

Berg-Nielsen, T. S., Vikan, A. and Dahl, A. A. (2002) Parenting related to child and parental psychopathology: a descriptive review of the literature, *Clinical Child Psychology and Psychiatry,* 7: 529-52.

Falkov, A. (1996) *A Study of Working Together 'Part 8' Reports: Fatal child abuse and parental psychiatric disorder*. London, DOH-ACPC Series 1.

Jenni A., Leinonen, J., Solantaus, T. and Punama¨ki, R-L. (2003) Parental mental health and children's adjustment: the quality of marital interaction and parenting as mediating factors, *Journal of Child Psychology and Psychiatry,* 44(2): 227–41.

Smith, M. (2004) Parental mental health: disruptions to parenting and outcomes for children, *Child and Family Social Work*, 9: 3–11.

Stanley, N., Penhale, B., Riordan, D., Barbour, R.S., and Holden, S. Working on the interface: identifying professional responses to families with mental health and child-care needs, *Health and Social Care in the Community,* 11: 208–18.

TABLE 5: KNOWLEDGE TEST: PARENTAL MENTAL ILLNESS AND CHILDREN

QUEST.	STATEMENT	TRUE/FALSE
2	At least half of all children whose parents have a psychiatric illness have persistent emotional and behavioural disturbance	Not true. Only one third show persistent problems (Rutter and Quinton, 1984)
3	Interagency working with families with children where parents have a mental illness is bedeviled by insurmountable obstacles of confidentiality of information	False: Said to be the case with around 25% of GPs and adult psychiatrists (Stanley et al. 2003)
4	Depressed mothers are more likely to be critical and rejecting of their children than non-depressed mothers	True (Berg-Neilson et al., 2002)
5	Depressed mothers are more likely to be withdrawn and listless than non-depressed mothers	True (Berg-Neilson et al., 2002)
12	In general, mothers with schizophrenia are more remote, insensitive, intrusive and self absorbed than mothers with depression and anxiety	True (Berg-Neilson et al., 2002).
13	Mothers with poorer mental health are very much more likely than mothers with better mental health to physically punish their children frequently	True (Smith,2004)
14	The age of the child will largely determine their vulnerability or resilience to disruptions in parenting behaviour associated with mental illness	True (Berg-Neilson et al., 2002)

Scoring: If rating of 4 or 5 (Agree) one point; 3 = no points; and 1 or 2 (Disagree) -1 point. (n=7 items, scores can range from -7 to +7).

10. Outcomes of Interagency Training for Young People with Harmful Sexual Behaviours

10.1. Introduction

Since the early 1990s there has been a growing recognition that children and young people are responsible for a significant proportion of reported and unreported instances of sexual abuse. This has led to the development of a moderate, but increasing, body of knowledge, policy, practice guidelines and services designed to respond to such children and young people.

Working Together (2006) places its guidance on young people with harmful sexual behaviour within a short section (section 11.32) on responses to all forms of abuse by children and young people. The guidance makes it clear that sexual abuse by young people is a safeguarding concern not just because of the risk to other children, but that the presence of such behaviour is often a significant marker of a young person's own unmet needs. Sexual abuse by young people therefore represents both a child welfare/ safeguarding concern and a criminal justice concern.

Working Together suggests that three core principles should underpin responses in situations of abuse by children and young people:

- there should be a co-ordinated approach on the part of youth justice, children's social care, education (including educational psychology) and health (including child and adolescent mental health) agencies;
- the needs of children and young people who abuse others should be considered separately from the needs of their victims; and
- an assessment should be carried out in each case, appreciating that these children may have considerable unmet developmental needs, as well as specific needs arising from their behaviour (2006, p.200).

10.1.1. Brief review of the literature

Official statistics indicate that approximately one in five offenders found guilty for a sexual offence in the UK are aged between 10-20 years old (Erooga and Masson, 2006). Young people in this age category also account for approximately 65% of all reprimands and cautions for sexual offences. Although the overwhelming majority of all sexual abuse does not reach the attention of the criminal justice system, nevertheless such official statistics suggest that sexual abuse perpetrated by children and young people constitutes a significant minority of all sexual abuse coming to the attention of the criminal justice and child protection systems. Sexual abuse perpetrated by children and young people is therefore far from being an isolated or unusual phenomenon.

The vast majority of adolescents engaging in sexually abusive behaviours are male. In a UK study reporting on a sample of 227 young people referred for sexually abusive behaviours in one UK city over a six year period, 92% of the young people referred were male and 8% (n = 19) female (Taylor, 2003). It was previously thought that the 'typical' adolescent sexual offender was in his mid to late adolescent years. However, the onset of puberty is now acknowledged as a peak time for the development of such behaviours. In Taylor's (2003) study, the average age when a child was first reported for harmful sexual behaviours was 11.5 years. Children aged 10 or less were responsible for just over a third of all the reported incidents of sexual abuse by young people under the age of 18 years.

Young people with harmful sexual behaviours are typically portrayed as having a number of social skills deficits, a lack of sexual knowledge and high levels of social anxiety (Hackett,

2004). Prior sexual victimisation of adolescent sex offenders has been a consistent finding across the adult and juvenile sex offender literature. Pre-adolescents with sexual behaviour problems typically have chronic sexual victimisation histories (Burton, 2000), as do adolescent females with sexually abusive behaviours (Hendriks & Bijleveld, 2006). Although reported rates vary significantly for male adolescents, it appears that a significant minority of young men who sexually abuse have histories of sexual victimisation. For example, in Taylor's (2003) study the overall figure for young men was 32%.

Children and young people presenting with harmful sexual behaviours frequently exhibit high levels of general behavioural and school problems alongside their harmful sexual behaviours. Families of young people with harmful sexual behaviours are widely described in the literature as multiply troubled and dysfunctional. For example, Manocha and Mezey (1998) found discordant and problematic family relationships in a third of all of the families referred as a result of adolescent sexually abusive behaviour. In this study, domestic violence, parental criminality and substance misuse, a lack of sexual boundaries and a history of sexual abuse in the family added in many cases to the catalogue of family problems.

The overwhelming majority of victims of young sexual abusers are younger children, though a minority also abuse peers or adults. Taylor (2003) found that mean age of victims in his study was just over eight years old, with a bi-modal distribution in relation to the age of victims with peaks at the ages of five and twelve years old. In general, it appears that about twice as many sexual offences are committed by young people against female victims as opposed to males (Manocha and Mezey, 1998; Dolan et al.. 1996; Taylor, 2003). In Taylor's study, out of a total of 402 alleged incidents of sexual abuse, only 3% involved strangers. In one of the largest international studies done to date, Ryan and colleagues (1996) found that the average number of known victims of adolescent sexual abusers at the time of referral was 7.7.

It was previously assumed that young people presenting with harmful sexual behaviours were at a high risk of developing patterns of sexual offences into adulthood. However, the research evidence does not support this assumption. In a six year follow-up study of a sample of 148 adolescents who had sexually abused, only 5% of young people who had been offered 'treatment' as a result of their sexual behaviours had reoffended sexually in this time period, as had 18 per cent of those who had not received such intervention (Worling and Curwen, 2000). The results of this and similar studies indicate that the majority of children and young people displaying harmful sexual behaviours do not become adult sex offenders.

Research into the effectiveness of interventions with children and young people who have displayed harmful sexual behaviours is still limited (Chaffin et al., 2002). However, the best evidence available to date indicates that assessment and intervention with this group of children should be cognitive behavioural in nature and multi modal, addressing the young person's behaviour in a family or systemic context (Hackett, 2004). Worling and Curwen (2000) found a reduction of 72 per cent in sexual recidivism for adolescents who had completed at least one year of cognitive behavioural intervention when compared to an untreated group. However, it is increasingly recognised that programmes of work designed to focus exclusively on sexually abusive behaviours in young people are limited in value and should be supported by attention to enhancing the young person's broader life skills, addressing social isolation, opening up access to appropriate opportunities in the education system, addressing family problems and improving the young person's relationships with parents or carers (Righthand and Welch, 2001; Home Office/ Department of Health, 2006). Some children, especially those who have experienced high levels of trauma, benefit from focused work on their own victimisation.

10.1.2. The importance of interagency working and training.

As far back as 1992, the Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children (NCH, 1992) identified a range of problems associated with professional responses to young people demonstrating sexually abusive behaviours in the UK. Amongst other issues, the following interagency working and training problems were identified:

- The lack of a co-ordinated management structure within which to deal with this issue;
- An absence of policy, practice or ethical guidance to assist practitioners;
- An overwhelming uncertainty regarding the legitimacy of the work and its fit within organisational cultures and remits;
- Clashes of agency philosophy relating to how young people's sexually abusive behaviours should be managed;
- A lack of inter-agency co-ordination; and
- A paucity of training on this subject.

According to the Committee, one of the most significant difficulties for professionals in dealing with young sexual abusers was the different ethos, aims and approaches of the criminal justice and child protection systems. Young people who sexually abuse straddle the remit of both of these traditionally separate systems and, at times, it was difficult for practitioners to balance attention to welfare issues with the need to ensure justice concerns were met. In addition, the need to raise awareness of the nature of the problem and professional confidence in dealing with it was highlighted by the Committee.

In reviewing progress more than a decade on from this important report, Hackett and colleagues (2005) found that 68% of local areas already had specific interagency policies and procedures in place relating to children and young people with sexually abusive behaviours, suggesting that it remains an issue of considerable relevance for safeguarding practice. However, many of these local area policies were minimal in scope. Whilst some areas had developed referral protocols between Youth Offending Teams and local safeguarding children's teams, 57% of 186 services surveyed that were working with this issue were of the view that child welfare/youth crime arrangements still worked against effective work in this area. This finding suggests that one of the importance aspects of interagency training in this area should be to assist workers to learn about other professionals and their remits, as well as to understand their own specific roles within case management.

Whilst the National Probation Service has developed accredited programmes, including training, for staff working with adult sex offenders, no such accreditation exists in the UK for those working with children and young people who have sexually abused. For many professionals, the only available training is that provided by the LSCB. In Hackett and colleagues' (2005) review, respondents indicated that training dimensions were considerably under-developed in their local areas. When asked to rate the adequacy of the training opportunities available to team members, 17% of services rated training opportunities as 'entirely inadequate' and 64% rated them as 'only partially adequate'. Concern was expressed about both the availability and quality of training, with some respondents criticising the very basic nature of interagency training on offer. Associated comments referred to the need for:

- more 'in-depth' and refresher training, building on introductory or awareness-raising training;
- training focusing on specific intervention approaches, not just assessment issues; and

- training on particular aspects of work, such as work with young people from an ethnic minority or work with service users with mental health problems.

Working Together (2006) also emphasises the need for clear guidance and training so that staff can distinguish between consenting and abusive sexual behaviours between young people. The guidance suggests that:

> "Staff should not dismiss some abusive sexual behaviour as 'normal' between young people, and should not develop high thresholds before taking action." (p. 199)

10.1.3. Previous evaluations

We are aware of no previous published studies on the impact of training relating to young people who have sexually abused. Three published UK studies exist about the impact of training on the attitudes of practitioners working with adult sex offenders.

Taylor, Keddie, and Lee (2003) measured the effectiveness of a two and a half day training course for nurses and social workers on the management of sexual offenders with learning disabilities. They found an improvement in participants' knowledge and attitudes towards sexual offenders following the training.

Using a pre-post design, Hogue (1995) examined the attitudes of 81 members of an interdisciplinary team (including prison and probation officers, psychologists and teachers) working with sex offenders in British prisons. In so doing, he adapted an existing 36-item measure of attitudes towards prisoners in general by replacing all references to 'prisoners' to 'sex offenders'. In general, respondents had more positive attitudes towards sex offenders, as well as a greater belief in the efficacy of sex offender treatment and increased confidence and knowledge following attendance at the three training programme. However, police officers were found to have significantly lower scores on the measure than the other professional groups and staff working closely with sex offenders were found to hold more positive views about them compared with those with only limited involvement.

Craig (2005) used Hogue's measure (named the Attitude Towards Sex Offenders Questionnaire, or 'ATS') with 85 residential hostel workers and probation officers before and after a two-day workshop designed to increase participants' awareness of issues when working with sex offenders. Consistent with Hogue's earlier study, Craig found that the training workshop was effective in increasing participants' knowledge and reported self-confidence in their work with sex offenders. However, there was no significant difference in attitudes towards sex offenders post-training. Indeed, rather than encouraging more positive attitudes towards sex offenders, there was a tendency for workers to report more punitive attitudes at the end of the workshop, with female workers more likely to show more negative attitudes than their male counterparts.

10.1.4. Courses

Six of the eight participating LSCBs offered course on young people who sexually abused others. Terminology for the courses varied somewhat between and within course descriptions, however 'young people who sexually harm' was the preferred descriptor in most LSCBs. The learning outcomes of the courses sampled were similar and are summarised in Box 1.

BOX 1: LEARNING OBJECTIVES OF AYPSAS COURSES

• Raise awareness of the needs of children who display sexually harmful behaviour • Understand how to intervene to address the risk involved for them and others • Consolidate and develop existing understanding, knowledge on children/ young people and sexually harmful behaviour • Review challenges that sexually harmful behaviour poses • Become familiar with relevant aspects of local procedures and legislation in relation to children/ young people and sexually harmful behaviour
Summary of Learning Objectives: For participants who are involved in carrying assessments and interventions of children with sexually harmful behaviour. Develop practical skills in recognising and responding to the needs of children with sexually harmful behaviour.

Arrangements for the courses differed only marginally between areas. In all six LSCBs the courses were one day in length and offered at Level Two for staff who had already completed an introduction to safeguarding course. However, in one LSCB the introductory awareness raising course was followed later by a more in-depth two day course on 'comprehensive assessment' of young people with harmful sexual behaviours. In all cases, LSCBs brought in external facilitators, usually staff from local specialist projects working in the LSCB area (usually NSPCC or Barnardo's).

10.2. Methods

10.2.1. Procedures

The procedures used were as described in Chapter 4.

10.2.2. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

A search of the literature failed to identify any published measures of professionals' knowledge, attitudes and self-efficacy in relation to juvenile sexual offenders/ young people with harmful sexual behaviours. The *Attitudes Towards Sex Offenders Scale (ATS)* (Hogue, 1995) was examined for its potential use in the current study. However, many of the 36 items on this non-standardised questionnaire were found to be inappropriate for the purposes of evaluating the LSCB courses, even in adapted form. For example, the ATS includes the statements 'If a sex-offender does well in prison, he should be let out on parole' and 'Most sex offenders have the capacity for love' which were inappropriate and irrelevant to the content and learning outcomes of the courses on offer. Consequently, a 21 item self-report questionnaire was developed specifically for this study. All items were developed with reference to the stated learning objectives of the courses and took into account recent research findings and practice consensus.

Items included *self-efficacy* statements such as, "I feel comfortable talking to young people about their sexual behaviour", statements designed to assess *knowledge*, e.g. "Without help, young people who sexually abuse are likely to continue to abuse" and statements designed to identify *attitudes*, such as, "I believe that the system for dealing with young people who sexually abuse should be less punitive and more understanding". Statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the

strength of their agreement ("strongly agree" to "strongly disagree"). Nine of the original 21 statements were designed for reverse scoring in order to reduce response bias (see Table 3).

The draft questionnaire was piloted with a class of 24 professional social workers undertaking a postqualifying course in child care social work. The internal reliability of the draft scale was assessed using Cronbach's alpha and one of the original twenty one statements was subsequently excluded because responses to these were inconsistent (Item 13 in Table 6). Test-retest reliability was assessed by comparing ratings made at the beginning and end of the training course (which was on attitudes towards young people who sexually abuse in general); there were no statistically significant changes in responses in any of the items and overall scores at both time points were highly correlated. The 20-item version of the scale used in the study is presented in Table 3. The reverse-scored items are indicated.

10.2.3. Data analysis

Procedures for data analysis are described in Chapter 4.

10.3. Results

10.3.1. Participants

Demographic data were available on 124 course participants (out of the 197 who participated in training) from six LSCB sites (Table 1 overleaf). Professional representation was widely distributed across social services, education and health; but more than one half of respondents were social workers. As with most other level two courses in this study, the great majority were white women with one to five years service experience. Indeed, no course participant had more than five years professional experience. In comparison to other courses, a relatively high proportion, more than eight in ten, volunteered to attend the course.

A series of chi-square tests of association established that there were no statistically significant differences in the proportions of respondents at T0 and T1 by age group, gender, years since professional qualification, years in present post, profession, ethnicity and primary motive for attendance (volunteered or required).

10.3.2. Psychometrics of the Scale

The internal reliability of the scale as assessed by Cronbach's alpha varied between 0.57 at T2, to 0.62 at T1, which is marginal, but adequate for exploratory research of this nature. Principal Components Analysis identified no less than seven factors. This indicates that the scale was attempting to measure a large number of underlying variables. Three factors were associated with different aspects of *knowledge*; the first was clearly related to evidenced-based knowledge of sexually abusing adolescents; the second to participants' self confidence in their knowledge base and the third with knowledge of the aetiology of sexually abusive behaviour. The fourth factor reflected with self confidence in relation to client interactions. Factor five was unclear. The sixth factor was associated with reasons for, and responses to, abuse. The final factor was associated with procedural knowledge.

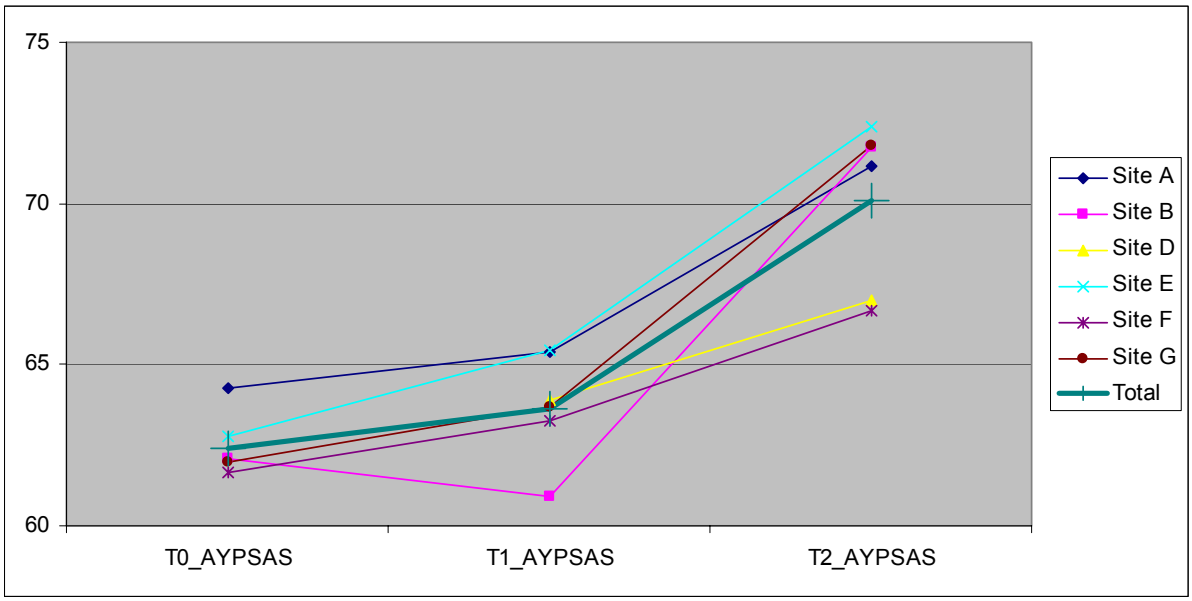
TABLE 1: COURSE PARTICIPANTS

		NUMBER	%
Site	A	43	21.8%
	B	31	15.7%
	D	8	4.1%
	E	23	11.7%
	F	50	25.4%
	G	42	21.3%
	Total	197	100.0%
Gender	Female	108	87.1%
	Male	16	12.9%
	Total	124	100.0%
Age	18-30	31	24.2%
	31-40	31	24.2%
	41-50	40	31.3%
	51+	26	20.3%
	Total	128	100.0%
Years in service	1 year of less	16	13.2%
	1-5 years	105	86.8%
	5-10 years	0	
	10 or more years	0	
	Total	121	100.0%
Years in post	1 year of less	34	28.6%
	1-5 years	85	71.4%
	5 or more years	0	
	Total	119	100.0%
Profession/occupation	Social work	56	61.5%
	Counselling/Psychologist	1	1.1%
	Probation	0	
	Teacher	5	5.5%
	Nurse/midwife/doctor	9	9.9%
	Police	6	6.6%
	Other	14	15.4%
	Total	91	100.0%
Ethnicity	White	121	94.5%
	BME	7	5.5%
	Total	128	100.0%
First motive	Volunteered	106	86.2%
	Required	17	13.8%
	Total	123	100.0%

10.3.3. Outcomes: Changes in mean total scores over time

Mean total scores for participants in each LSCB at each time point (where adequate numbers were available) are shown in Figure 1. The total mean scores for all courses are also shown.

FIGURE 1: TOTAL SCORES (MEANS) BY LSCB



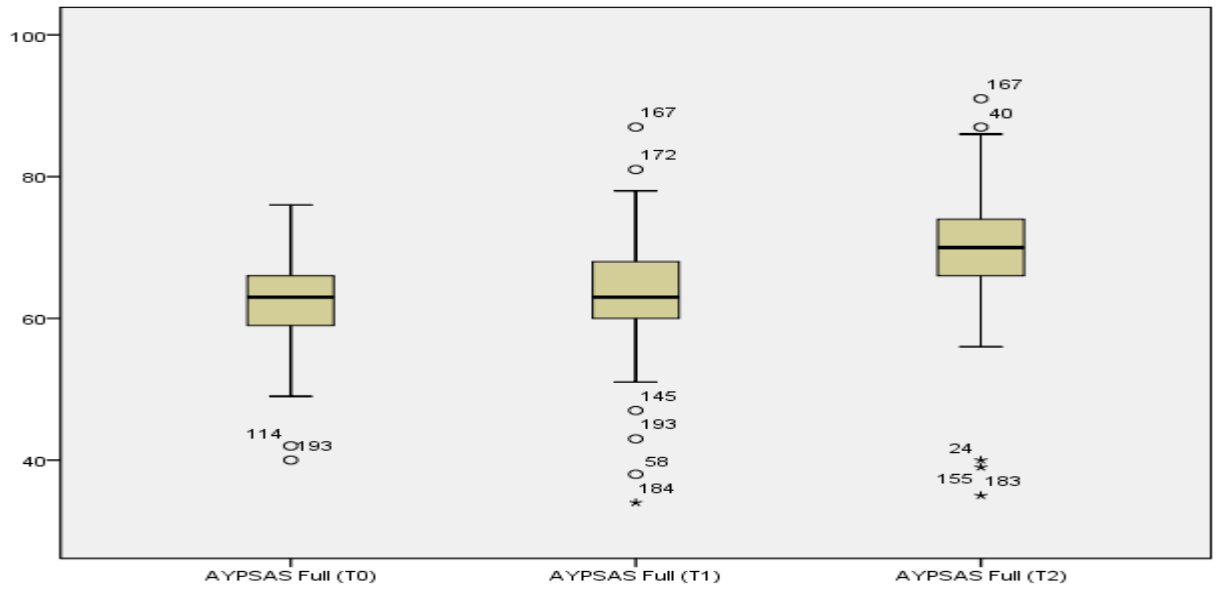
It is evident that there is a very similar pattern in all sites and this is confirmed by the statistical analysis (Table 2). Thus, there is no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("very large" effect size), which was highly statistically significant. It was not possible to determine whether the improvements in score were sustained at T3 due to low response rates (n=17 respondents).

TABLE 2: ATTITUDES TOWARDS YOUNG PEOPLE WHO HAVE SEXUALLY ABUSED SCALE TOTAL SCORES: PAIRED SAMPLES T-TEST

SCALE	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 - T1	90	62.36	6.14	63.46	7.79	1.10	1.52	-0.34	2.54	89	0.133	0.16
T1 - T2	147	63.57	6.70	70.12	7.40	6.54	9.87	5.23	7.85	146	0.000	0.93

The same overall pattern is shown in the box and whisker plots (Figure 2). Here it is evident that the range of scores at T2 is quite large, with some high scores (top quartile) matched by some relatively low scores (bottom quartile) and several outliers towards the lower end of the scoring scale.

FIGURE 2: DISTRIBUTION OF TOTAL SCORES (POSSIBLE RANGE 20 – 100) AT SUCCESSIVE TIME POINTS



10.3.4. Outcomes: Changes in item scores over time

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test for non-parametric data showed that there were statistically significant improvements on 16 of the 20 items (Table 3). Participants felt significantly more comfortable in talking to young people about their sexual behaviour at the end of the courses and were less concerned about distressing young people in so doing. Participants also reported that they had significantly more strategies that they could use to help young people change their abusive behaviour.

Participants' knowledge base was improved in a number of ways. Their knowledge about the reasons leading to abusive behaviours in young people was raised very significantly at the end of the course, as was their understanding of the frequency of family problems in young people's backgrounds. They felt significantly more able to identify key areas for assessment and to distinguish between appropriate and inappropriate forms of sexual behaviour in young people. At the end of the course, participants' knowledge of local area policy and procedures was very significantly improved.

TABLE 3: ATTITUDES TOWARDS YOUNG PEOPLE WHO HAVE SEXUALLY ABUSED (AYPSAS) ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	I feel comfortable talking to young people about their sexual behaviour	3.7	0.85	4.0	0.67	147	-5.602	<0.001
Q2	Most adolescents who sexually abuse have been sexually abused themselves	3.1	0.95	3.0	1.19	144	-1.105	0.269
Q3	There are strategies I can use to help young people who sexually	3.5	0.84	4.0	0.71	147	-7.011	<0.001

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
	abuse to change their behaviour							
Q4	If a young person sexually abuses a sibling they should always be removed from the family home	2.9	0.99	2.7	1.11	146	-2.714	0.007
Q5	Without help, young people who sexually abuse are likely to continue to abuse	3.7	0.88	3.9	1.00	147	-1.996	0.046
Q6	Placing young people on the Sex Offenders register is unfair and unnecessary in most cases	2.9	0.94	3.1	1.03	147	-1.539	0.124
Q7	I have a good understanding of the reasons why young people sexually abuse	3.0	0.93	4.1	0.61	144	-9.02	<0.001
Q8	The family backgrounds of young people who sexually abuse are usually highly problematic	3.3	0.96	3.9	1.00	147	-5.516	<0.001
Q9	All young people who display abusive sexual behaviours need therapeutic intervention	3.6	0.88	3.7	1.06	146	-1.373	0.170
Q10	I have a good understanding of local policy and procedures to young people who sexually abuse	2.9	0.97	3.8	0.79	146	-8.162	<0.001
Q11	Young people who deny their sexual offences are necessarily high risk	3.7	0.89	3.4	1.27	146	-2.615	0.009
Q12	I know what information to look for in making an assessment of a young person who has sexually abused	2.8	0.92	3.9	0.70	142	-8.773	<0.001
Q14	There is no such thing as a spontaneous sexual offence	2.8	0.81	3.2	1.27	141	-3.523	<0.001
Q15	Young women who sexually abuse do so for much the same reasons as young men who abuse	3.1	0.62	3.4	0.92	141	-3.96	<0.001
Q16	Young people's sexually abusive behaviour is usually about power, rather than about sex	3.4	0.74	3.6	0.95	143	-2.739	0.006
Q17	I am afraid of distressing a young person I ask about their abusive behaviour	2.7	0.92	2.4	0.89	142	-3.244	0.001
Q18	Young people with learning disabilities who sexually abuse do so because they don't know the rules and conventions of normal sexual behaviours	3.1	0.91	3.2	1.06	143	-1.072	0.284
Q19	I can distinguish between appropriate and inappropriate sexual behaviours in young people	3.8	0.69	4.3	0.56	143	-6.878	<0.001
Q20	Some young people who sexually abuse grow out of their offending as they get older	3.0	0.72	3.5	0.93	142	-4.972	<0.001
Q21	I believe that the system for dealing with young people who sexually abuse should be less punitive and more understanding	3.5	0.78	3.8	0.80	143	-4.896	<0.001

Reverse scored: 2, 4, 5, 6, 9, 11, 15, 16, 17

The four items on which there were no changes overall were numbers 2, 6, 9 and 18. Of these items, participants' knowledge of the frequency of young people's own sexual abuse histories (Item 2) did not alter as a result of the course. Whilst in the past it was commonly assumed that young men abused children as a direct consequence of having experienced sexual abuse themselves earlier in their childhoods, participants attending the LSCB courses appear to have entered the training with a more balanced view of this rather complex issue. It is likely that a distinct sub group of young people exists for whom traumatic sexualisation through sexual abuse does indeed project them into patterns of abusive behaviours in adolescence, though this is not shared by other more generally delinquent youth for whom sexually abusive behaviour forms one part of a pattern of disinhibited and aggressive interpersonal behaviour problems.

Participants' views of the appropriateness and fairness of placing young people on the sex offenders' register (Item 6) also did not change, possibly because participants were already clear at the outset of the course about the importance of attending to child welfare concerns and about the stigmatising socio-political context in which management of sex offenders takes place in the UK. Participants were also not sure about whether all young people with harmful sexual behaviours need therapeutic interventions (Item 9) indicating that more work needs to be undertaken for participants to be able to distinguish between cases where intensive therapeutic intervention is required and others where limited monitoring would suffice. Participants were also unsure, both at the outset and end of courses, of the extent to which the behaviour of young sexual abusers with learning disabilities is a consequence of their lack of awareness of the parameters of normal sexual behaviours. It could be that this was an issue rarely raised in basic level awareness raising courses.

10.3.5. Predictors

The regression analysis of scores at the start of the courses showed that only score at T0 was a significant predictor variable of score at the start of the course. In other words, taking all these variables and their interactions into account, there were no significant effects on T1 scores associated with any demographic factors, profession, or the LSCB in which the courses took place. The regression model accounted for 25% of the variance.

The regression analysis to identify predictors of scores at the end of the course (T2) showed that scores at the start of the course and being 51 years of age or older were the only statistically significant predictors. In other words, controlling for all other potential predictors, the higher the mean total score at the start and being in the oldest age group, the higher the score at the end of the course (see Table 4). This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. Other than age, no other demographic variables, including profession and experience had any effect and neither did required, as opposed to voluntary attendance. The regression model accounted for 36% of the variance.

TABLE 4: PREDICTORS OF ATTITUDES TOWARDS YOUNG PEOPLE WHO HAVE SEXUALLY ABUSED SCALE AT T2 (LINEAR REGRESSION ANALYSIS)

	B	STD. ERROR	BETA	*T*	*P*	95% C.I.	
(Constant)	29.02	10.84		2.68	***0.010***	7.17	50.88
T1 AYPSAS Score	0.65	0.15	0.49	4.23	***<.001***	0.34	0.95
Age							
31-40	-0.80	2.51	-0.05	-0.32	0.750	-5.86	4.26
41-50	-2.82	2.50	-0.18	-1.13	0.265	-7.86	2.21

51+	7.07	3.48	0.33	2.03	***<.05***	0.05	14.09
Adjusted R Square	***0.36***						

10.4. Discussion

As with other courses, the vast majority of participants were women which may well reflect the gender balance of frontline workers in the agencies represented in the courses. The majority of participants were social workers, with approximately six times the number of participants identifying this professional designation than any other single profession. Several professional groups were noticeable by the infrequency of their attendance. No probation officer attended any of the courses. Whilst the remit of the National Probation Service is to work with adult offenders, it is clearly relevant for probation officers to have a working knowledge of research, assessment approaches and intervention responses to younger sexual offenders, not least because of the issue of transitions from youth justice to adult criminal justice systems.

Similarly, it is somewhat surprising that out of 197 course participants, only 10 in total (5%) were employed within a Youth Offending Team. As the continuing child welfare/ criminal justice divide was highlighted as a significant barrier to effective practice in Hackett and colleagues' (2005) review, this is a concern. Similarly, police officers were under-represented on the courses, with only six attending overall; this is surprising given their critical role in case management when adolescents are convicted or cautioned as a result of sexually abusive behaviours.

In common with most of the other courses studied in this project, all participants were relatively recently qualified with no professionals with more than five years service attending any of the courses in the six LSCBs. As most participants volunteered to come on these courses, it appears that more experienced workers are either not putting themselves forwards for courses on offer, or they are not being prioritised for places. This is concerning because research findings on sexual abuse by young people and practice responses have changed significantly in the last few years, for instance on the question of risk and recidivism (as noted above). Interventions approaches proposed in training in the 1990s, often based on models of confrontational models of practice derived from the adult sex offender field, are now recognised as ineffective and inappropriate (Hackett, Masson and Phillips, 2006).

The *Attitudes Towards Young People who have Sexually Abused* scale developed especially for this study performed adequately for the purposes of this evaluation. Exploratory principal components analysis showed that the scale requires further development: at present it is attempting to measure too many variables. Further refinement of this scale through the collection of data from larger samples for further psychometric analysis would be justified. This process would also improve the internal reliability of the measure.

In conclusion, there is ample evidence of the effectiveness of these interagency courses in improving professionals' attitudes towards young people presenting with harmful sexual behaviours, in particular in relation to their reported levels of self-efficacy and their knowledge base. The effect size attributable to the courses is "very large". In this way, it appears that courses did indeed meet their core objective to raise awareness of the needs of children who display sexually harmful behaviour to develop participants' understanding and knowledge. Courses were especially successful in helping develop professionals' understanding of the aetiology of sexually abusive behaviour, including family and environmental influences.

Similarly, courses helped to inform participants about the rate of recidivism in this group and increased knowledge that some young people do, indeed, grow out of such offending behaviour through their adolescence and into adulthood. This is particularly important

knowledge for professionals to have, not least because there is evidence that professionals frequently over-estimate the risk of re-offending, leading to intrusive, costly and unnecessary interventions for young people presenting with low levels of risk (Hackett, Masson and Phillips, 2006).

It is particularly heartening that there was a reported significant increase in participants' abilities to distinguish between appropriate and inappropriate forms of sexual behaviour in young people, which is a key issue identified in *Working Together* (2006). Similarly, it is clear that participants' knowledge of local area policy and procedures was very significantly improved. However, some areas of knowledge were not improved as a consequence of these one-day interagency courses. These include limited recognition of the different nature and responses required to young women with harmful sexual behaviours, the needs of young people with learning disabilities who sexually abuse and the need to offer tiered levels of intervention according to assessed levels of risk and need. It may be that these areas represent knowledge which are particularly suitable for more advanced or 'in-depth' training, building on introductory or awareness-raising courses, as requested by respondents in the survey undertaken by Hackett et al., (2005).

10.5. References

Burton D.L. (2000) Were adolescent sexual offenders children with sexual behaviour problems? *Sexual Abuse* 12, 1: 37-48.

Chaffin, M., Letourneau, E. and Silovsky, J.F (2002) Adults, Adolescents and Children Who Sexually Abuse Children: A Developmental Perspective. In: Myers, J., Berliner, L., Briere, J., Hendrix, C.T., Jenny, C. and Reid, T. (eds) *The APSAC Handbook on Child Maltreatment, Second Edition.* Thousand Oaks, Sage.

Craig, L. A. (2005). The impact of training on attitudes towards sex offenders. *Journal of Sexual Aggression*, 11: 197-207.

Hogue, T. E. (1995). Training multi-disciplinary teams to work with sex offenders: Effects on staff attitudes. *Psychology, Crime & Law*, 1: 249-59.

Hackett, S. (2004) *What Works for Children and Young People with Harmful Sexual Behaviours?* Barkingside, Barnardo's.

Hackett, S., Masson, H. and Phillips, S. (2005) *Services for Young People Who Sexually Abuse. A report on mapping and exploring services for young people who have sexually abused others.* Youth Justice Board for England and Wales, available at: http://www.yjb.gov.uk/Publications/Scripts/prodView.asp?idproduct=267&eP=

Hackett, S., Masson, H. & Phillips, S. (2006) Exploring Consensus in Practice with Youth Who Are Sexually Abusive: Findings from a Delphi Study of Practitioner Views in the United Kingdom and the Republic of Ireland. *Child Maltreatment* 11(2): 146-56.

Hendriks, J. and Bijleveld, C.C.J.H. (2006). Female adolescent sex offenders-an exploratory study. *Journal of Sexual Aggression*, 12(1), pp. 31-41.

Erooga, M. and Masson, H. (2006) Children and Young People with Sexually Harmful or Abusive Behaviours. Underpinning knowledge, principles, approaches and service provision. In: Erooga, M. and Masson, H. (eds) (2006) *Children and Young People who Sexually Abuse Others*: *Current Developments and Practice Responses*, Routledge.

HM Government (2006) *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*.

Home Office/ DH (2006) The needs and effective treatment of young people who sexually abuse: current evidence.

Manocha, K. and Mezey, G. (1998) British adolescents who sexually abuse: a descriptive study, *Journal of Forensic Psychiatry*, 9(3): 588-608.

Righthand, S. and Welch, C. (2001) *Juveniles Who Have Sexually Offended. A Review of the Professional Literature*. Washington, Office of Juvenile Justice and Delinquency Prevention.

Ryan, G., Miyoshi, T.J., Metzner, J.L., Krugman, R.D. and Fryer, R.G. (1996) Trends in a national sample of sexually abusive youths. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33: 17-25.

Taylor, J.F. (2003) Children and young people accused of child sexual abuse: A study within a community, *Journal of Sexual Aggression,* 9(1): 57-70.

Taylor, J. L., Keddie, T., and Lee, S. (2003). Working with sex offenders with intellectual disability: Evaluation of an introductory workshop for direct care staff. *Journal of Intellectual Disability Research*, 47: 203-9.

Worling, J. and Curwen, T. (2000) Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction, *Child Abuse and Neglect*, 24: 965-82.

11. Safeguarding Children of Drug Misusing Parents

11.1. Introduction

Working Together to Safeguard Children (HM Government 2006, Sec. 11.27) cites an influential report of the Advisory Council on the Misuse of Drugs (2003) called "*Hidden Harm*" which estimated that there were between 200,000 and 300,000 children of problem drug users in England and Wales; this amounted to between two and three per cent of all children under the age of 16. The report concluded that "…parental drug misuse can and does cause harm to children and young people at every age, from conception to adulthood, including physical and emotional abuse and neglect". Nevertheless, it is important not to generalise or make assumptions about the impact on a child of parental drug and alcohol misuse. *Working Together* consequently recommended that "A thorough assessment is required to determine the extent of need and level of risk of harm in every case".

Neglect of children, rather than physical or sexual abuse, is the most likely reason for intervention by social services in families where one or both parents have drug problems (Magura and Laudet 1996).

11.1.1. Brief review of research

Barnard and McKeganey (2004) have published a comprehensive narrative review of the literature on drug misuse. *Working Together* (2006) helpfully summarised the evidence about the impacts of substance misuse as follows:

> Maternal substance misuse in pregnancy can have serious effects on the health and development of an unborn child, often because of the mother's poor nutrition and lifestyle. Newborn babies may experience withdrawal symptoms that may interfere with the baby's attachment to their parents or caregivers. Babies may experience a lack of basic healthcare and poor stimulation, and older children may experience poor school attendance, anxiety about their parents' health and taking on caring roles for siblings.
>
> Substance misuse can affect a parent's practical caring skills: perceptions, attention to basic physical needs, control of emotion, judgement and attachment to or separation from the child. Some substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological distress or neglect. Children are particularly vulnerable when parents are withdrawing from drugs. The risk is greater when the adult's substance misuse is chaotic or otherwise out of control, and when both parents are involved. The risk is also greater where there is a dual diagnosis of mental health problems and substance misuse (Sec. 9.18).

The guidance continues with the warning that:

> Some substance-misusing parents may find it difficult to give priority to the needs of their children, and finding money for drugs and/or alcohol may reduce the money available to the household to meet basic needs, or may draw families into criminal activities. Children may be at risk of physical harm if drugs and paraphernalia (e.g. needles) are not kept safely out of reach. Some children have been killed through inadvertent access to drugs (e.g. methadone stored in a fridge). In addition, children may be in danger if they are passengers in a car while a drug/alcohol-misusing carer is driving. The children of substance-misusing parents are at increased risk of developing alcohol and drug use problems themselves, and of being separated from

their parents. Children who start drinking at an early age are at greater risk of unwanted sexual encounters, and injuries through accidents and fighting (Sec. 9.19).

11.1.2. The importance of interagency working and training

Forrester (2000) studied 50 families on the Child Protection Register in an inner London borough through an examination of case files and social workers' rating of parental substance misuse as a child protection concern. Parental substance use was considered a cause for concern in just over half of families. More recently, Clever et al. (2008) examined over 350 case files in six local authorities providing children's social care; they concluded that there was evidence of parental substance misuse in 60% of cases. Nevertheless, services for alcohol and drug misuse are not routinely involved at any stage in the child protection process. Thus, they found "little evidence" that social workers consulted these specialist services and that staff from substance misuse services were present at fewer than one in five child protection case conferences.

Working Together (2006) states clearly that it is the responsibility of LSCBs to develop local policies and procedures, including inter-agency protocols for the co-ordination of assessment and support, particularly across adult drug services and children's services. This requires close collaboration with local Drug Action Teams, Crime and Disorder Reduction Teams and local drug services, as well as health, maternity services, adult and children's social care, courts, prisons and probation services (Sec. 11.52)

Clever et al. (2008) argued strongly that practitioners providing services for substance misuse be included in interagency training (as well as domestic violence services) They contended that interagency training "…can promote an understanding of the roles and responsibilities of professionals working in different organisations, their different thresholds for services, the legal frameworks within which they work, and issues surrounding confidentiality and information sharing." They considered that, "It will also provide opportunities to develop inter-agency networks, increase levels of trust, and provide insights into the philosophy and work of each others' organisations."

11.1.3. Previous evaluations

There do not appear to be any previous published evaluations of training health and social care staff about drug misusing parents and safeguarding children.

11.1.4. Courses

Four of the LSCBs offered courses on safeguarding the children of drug misusing parents. One LSCB offered a course with a particular focus on pregnant women, although this group was also considered in the other courses. The learning outcomes of the courses sampled were very similar and are these are summarised in Box 1.

BOX 1: LEARNING OBJECTIVES OF COURSES

• Develop awareness and understanding of the impact of parental drug/substance misuse and the developmental outcomes of children • Identify legislation in the field of drug misusing parents • Familiarise participants with local guidance on working with drug misusing parents and their children • Investigate roles and responsibilities in relation to identifying, assessing and protecting children living with drug misusing parents • Explore inter-agency responses to child protection and drug misusing parents
Summary of learning objectives: Identify the impact of drug/substance misuse on children and the parental role. Be better equipped to respond to the needs of children exposed to parental drug/substance misuse. Offer strategies to support multiagency working in this field.
Special site features: Site A had two types of courses: Working with Drug Misusing Parents; Working with Substance Misusing Pregnant Women.

Courses lasted seven hours, including lunch, which was seen as a good opportunity for the kinds of networking and informal exchanges between staff from different agencies described by Clever et al. (2008). These courses typically combined lectures based on research and presentation of good practice guidelines; videos; presentation and discussion of interagency procedures; exploration of personal attitudes; case studies of safeguarding; and practical communication exercises.

11.2. Methods

11.2.1. Procedures

Procedures are described in Chapter 4.

11.2.2. Measures

The demographic questionnaire requested standard information about age, gender, ethnicity, profession, experience and reasons for attending the interagency course.

A search of the literature for suitable measures identified a survey by Adams (1999) of the attitudes and knowledge of social workers concerning drug misusing parents. However, the questions had not been developed or tested as a scale. Further, the questions themselves had been designed with a particular professional group in mind and very much within the context of the 'refocusing' debate which preceded the publication of the previous version of *Working Together*. Consequently, it was judged unsuitable for the purposes of this study. A standardised measure of professional attitudes to drug use had been developed and tested by Caplehorn et al. (1996), but this focuses on methadone treatment and does not consider parenting. Thus, in the absence of any suitable published measures of professionals' knowledge and self-efficacy in relation to safeguarding children of drug misusing parents we developed a self-report questionnaire specifically for this study.

A set of statements was compiled with reference to the stated learning objectives of the courses. These included self-efficacy statements such as, "I feel confident in my ability to communicate effectively with parents about the impact of their drug and alcohol misuse on their children" and statements designed to assess knowledge, e.g. "Research has shown a significant link between parental drug misuse and risk of sexual abuse of children" (in this case a false statement). The statements were presented alongside 5-point Lickert scales

and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree"). Four of the statements were designed for reverse scoring in order to reduce response bias.

The draft questionnaire was piloted with 16 professionals at the start of a one day interagency course run in one of the participating LSCBs. The internal reliability of the draft scale was assessed using Cronbach's alpha and three of the original fifteen statements were excluded because responses to these were inconsistent. Test-retest reliability was assessed with a small group of interagency trainers by comparing ratings made at the beginning and end of a one day workshop as part of the evaluation project. Scores at both time points were highly correlated. The 12-item version of the scale used in the study is presented in Table 3. The excluded and reverse-scored items are indicated. In addition, respondents were asked to list up to five risks of the effects of drug use on the developmental outcomes of children.

11.2.3. Data analysis

Data analysis procedures were as described in Chapter 4.

11.3. Results

11.3.1. Participants

Demographic data were available on 87 course participants from three LSCB areas (Table 1). The two courses run evaluated in LSCB A were both on drug misuse by pregnancy women; the other courses in the evaluation were generic. Site F provided three courses on this topic.

There was a wide range of staff attending these courses, probably the widest representation of any of the level two courses to staff in direct contact with children. In addition to a substantial number of both children and families social workers and a few adult social workers, there were nurses and a few midwives. Also well represented were family support and early years workers. Others included housing officers, probation officers, mentors, foster carers and a children's advocate. However, there was only one doctor and only four participants who identified themselves as substance misuse specialists. No police apparently attended.

Almost all participants were women and the overwhelming majority was white. In common with other courses being evaluated, none of those participating had been in service for longer than five years. In comparison to other courses, a relatively high proportion, more than eight in ten, volunteered to attend the course.

A series of chi-square tests of association established that there were no statistically significant differences in the proportions of respondents at T0 and T1 by age group, gender, training site, years since professional qualification, years in present post, ethnicity and primary motive for attendance (volunteered or required).

TABLE 1: COURSE PARTICIPANTS

		COUNT	COLUMN N %
Site	A	23	21.7%
	B	19	17.9%
	E	5	4.7%
	F	59	55.7%
	Total	106	100.0%
Gender	Female	83	96.5%
	Male	3	3.5%
	Total	86	100.0%
Age	18-30	18	21.2%
	31-40	29	34.1%
	41-50	27	31.8%
	51+	11	12.9%
	Total	85	100.0%
Service years	1 year of less	13	15.9%
	1-5 years	69	84.1%
	5-10 years	0	
	10 or more years	0	
	Total	82	100.0%
Post years	1 year of less	34	40.0%
	1-5 years	51	60.0%
	5 or more years	0	
	Total	85	100.0%
Profession	Social work	25	28.7%
	Family support/early years worker	10	11.5%
	Drug/Alcohol misuse specialist	4	4.6%
	Counselling/Psychologist	2	3.2%
	Probation	3	3.4%
	Teacher	2	3.2%
	Nurse	10	11.5%
	Midwife	3	3.4%
	Doctor	1	1.1%
	Police	0	
	Housing officer	5	5.7%
	Other	23	26.5%
	Total	87	100.0%
Ethnicity	White	80	92.0%
	BME	7	8.0%
	Total	87	100.0%
First motive	Volunteered	74	85.1%
	Required	13	14.9%
	Total	87	100.0%

11.3.2. Psychometric properties of the scale

The internal reliability of the scale as assessed by Cronbach's alpha was 0.67 at T0 (satisfactory); 0.72 at T1 (good) and 0.61 at T2, which is acceptable.

Exploratory principal components analysis suggested tat the scale was measuring three main factors, associated with: knowledge in relation to procedures and processes; self-efficacy and research based knowledge.

11.3.3. Outcomes: Changes in mean total scores over time

Mean total scores for participants in each LSCB at each time point (where adequate numbers are available) are shown in Figure 1. No registration data were available from Site E. The total means scores for all courses are also shown. For reasons which are not obvious, only two participants at T2 returned a follow up questionnaire three months later (T3) rendering the analysis meaningless, so this component has been removed from the report.

It is evident from the chart that there is a very similar pattern in all sites and this is confirmed by the statistical analysis (Table 2). Thus, there is no statistically significant difference in mean total scores between registration (T0) and the start of the courses (T1) and the effect size is interpreted as a "small effect". Between the start (T1) and end (T2) of the course, there was a substantial improvement in scores ("very large" effect size), which was highly statistically significant.

FIGURE 1: TOTAL SCORES (MEANS) BY LSCB

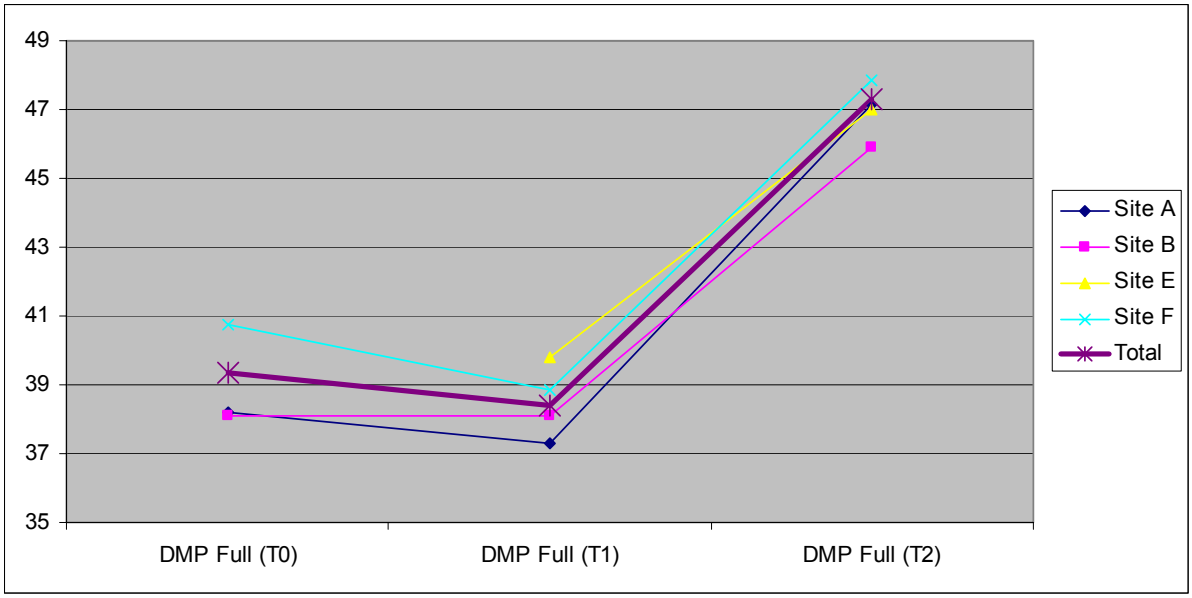
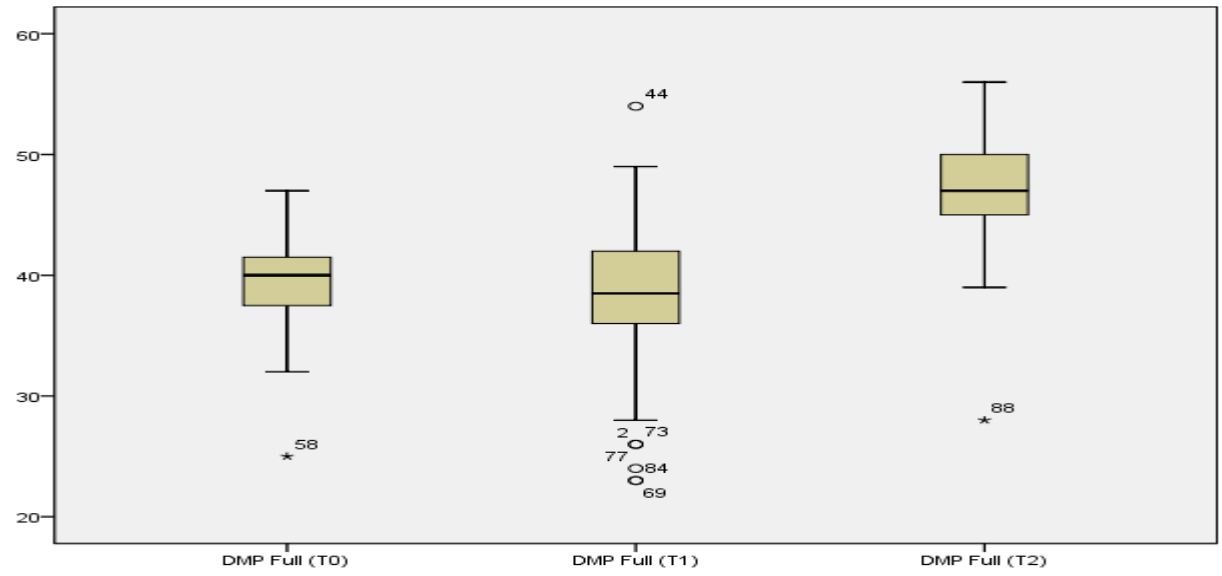


TABLE 2: DRUG MISUSING PARENTS SCALE TOTAL SCORES: PAIRED SAMPLES *T*-TEST

PAIRED SAMPLES	N	MEAN 1	SD	MEAN 2	SD	MEAN DIFFERENCE	*T*	95% C.I.		*DF*	*P*	COHEN'S *D*
T0 -T1	23	39.09	4.92	39.09	4.92	-0.22	-0.35	-1.51	1.08	22	.731	0.05
T1 - T2	70	38.14	5.77	47.10	4.34	8.96	12.23	7.50	10.42	69	<.001	1.77

The same overall pattern is shown in the box and whisker plots (Figure 2). Overall, it is clear that at T2 all but one of the participants had scored higher than the top two quartiles at the beginning of the courses.

FIGURE 2: DISTRIBUTION OF TOTAL SCORES (POSSIBLE RANGE 12 – 60) AT SUCCESSIVE TIME POINTS



11.3.4. Outcomes: Changes in item scores over time

An analysis of differences between mean scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test showed that there were statistically significant improvements on 9 of the 12 items (see Table 3 below). Over the course of the programme, participants' responses showed very significant improvement in: their understanding of local interagency procedures on safeguarding children in cases of parental substance misuse; how and with whom to share information; and where parents who are drug users should be referred to.

There were significant improvements in their understanding of the effects of parental drug misuse and the associated risks to children and also in their confidence that they could identify those risks. They were also very significantly more likely to feel confident in their ability to communicate effectively with parents about the impact of their drug and alcohol misuse on their children and to be familiar with strategies to engage hard to reach parents. Further, they were confident in their knowledge of types of drugs and local terminology. One attitude item is worth noting because it was not included in the final scale: at the end of the course, participants were very significantly more likely to agree with the statement that "Many parents whom misuse drugs and/or alcohol are good enough parents."

TABLE 3: DRUG MISUSING PARENTS (DMP) SCALE ITEM MEANS AT T1 AND T2 (WILCOXON TEST)

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	I feel confident in my ability to communicate effectively with parents about the impact of their drug and alcohol misuse on their children	3.1	1.01	4.1	0.61	94	-6.81	<0.001
Q2	Many parents whom misuse drugs and/or alcohol are good enough parents	2.8	0.82	3.4	0.96	93	-4.934	<0.001
Q3	I can name and differentiate between types of drugs and I know the 'street' terms used for them in my local area	3.1	1.23	4.3	0.76	95	-7.101	<0.001
Q4	At least half of the families on social workers' childcare caseloads have parents with drug or alcohol problems	3.3	0.82	3.5	1.17	94	-1.689	0.091
Q5	I have a good understanding of local interagency procedures on safeguarding children in cases of parental substance misuse	3.1	1.05	4.1	0.56	94	-7.049	<0.001
Q6	It is always damaging for children when the primary carer abuses alcohol	2.5	1.10	2.6	1.15	95	-0.706	0.480
Q7	Parental substance misuse may put a child at an increased risk of neglect and emotional or physical abuse	4.1	1.00	4.4	0.62	94	-2.642	0.008
Q8	Research has shown a significant link between parental drug misuse and risk of sexual abuse of children	2.9	0.79	2.6	1.09	95	-2.167	0.030
Q9	Parental substance misuse does not put a child at higher risk of developing mental health problems in adolescence	3.5	0.85	3.4	1.19	95	-0.891	0.373
Q10	I can describe the potential effect of parental substance misuse on children's development	3.1	0.99	4.3	0.66	94	-7.287	<0.001
Q11	Drug use by either parent should automatically result in a child protection referral	2.8	1.26	2.8	1.36	95	-0.319	0.750
Q12	I know where parents who are drug users should be referred to	3.2	1.15	4.3	0.72	94	-6.217	<0.001
Q13	I am familiar with strategies to engage hard to reach parents who misuse drugs and alcohol	2.7	1.01	3.8	0.80	95	-6.829	<0.001
Q14	I am confident how and with whom to share information about a drug using parents	3.3	1.02	4.3	0.67	95	-6.444	<0.001
Q15	I can identify at least five risks of the effects of drug use on the developmental outcomes for children	3.1	1.11	4.3	0.81	74	-5.753	<0.001

Reversed scored: 9, 11, 12, 14
Dropped from final scale: 2, 6, 11

11.3.5. Open-ended question

Answers to the open question tended to be broader at the start of the courses, referring to "neglect", "emotional", and "cognitive" problems and more specific at the end. There were two types of courses: 1. Drug using pregnant women, 2. Drug using parents. Answers differed for these two courses. On the two drug using pregnant women courses answers were more specifically related to pregnancy and the unborn child, mentioning such issues as: foetal distress; withdrawal symptoms, problems with bonding; drug dependant baby; low birth weight and development delay. For the generic course, issues mentioned included: physical disability, basic physical needs not being met; behavioural difficulties; learning difficulties and poor educational achievement.

11.3.6. Predictors

The regression analysis of scores at the start of the courses showed that none of the potential predictor variables – including registration score - was significant predictors of scores at the start of the course.

In contrast, the regression analysis to identify predictors of scores at the end of the course (T2) showed that scores at the start were statistically significant in predicting scores at the end of the course. In other words, controlling for all other potential predictors, the higher the mean total score at the start, the higher the score at the end. This analysis shows that the course provider, and therefore also the length of the course had no significant influence on outcomes. In other words, all courses produced similar, positive results. No demographic variables, including profession and experience had any effect and neither did "required", as opposed to voluntary attendance. However, this regression model accounted for only 12% of the variance.

11.4. Discussion

Although only four of the eight LSCBs were offering courses on safeguarding children with drug misusing parents during the study period. Nevertheless, it is evident that these courses were successful in attracting staff from many of the statutory and voluntary organisations as envisaged by *Working Together* (2006). Disappointingly, the numbers of staff from specialist drug misuse services and probation were small and that the police and doctors were barely represented. As was the case with courses on parental mental illness, this is a matter of some concern because one of the explicit goals was to promote interagency working in this field. It is difficult to see how this can be achieved if key players are not engaged.

The other objectives of the courses were being achieved for those who participated. Thus, participants in general had developed their understanding of the impact of parental drug misuse on the developmental outcomes of children and were aware of risk factors. They were more knowledgeable about local guidance and confident in their knowledge of their roles and responsibilities in relation to identifying, assessing and protecting children living with drug misusing parents. The effect size of changes attributable to the courses was "very large". Unlike the courses on parental mental illness, there was no decrease in ratings on knowledge items at the end of the course.

The Safeguarding Children of Drug Misusing Parents scale developed especially for this study performed quite satisfactorily in terms of its internal reliability. Exploratory principal components analysis provided some evidence of its validity in measuring discrete factors associated with self-efficacy and knowledge. Further refinement of this scale through the collection of data from larger samples for further psychometric analysis would be justified.

In conclusion, there is good evidence of the effectiveness of these interagency courses in improving professionals' self-efficacy and knowledge of safeguarding children of drug misusing parents. Further efforts to recruit certain participants would be desirable.

11.5. References

Adams, D. (1999) Towards a family support approach with drug-using parents: the importance of social worker attitudes and knowledge, *Child Abuse Review*, 8: 15-28.

Advisory Council on the Misuse of Drugs (ACMD) (2003) *Hidden Harm – Responding to the needs of children of problem drug users.*

Barnard, M. and Barlow, J. (2003) Discovering parental drug dependence: silence and disclosure. *Children Society*, 17: 45–56.

Barnard, M and McKeganey, N. (2004) The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction,* 99: 552–59.

Caplehorn, J., Irwig, L., Saunders, J. and Chir, B.(1996) Attitudes and Beliefs of Staff Working in Methadone Maintenance Clinics, *Substance Use and Misuse*, 31: 437-52.

Cleaver, H. Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child Protection, Domestic Violence and Parental Substance Misuse: Family Experiences and Effective Practice*. London, Jessica Kingsley Publishers.

Forrester, D. (2000) Parental substance misuse and child protection in a british sample, *Child Abuse Review,* 9(4): 235-46.

Kroll, B. and Taylor, A. (2003) *Parental Substance Misuse and Child Welfare*. London, Jessica Kingsley Publishers.

Magura, S. and Laudet, A. B. (1996) Parental substance abuse and child maltreatment: review and implications for intervention. *Children and Youth Services Review,* 18: 193-220.

12. Outcomes of Interagency Training for Female Genital Mutilation and Safeguarding Children

12.1. Introduction

Working Together (2006, Secs 6.11-12) explains that:

> Female genital mutilation (FGM) is a collective term for procedures that include the removal of part or all of the external female genitalia, for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The procedure is typically performed on girls aged between four and 13, but in some cases FGM is performed on newborn infants or on young women before marriage or pregnancy. A number of girls die as a direct result of the procedure, from blood loss or infection[13].
>
> FGM has been a criminal offence in the UK since the Prohibition of Female Circumcision Act 1985 was passed. The Female Genital Mutilation Act 2003 replaced the 1985 Act and makes it an offence, for the first time, for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.

The Guidance goes on to observe FGM is quite common in the UK, primarily among immigrant and refugee communities. It suggests that:

> Suspicions may arise in a number of ways that a child is being prepared for FGM to take place abroad. These include knowing that the family belongs to a community in which FGM is practised and is making preparations for the child to take a holiday, arranging vaccinations or planning absence from school. The child may also talk about a 'special procedure' taking place. Indicators that FGM may already have occurred include prolonged absence from school, with noticeable behaviour change on return and long periods away from classes or other normal activities, possibly with bladder or menstrual problems (sec 1.4). Midwives and doctors may become aware that FGM has been practised on an older woman, and this may prompt concern for female children in the same family.

Working Together notes that the legal basis for intervention is under s47 of the Children Act 1989 if a local authority has reason to believe that a child has suffered, or is likely to suffer, FGM. However, it continues to explain that:

> … despite the very severe health consequences, parents and others who have this done to their daughters do not intend it as an act of abuse. They genuinely believe that it is in the girl's best interests to conform to their prevailing custom. So, where a child has been identified as at risk of significant harm, it may not be appropriate to consider removing the child from an otherwise loving family environment. Where a child appears to be in immediate danger of mutilation, consideration should be given to getting a prohibited steps order. If a child has already undergone FGM, particular attention should be paid to the potential risk of harm to other female children in the same family (Sec 6.15).

[13] See also WHO (2008)

12.1.1. Brief review of the literature

It is clear (WHO, 2008) that the elimination of FGM requires concerted international and interagency interventions. But at a local level, Webb et al. (2002) sought, with reference to three case studies, to identify barriers to effective child protection in instances of FGM in the UK. They argued that failures are associated with "stereotyping, colour blindness, cultural deficit and inadequate training of professionals…" These are, they considered, compounded by "…the denial of abuse in ethnic minority communities, cultural differences in attitudes to disability and child-rearing, the vulnerability of women in highly patriarchal communities, difficulties in providing mental health services across cultural boundaries and a lack of settings in which to provide appropriate alternative care and places of safety."

12.1.2. The importance of interagency working and training

FGM is a social and educational, as well as a health problem (WHO 2008). Local responses require the efforts of social workers, nurses, doctors and teachers and there is a prima facie case for interagency safeguarding training. However, there are as yet no descriptions of such courses in the literature.

12.1.3. Previous evaluations

There do not appear to be any previous published evaluations of training health and social care staff about FGM.

12.1.4. Courses

Two of the eight participating LSCBs (Site A and Site B) were offering specialist (Level 3) courses in female genital mutilation and child protection during the study period. The course themselves were different for other courses in this study in the sense that they were in the form of half-day or lunchtime briefing and discussion sessions. Their learning outcomes were expressed in very similar terms and these are summarised in Box 1.

BOX 1. LEARNING OBJECTIVES – FEMALE GENITAL MUTILATION

• Understand definition, types, prevalence and socio-cultural context of Female Genital Mutilation • Understand the health and social consequences and warning signs of Female Genital Mutilation • Familiarise participants with legislation and roles, responsibilities related to Female Genital Mutilation • Being informed on regional and international human rights conventions on Female Genital Mutilation
Summary of learning objectives: Identify the signs and impact of Female Genital Mutilation on children. Provide participants with an understanding of own and other agencies' contribution to safeguard children exposed to Female Genital Mutilation.

12.2. Methods

12.2.1. Procedures

The procedures were as described in Chapter 4

12.2.2. Measures

A self-report questionnaire was developed specifically for the evaluation of the sessions. Statements were compiled with reference to the stated learning objectives of the courses and to the summary of evidence in *Working Together* (2006). These included self-efficacy statements such as, *"I have a good understanding of local interagency procedures on safeguarding children who are at risk of or have undergone female genital mutilation"*, statements designed to assess knowledge, e.g. *"Female genital mutilation is usually carried out on girls aged between 1 and 3* (in this case a false statement)*."* The statements were presented alongside 5-point Lickert scales and respondents were asked to indicate the strength of their agreement ("strongly agree" to "strongly disagree"). The 10-item questionnaire is presented in four of the ten initial statements were designed for reverse scoring in order to reduce response bias, but they have been re-revered in Table 2 to aid clarity of presentation. Finally, respondents were asked to "*List some key motives that drive parents to perform female genital mutilation on a female child*".

12.3. Results

12.3.1. Participants

Demographic data were available on only 27 out of 52 (52%) course participants on three courses in two LSCB areas (Table 1). The great majority of participants were social workers or child/family support workers and all were women. There were three nurses, but no GPs or paediatricians. All participants had five years experience or less. In comparison to other courses, a very high proportion (over 80 per cent), had volunteered to attend the training.

TABLE 1: COURSE PARTICIPANTS

		NUMBER	COLUMN N %
Site	A	16	30.8%
	B	36	69.2%
	Total	52	100.0%
Gender	Female	26	100.0%
	Male	0	
	Total	26	100.0%
Age	18-30	5	19.2%
	31-40	13	50.0%
	41-50	4	15.4%
	51+	4	15.4%
	Total	26	100.0%
Years in service	1 year or less	7	25.9%
	1-5 years	20	74.1%
	5-10 years	0	
	10 or more years	0	
	Total	27	100.0%

Years in post	1 year or less	10	37.0%
	1-5 years	17	63.0%
	5 or more years	0	
	Total	27	100.0%
Profession/occupation	Social worker	13	48.1%
	Child/Family support worker	9	33.3%
	Teacher	1	0.76%
	Nurse	3	11.1%
	Education Welfare Officer	1	0.76%
	Total	27	100.0%
Ethnicity	White	24	88.9%
	BME	3	11.1%
	Total	27	100.0%
First motive	Volunteered	21	84.0%
	Required	4	16.0%
	Total	25	100.0%

12.3.2. Outcomes: Changes in mean total scores over time

Registration (T0) data were obtained from only 12 (23%) of the sample and in only one of the two LSCBs. This was largely because these course were quite informal and participation quite variable. Many participants 'dropped in'. Consequently we do not report T0-T1 data.

The number of participants from whom we collected data was too small to conduct robust psychometric analyses of the questions considered as a scale. Instead we present an analysis of differences between mean paired scores for each scale item at T1 and T2 using the Wilcoxon signed-rank test. Forty five participants out of 52 (87%) of attendees completed the questionnaire on both occasions, although it can been seen in the table that a small number of participants did not answer all the questions. These tests showed that there were statistically significant improvements on 8 of the 10 items (Table 2).

At the start of the course there was strong agreement with the statement that FGM must not be considered a culturally acceptable practice and recognition that it is a criminal offence in the UK; these opinions had strengthened by the end of the course. Knowledge of FGM had increased, but not across the board. For example, respondents were disagreed, correctly, with the statement that FGM is usually carried out on girls aged between 1 and 3. This is true; as *Working Together* notes, it is typically carried out on girls aged 4 to 14, although there is variation between countries (see UNICEF, 2005). However, they were inclined to believe that FGM doubles the chance of women dying in childbirth; there is no evidence for this statement. It is true, however, that *babies* born to women who have undergone FGM suffer a higher rate of neonatal death compared with babies born to women who have not undergone the procedure (WHO, 2008).

Respondents disagreed significantly more strongly with the statement that certain forms of female genital mutilation do not place a child at risk of significant harm. The WHO paper, citing research, states: "Almost all those who have undergone female genital mutilation experience pain and bleeding as a consequence of the procedure. The intervention itself is traumatic as girls are usually physically held down during the procedure…" (WHO, 2008, p. 11). They also strongly supported the view that a child who has undergone female genital mutilation should be seen automatically as a child in need.

TABLE 2: FEMALE GENITAL MUTILATION ITEM MEANS AT T1 AND T2

		T1	SD	T2	SD	N	Z	SIG. (2-TAILED)
Q1	Female genital mutilation must not be considered as culturally acceptable practice	4.3	1.23	4.8	0.86	44	-2.064	0.039
Q2	Female genital mutilation is usually carried out on girls aged between 1 and 3	2.6	0.96	2.3	1.18	45	-1.991	0.047
Q3	A child who has undergone female genital mutilation should not be seen automatically as a child in need	2.8	1.33	2.2	1.64	44	-1.843	0.065
Q4	Female genital mutilation is a criminal offence in the UK	4.3	1.08	4.9	0.63	43	-2.915	0.004
Q5	Female genital mutilation doubles the chance of women dying in childbirth	3.4	0.91	3.6	0.98	42	-1.316	0.188
Q6	I have a good understanding of local interagency procedures on safeguarding children who are at risk of or have undergone female genital mutilation	2.9	1.18	4.2	0.74	45	-5.248	<0.001
Q7	If a mother had had female genital mutilation this should be reported as a child protection concern if she has a female child	3.2	1.04	4.0	1.22	45	-3.729	<0.001
Q8	I know how to communicate about the legal and health implications of female genital mutilation with a woman who has undergone this procedure	2.3	1.22	4.0	0.78	45	-5.525	<0.001
Q9	In order to prevent a child undergoing any form of female genital mutilation, she should be removed from the family	2.5	1.14	2.0	1.24	45	-2.170	0.030
Q10	Certain forms of female genital mutilation do not place a child at risk of significant harm	2.6	1.10	2.0	1.43	45	-2.719	0.007

Note: Original scoring used for Items 2, 3, 9 and 10.

Participants had very significantly improved their self-reported understanding of local interagency procedures and were very significantly more likely to give the correct answers to questions about these matters, including reporting. They were also very significantly more confident that they could speak about the legal and health implications of FGM with a woman who has undergone the procedure.

12.3.3. Open-ended question

Responses to the open question which asked participants to list some key motives that drive parents to perform female genital mutilation on a female child were subject to content analysis. They were compared at the start and end of the courses. Typically respondents gave one to three correct answers out of five at the start and three to five correct answers at the end of the course. By far the most common answers concerned “culture”, “tradition”, “religious beliefs” and “myths”.

Other correct answers proposed included: family and community pressure for an accepted rite of passage; family honour; the belief that FGM enhances male sexual pleasure while suppressing female sexual pleasure and that it maintains chastity. Finally, at the end of the courses only, some participants mentioned the erroneous belief that baby could die if its head touches clitoris during child birth.

12.4. Discussion

12.4.1. Course participants

These short courses on FGM in the two LSCBs were relatively new, yet they addressed an important and sensitive issue. We only have demographic information about half the attendees, but it looks at though they are reaching a predominantly social services audience; doctors are conspicuous by their absence. Of course, GPs and paediatricians may already be receiving single agency training on FGM and safeguarding, although LSCBs would be wise to check this. Further, because FGM is probably more prevalent that many people assume, LSCB training groups should consider the training needs of staff on this matter.

12.4.2. Did it make a difference?

There is strong statistical evidence that participants on these short courses/briefings significantly increased their knowledge in general about female genital mutilation and safeguarding children, as well as their understanding of the law and of local interagency policies and procedures. They also felt more confident about communicating with the women concerned. These findings are encouraging.

12.5. References

UNICEF (2005). *Female genital mutilation/female genital cutting: a statistical report*. New York, UNICEF.

Webb, E., Maddocks, A. and Bongilli, J. (2002) Effectively protecting black and minority ethnic children from harm: overcoming barriers to the child protection process, *Child Abuse Review*, 11: 394–410.

World Health Organisation (2001) *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery. A Teacher's Guide.* WHO/FCH/GWH/01.3 WHO/RHR/01.16. Geneva, WHO.

World Health Organisation (2008) *Eliminating Female genital mutilation: An interagency statement.* Geneva, WHO.

13. The Costs of Training[14]

13.1. Introduction

We have seen in the preceding chapters that there is strong evidence for the effectiveness of the training courses in terms of the participants' learning about working together to safeguard children and furthermore, that they value the experience. But is the interagency training carried out under the auspices of the LSBCs good value for money? Is there much variation on the costs of courses provided by the different LSCBs in the sample? How do these costs compare with the prices charged by commercial and voluntary sector providers for similar courses? In-house trainers provided by the partner agencies are on the surface "free" because they do this work in the agency's time; but this represents an opportunity cost to the agency. Taking this into account, is it more or less expensive to bring in a freelance trainer to deliver the training?

In Chapter 2 we noted that contributions to the costs of interagency training courses were made by partner agencies in at least two ways: through direct financial contributions to the LACS budget ("annual subscriptions") and indirectly, through the provision of members of their staff who acted as trainers. In addition, other "in kind" goods and services are contributed, for example, the use of training venues. Further, there is the contribution made by partner agency representatives to the training support group which has the important task of planning and promoting the programme of courses each year and monitoring their quality. A realistic appreciation of the full economic costs of each course needs to take all these elements into account.

Given the comments about the varying levels of these contributions within and between LSCBs, an analysis of the costs to participating agencies of delivering interagency training is likely to be of interest both to LSCBs and partner agencies which contribute to core funding.

In addition, agency representatives were conscious of the costs of their staff participating in training. The opportunity costs of releasing staff to attend a one or two day courses is not insignificant, particularly if it also involves replacing that person with a cover – as in the case when a classroom teacher is replaced by a supply teacher. Training is rightly considered as an investment for the agency – but how much does that initial investment cost?

In this project these two aspects of the costs of training were assessed: the costs of providing training, in total and according to agency; and the costs to each agency of participating in training.

13.1.1. Brief review: the costs of training interventions

Given that the investment in training activities in organisations probably runs into hundreds of billions of pounds annually, it is surprising that there is so little research on the costs and cost-effectiveness of training courses (Salas and Cannon-Bowers, 2001).

A research review of continuing professional development (CPD) in health care carried out for the NHS in England by Brown and colleagues (2002) identified only nine studies reporting economic analyses of CPD initiatives. These authors complained that "the evidence which does exist is not consistent in its approach to costing or analysis." Brown et al. (2002) published their work in the *British Medical Journal,* concluding that that more cost effectiveness studies were urgently needed since there is no evidence base to determine the economic value of CPD in health care. Surprisingly, the reaction to this paper was muted: there was little in the way of 'rapid response' in the *BMJ* itself, beyond one writer suggesting

[14] We acknowledge the work of Sophie Helm who collated the data reported in this chapter and calculated the hourly costs of staff participating in the training courses.

that the published evidence would be used by government to slash CPD budgets. That has not happened, but nor for that matter, has there been any apparent increase in the number of cost-effectiveness or cost-efficiency studies of CPD.

Examining the studies included in Brown et al.'s review, it is apparent that none of these took the form of a standard training course, such as those which we have evaluated in this project. Rather, they included a wide range of educational interventions such as "guidelines with workshops and practice visits" and "face to face outreach plus materials". On closer examination, the evaluations were, in practice, evaluations of a treatment or procedure in which professionals had been trained; consequently, the measure of effectiveness was health gains for the patient. For example, the aim of the "guidelines with workshops and practice visits" intervention (Morrison, 1999) was to teach about the treatment of infertility. The outcome measure was the number of pregnancies (for the patients) rather what the trainees actually learned. There are more than a few missing steps in the implied series of causes and effects. Certainly, a stepwise approach to the evaluation of training (Carpenter et al., 2007) requires that the intermediate steps be assessed before any plausible conclusions can be reached. The first steps are to assess the content of training and to assess the impacts of the training on the learning outcomes for the participants' knowledge, attitudes and self-efficacy, as we have attempted in the current study.

Beach et al, (2005) in the US carried out a systematic review of educational interventions for health care staff on 'cultural competence'. These interventions were generally in the form of training courses. They concluded that there was 'poor evidence' to determine the costs of cultural competence training; they found only five studies, none of which included complete estimates of costs.

Consequently, in the absence of a model for the collection and analysis of data pertaining to the costs of training, we had to develop one for this study[15].

13.2. Methods

13.2.1. Determining the costs of delivery of training

The costs of providing training were assessed with considerable assistance from the training coordinators and the finance department of the host partner agency concerned. We aimed to generate a comprehensive picture and so these costs included:

1. The employment and office costs and travel expenses of the training co-ordinators and training support staff
2. Agency management costs and overheads, including office space and running costs.
3. Costs attributable to the time spent by members of the training sub group in the planning and implementation of training
4. Costs attributable to the time spent by in-house trainers from the partner agencies
5. The fees and expenses of external, commissioned trainers
6. Charges for the use of training venues, including catering, of the costs attributable to agencies for the "free" use of partner agency facilities (training venues)
7. Costs were apportioned to agencies, whether or not there was a financial transaction. For example, when agency premises were used for training or when training was provided without charge by a staff member from one of the LSCB agency members. If there were two trainers from different agencies, the costs of both were calculated and apportioned.

[15] We would like to acknowledge the advice of Prof. Jennifer Beecham (PSSRU) on the methods of data collection used for this exercise. However, any mistakes or omissions are our own.

Following a workshop on this topic with the research team, training coordinators collected the data required with the assistance of their business manager or finance officer. The data were collected and entered into an Excel spreadsheet. This spreadsheet (reproduced in the Tables below) clarified the methods and assumptions, agreed in the workshop. For example, how much time should be allowed for the design of a "new" training course (4 day's work for 1 day's training) versus an "old" course which had been previously given (1 day's work). Similarly, at a later workshop with the researchers, we clarified that the training coordinators should enter the proportion of their time spent on LSCB interagency training, not including any single agency training which they undertook or were commissioned to provide.

With these data, plus the number of training courses provided, it was possible to calculate the average cost of a course, and to note any differences between courses provided by different LSCBs.

13.2.2. Determining the costs of participating in training

The cost to agencies of their staff participating in training was also estimated. Training coordinators were asked to choose two typical courses, one at level one course and one level 2 course each lasting one day. They provided a list of participants' job titles and agencies (but not names). These were used by the research team to calculate the cost of each participant attending for seven hours. Hourly costs for health and social care staff were taken, as far as possible, from the PSSRU *Unit Costs of Health and Social Care* (2007) with the relevant non-London or London multiplier applied.

For staff in other agencies we employed a version of the PSSRU methodology to derive a cost per working hour for each professional, based on costs associated with salaries and an estimate of direct and indirect overheads and capital. We took working time as a 37.5 hour week for 42 weeks per year (allowing for leave, including sick leave). After discussion, it was agreed that the same formula should be applied to teachers; although their vacation time was longer, it was accepted that they worked longer than 37 hours per week during term time and spent part of the school holidays preparing for the following term[16].

For most workers in the statutory sector, including, for example, teachers, police and fire officers and librarians, salaries were based on the midpoint of the ranges taken from published pay scales, e.g. for teachers[17]. However, a feature of the changing faces of both children's and adults' services is the plethora of new job titles and employers. In order to estimate these salaries as accurately as possible, we carried out electronic searches of job websites, such as *the Guardian*[18] using the job title given and checking that the employing agency matched in terms of its aims and functions. Hourly salary rates for sessional workers were found on employment agency websites, such as *trovit*[19]. Where the job title and agency were unclear, we contacted the training coordinator who was almost always able to clarify the nature of the post. The same methods were used to estimate the salary costs of members of the training sub group. The range of hourly costs varied greatly, as might be expected.

The cost of attendance was estimated using the hourly rate x eight hours (six hours training; one hour for lunch and breaks; and one hour for additional travelling time to and from the venue).

13.2.3. Validation of the costing methods

At the final workshop with the training coordinators, the main time was given over to validating the data supplied. Each participant was presented with an extensive spreadsheet

[16] http://www.atl.org.uk/policy-and-campaigns/policies/working-time.asp
[17] http://www.teachers.org.uk/resources/excel/TeachPayScale08-11-OutLondon3.xls
[18] http://jobs.guardian.co.uk
[19] http://jobs.trovit.co.uk/jobs/sessional-support-worker (all accessed 24.02.09)

containing all the data and sums. They worked in pairs, all in the same room, taking it in turns to interrogate their costing partner about the figures and the assumptions behind them. When an issue emerged, they consulted a member of the research team; if it appeared to be a matter of general interest to the group, the researcher interrupted the interrogations and introduced the issue for open discussion so that a consensus could be achieved. Through this process we agreed a consistent approach so that it would be reasonable to compare costs across sites and report differences.

13.3. Findings

13.3.1. The costs of delivery of training

The estimated comprehensive costs of the delivery of training in the eight LSCBs in 2007/8 are shown in Table 1 (below).

Infrastructure

The employment and office costs of the training coordinator and support staff were around 56% of the total costs (range 44% to 63%). However, almost all the training coordinators contributed to the delivery of training, some of them quite substantially.

Most of the training sub groups met on a two monthly schedule for two to 2.5 hours, with a modal attendance of ten people. The total cost of these meeting varied between around £2,000 and £4,000 per annum.

Expenditure on external trainers in the LSCBs varied from nothing to over £27,000. Conversely, one LSCB did not use any internal trainers at all (Site H). Even excluding the two cases with nil expenditure on either type of trainer, the ratio of expenditure on external to internal training varied hugely from 1.21 to 0.15.

Cost of trainers per day

The mean cost of an internal trainer (including the allowance for preparation of new and previously taught courses) and travel expenses was £488 (range £408 - £554).

The mean cost of an individual external trainer, including expenses, was £798 (range £275 - £1,200). The modal[20] cost was £500 (excluding expenses). However, sometimes training in certain specialist areas such as sexual abuse was given by a group of experts and here the daily rate was as high as £3,300 (3 x £1,100). Service users contributing to courses, i.e. providing input rather than running the training were paid £150 - £180.

e-Learning

Half the LSCBs had contracted with commercial e-learning providers to provide 'foundation' level training through on-line learning. The costs varied considerably. Site C had paid a set up fee of less than £1,000 but there was an additional charge of £2 for each person registering on the site and completing the course on line. This was met by the LSBC for all staff of partner agencies. At the other end of the scale, Site D had paid an upfront subscription of £5,000 for unlimited use (in terms of course registrants). The numbers of successful completions are noted in Table 1 (overleaf). In Site C the figures are likely to be an underestimate; not all individuals submitted their certificate to the LSCB on completion of the course and the training coordinator has no other way of knowing. Only one of the sites had used the service for a full year and, although tempting, it would not be valid to attempt a comparative analysis of costs and outcomes at this stage. For the same reason, we have not included the costs of e-learning in the overall analysis of costs.

[20] The 'mode' refers to the value most frequently occurring.

TABLE 1: COSTS OF DELIVERING TRAINING BY LSCB

	A	B	C	D	E	F	G	H
Employment and office costs of Training Co-ordinator and Admin/Support staff								
1. Salaries and overheads								
a. Training co-ordinator: % time in post	85%	80%	60%	65%	70%	50%	85%	40%
Pro-rata employment cost	£40,953	£36,550	£22,866	£36,062	£32,040	£22,630	£42,054	£22,952
Travel and subsistence	£600	£900	£819	£60	£1,600	£3,500	£2,185	£0
CPD related expenses	£1,000	£2,000	£400	£200	£500	£1,000	£465	£500
b. Admin/Support staff								
Salary of 1st	£14,600	£17,267	£13,225	£13,578	£11,315	£19,710	£20,930	£8,456
Salary of 2nd	---	---	£3,153	£2,263	---	---	---	£7,550
Salary of **3rd**	---	---	---	£33,872	---	---	---	---
2. Office costs (Actual or 10% salary).	£3,805	£6,295	£2,777	£5,875	£3,919	£2,990	£9,196	£3896
Total	**£ 60,958**	**£61,029**	**£43,610**	**£91,910**	**£49,327**	**£49,830**	**£92,103**	**£43,354**
B. E-learning provision (if applicable)	---	---	£973 + £2/user	£5,000	£2,500	---	£6,500	---
Successful completions (period)			84 (11mths)	500 (5mths)	1,300 (10mths)		129 (12mths)	
C. Training Sub Group meetings (or equivalent group)	6	6	6	5	6	5	6	6
Average length (hours)	2	2.5	2	2	2.5	2	2	0.6[21]
Cost of room	0	£150	0	0	0	0	£120	0
No. members attending	11	10	10	10	11	9	11	10
Cost	£3,478	£4,361	£3,670	£2,997	£4,014	£2,144	£3,935	£1,372

[21] Training was only part of the agenda at the meeting

	A	B	C	D	E	F	G	H
3. Trainers from Partner Agency	£24,245	£25,262	£14,410	£22,483	£13,380	£14,114	£51,484	£0
4. External (freelance) trainers	£3,600	£9,574	£15,300	£27,400	£4,325	£0	£15,079	£12,000
5. Venues	£10,060	£16,510	£11,400	£10,747	£9,817	£16,360	£43,045	£12,000
TOTAL (excluding e-learning)	**£98,742**	**£116,736**	**£98,122**	**£155,537**	**£80,773**	**£65,088**	**£162,601**	**£68,726**
No. of course days in year	63	51	57	74	42	37	84	24
Cost per course/day	£1,567	£2,289	£1,721	£2,102	£1,923	£1,786	£1,935	£2,863

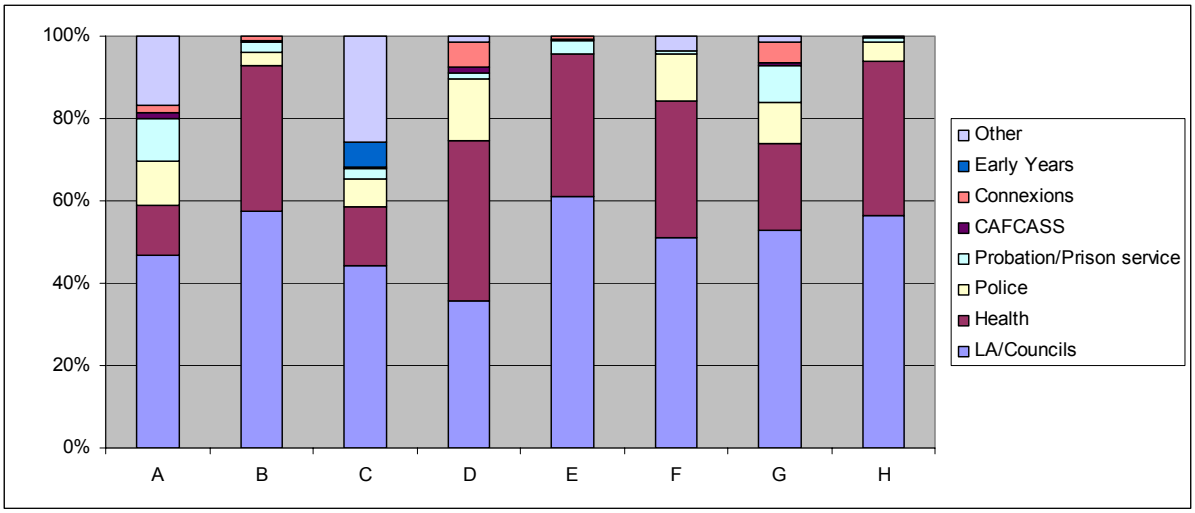
Cost per participant/day

Taking all the costs of providing training into account, with the exception of spending on subscriptions to e-learning providers, the mean cost per day/course was just under £2,000 (range £1,567 - £2,863). Actual attendance figures, i.e. excluding those participants who did not turn up, were obtained from the training administrators for one typical Level 1 course and one typical Level 2 course in each LSCB[22]. The mean number of attendees on a level 1 course was 16.4, meaning that the mean cost per participant was £119. On a level 2 course, the mean attendance was 19.3, giving a mean cost per participant of £102.

9.5 Proportional costs to partner agencies

As a reminder of the findings concerning the variable proportions of core funding contributed to the LSCB by partner agencies we reproduce below the figure shown previously in Chapter 2. In most cases it is safe to assume that this reflects the proportion of each partner agency's contribution to the employment and support costs of the training coordinator. In Site D however, these costs were met directly by Children's Services and so the stacked bar represents other costs.

FIGURE 1: PROPORTION OF CORE FUNDING CONTRIBUTED BY PARTNER AGENCIES BY LSCB



As noted above, many partner agencies made an indirect contribution to the training by providing in-house trainers. As explained in Chapter 3, these were professional members of staff with expert knowledge and delivered the training as part of their general duties or, sometimes, on top of them. They nevertheless represent a cost to the agency. A breakdown of these costs is given in Table 2.

[22] The target number of participants was typically 20. Training administrators generally operated an airline booking system, anticipating that some of those registering would drop out for personal or professional reasons. The weather, which also affected attendance, could not be anticipated.

TABLE 2: COSTS OF IN-HOUSE TRAINERS PROVIDED BY LSCB PARTNERS[23]

	EDUCATION	CHILDREN'S SOCIAL CARE	HEALTH	VOLUNTARY	POLICE	PROBATION	TOTAL
Site A	£3,260	£6,428	£11,553	0	0	0	£22,245
Site B	£3,185	£8,547	£6,579	£5,382	£1,569	0	£25,626
Site C	0	£4,418	£9,034	0	0	0	£14,410
Site D	0	£1,168	£19,701	0	£1,569	0	£22,437
Site E	£2,772	£1,099	£6,272	£2,427	0	£161	£14,114
Site F	0	£8,515	£3,908	0	£957	0	£13,380
Site G[24]	£8,813	£11,140	£13,005	£5,944	£12,115	£124	£51,484
Total	£18,030	£41,315	£70,052	£13,753	£16,210	£285	£163,696
Mean (% total costs)	£2,576 (11%)	£5,902 (25%)	£10,007 (43%)	£1,965 (8%)	£2,316 (10%)	£41 (<1%)	£22,919 (100%)

The health service, through nurses and doctors with specialist knowledge, made the largest in-kind contribution (43%) to these costs. (Doctors were of course much more expensive than the nurse specialists). The overall contribution of education and children's social care (36%) was not far behind. The police made a substantial contribution in just one of the LSCBs. A higher proportion of training was made by voluntary sector organisations, including Barnados and the NSPCC. The figures in Table 2 represent the costs of trainers for which no charge was made to the LSCB.

We then calculated the proportional contribution to the comprehensive cost of training delivery shown in table 1. These include contributions to the employment and office costs, involvement with the training support group and venue costs, as well as internal trainers. These proportions are shown in the following figures 2 – 9. Note, it is difficult to make comparisons across all sites because in sites H, G and F a substantial proportion of the costs were attributed to the local authority (council). Nevertheless, it is clear that there was substantial variation across sites.

[23] Smaller contributions have been excluded.
[24] Site H commissioned all its training and is therefore excluded from the summary table.

FIGURE 2: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE A

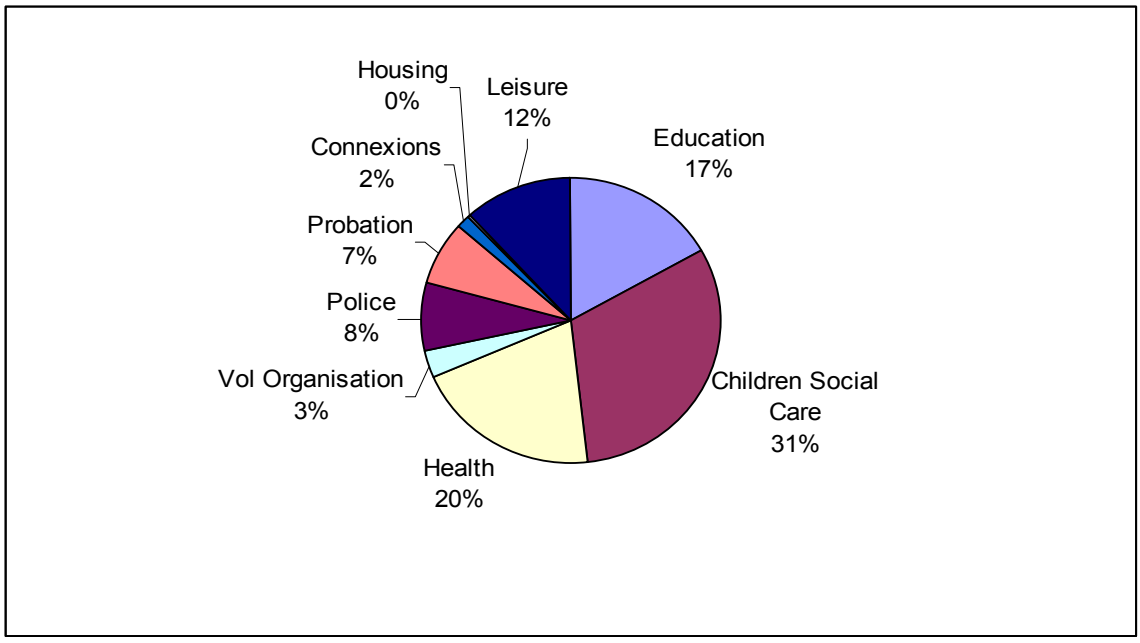


FIGURE 3: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE B

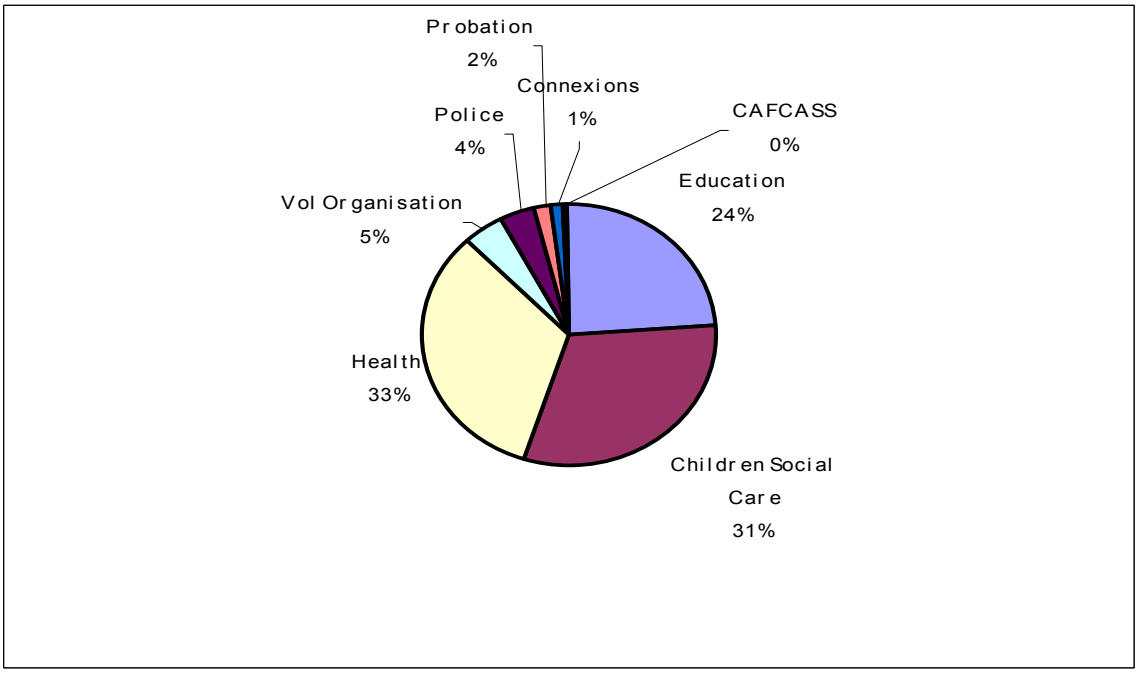


FIGURE 4: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE C

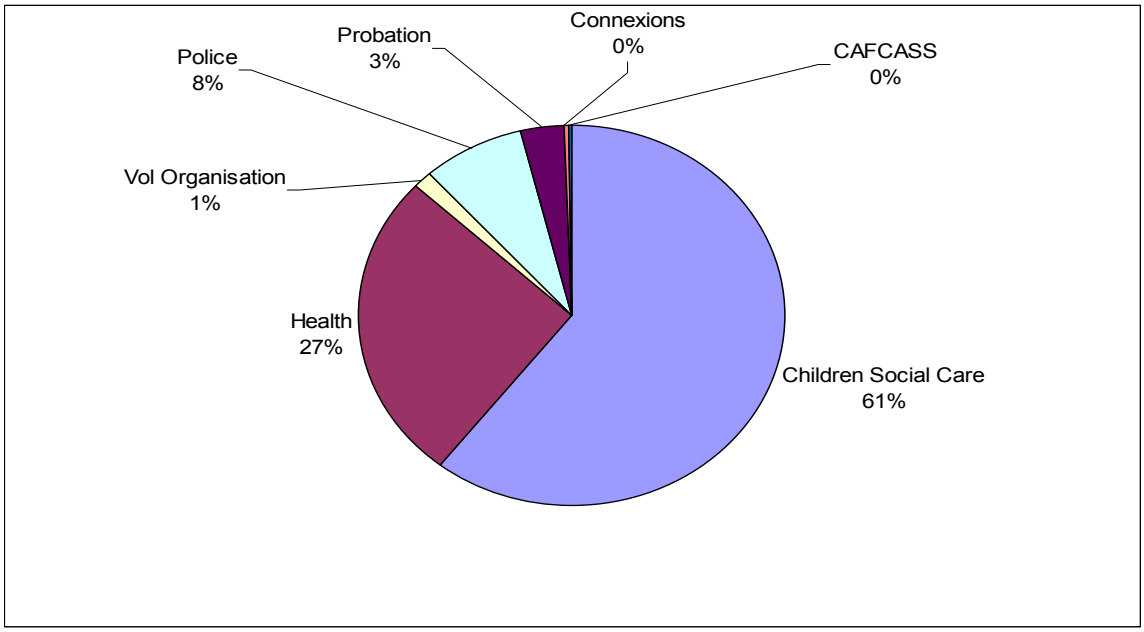


FIGURE 5: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE D

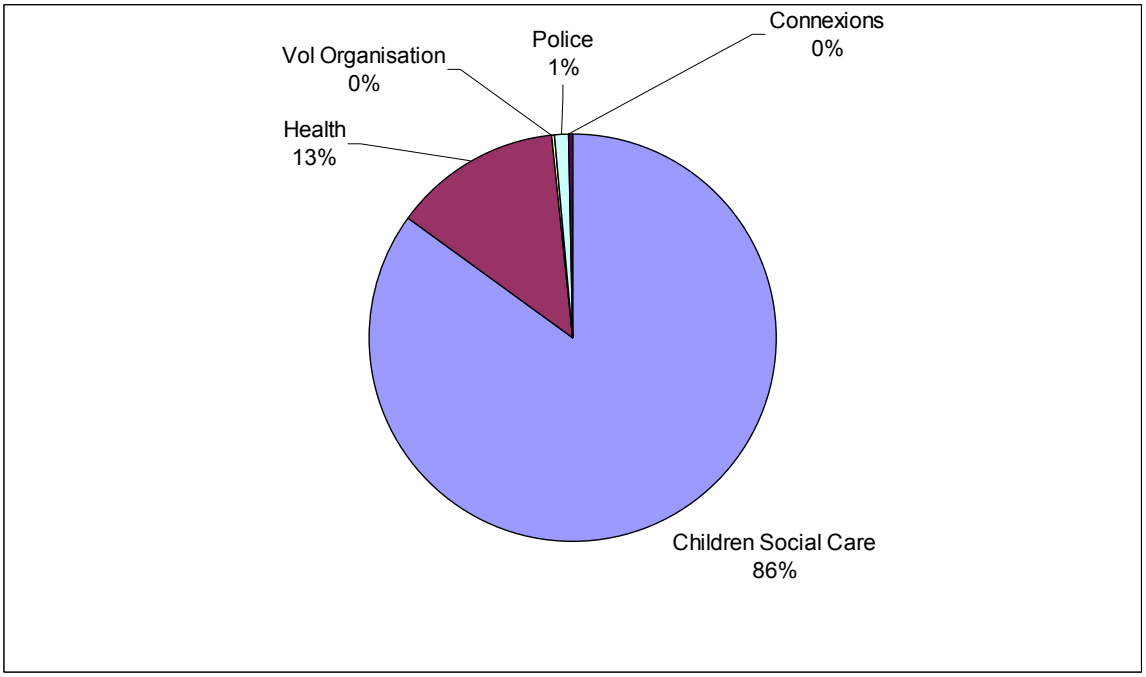


FIGURE 6: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE E

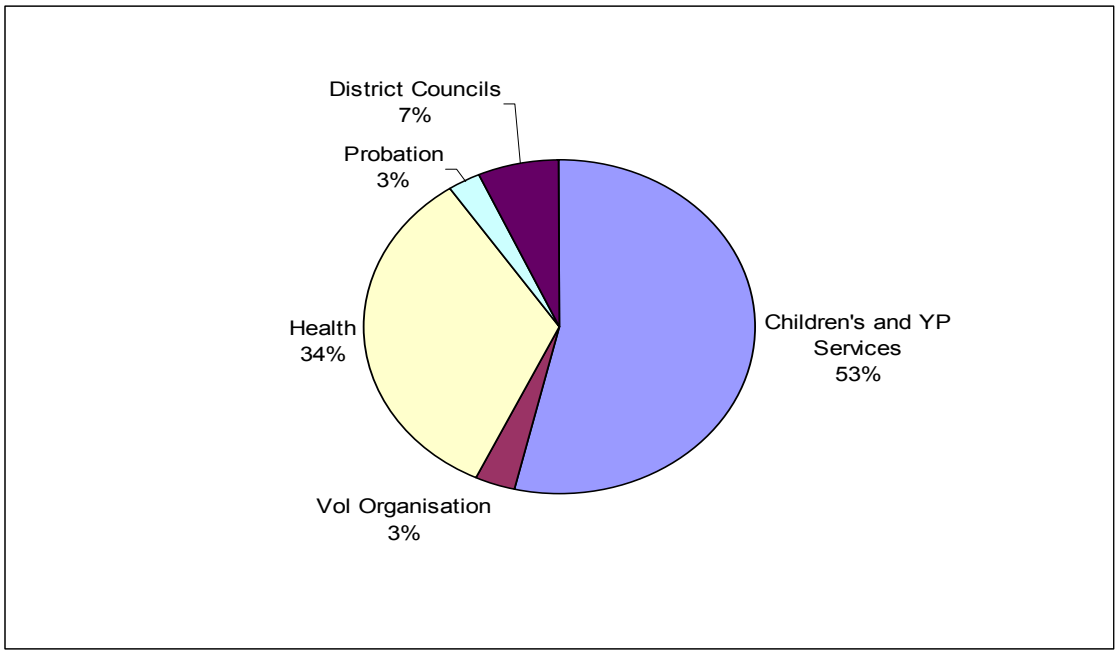


FIGURE 7: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE F

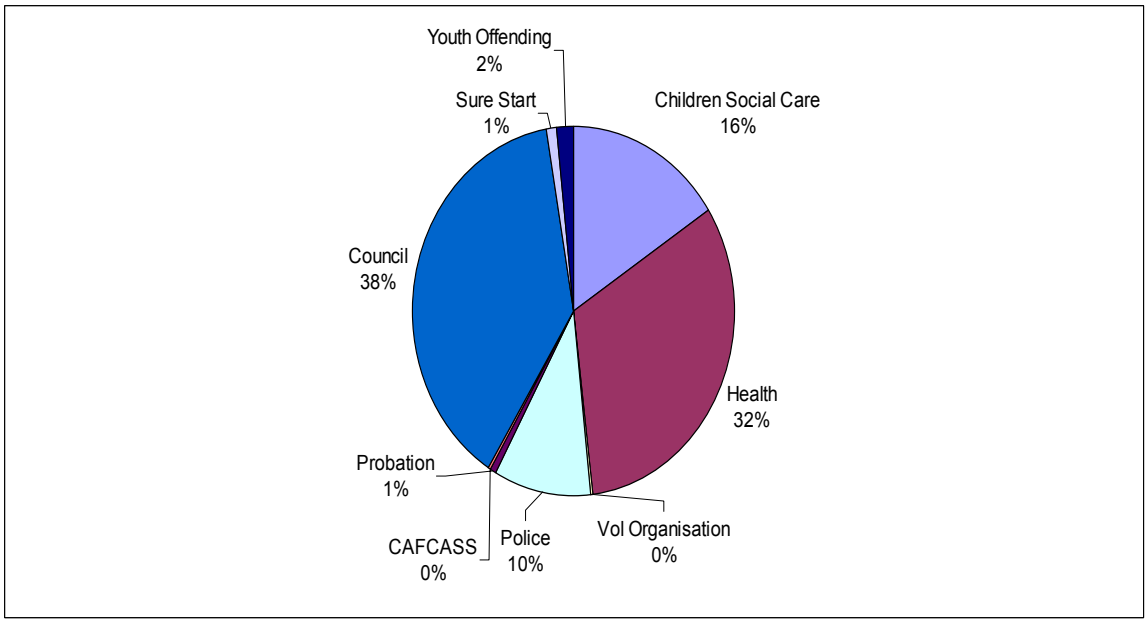


FIGURE 8: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE G

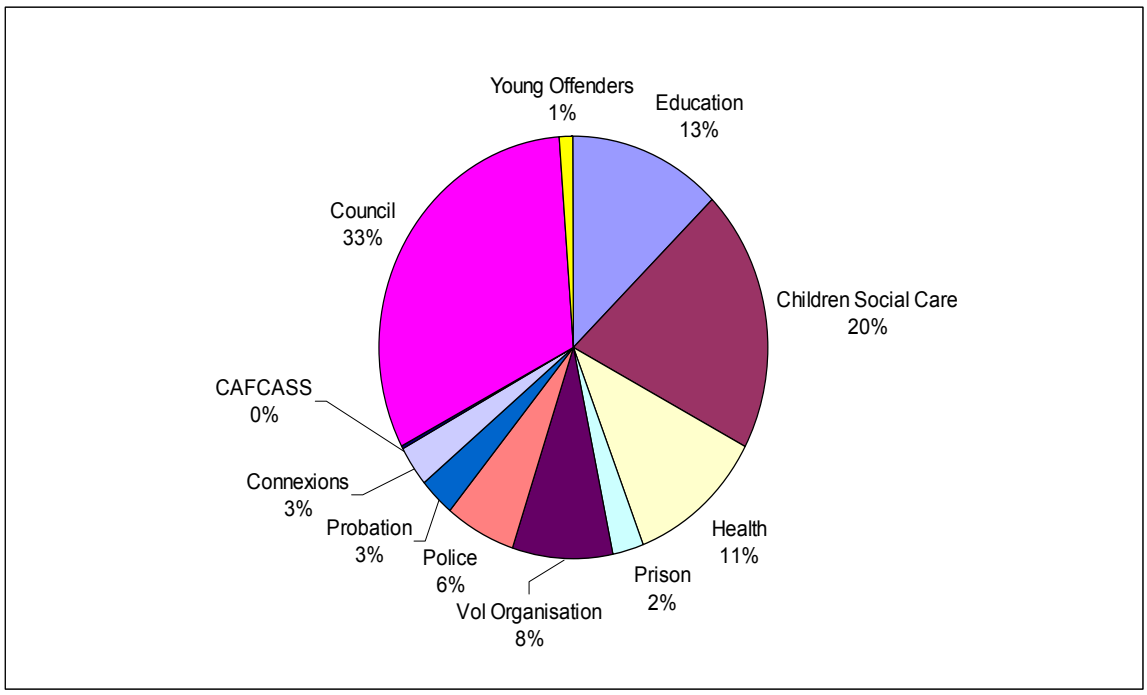
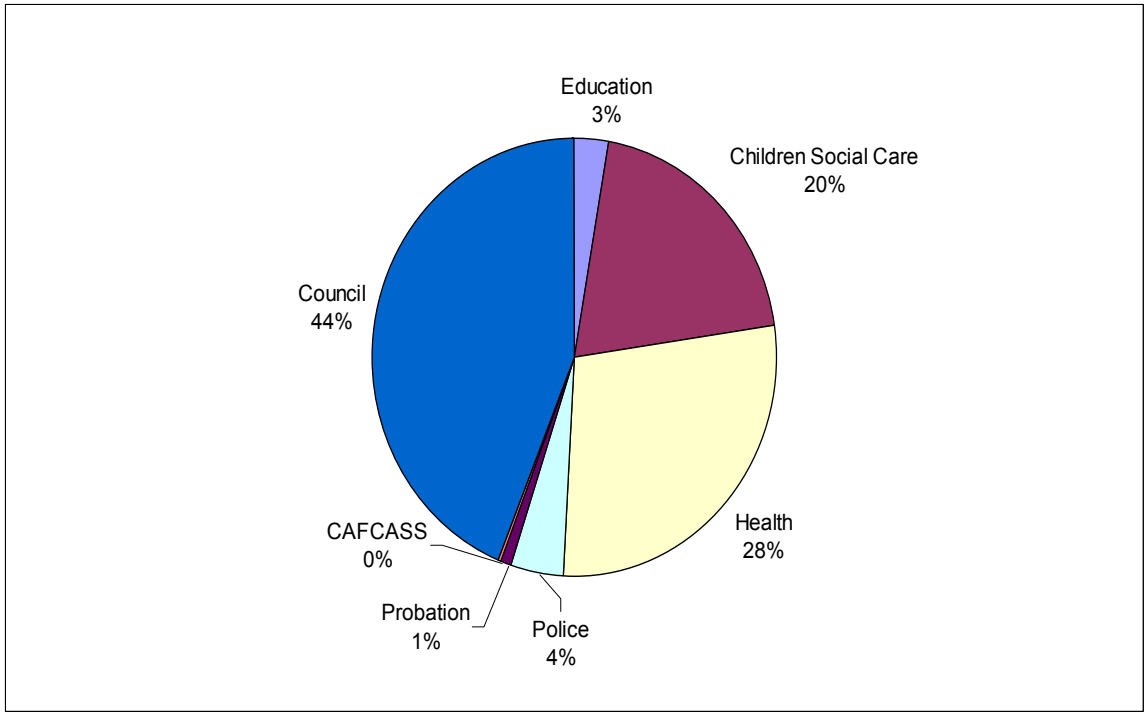


FIGURE 9: PROPORTIONAL TRAINING DELIVERY COSTS FOR AGENCIES SITE H



13.3.2. The costs of participating in training

A summary of the costs of staff participating in training is given in table 3. These are based on a sample of two courses in each agency. The costs were for staff who were shown on the attendance sheets actually to have attended.

TABLE 3: COSTS OF PARTICIPATING IN TRAINING

LSCB	LEVEL ONE	MEAN COST PER PARTICIPANT	LEVEL TWO	MEAN COST PER PARTICIPANT	OVERALL MEAN
Site A	£3,702	£185	£5,381	£224	£204
Site B	£3,432	£137	£2,486	£130	£134
Site C	£3,284	£156	£3,802	£181	£169
Site D	£1,707	£107	£3,031	£151	£129
Site E	£5,098	£204	£5,486	£219	£212
Site F	£1,447	£124	£1,372	£152	£137
Site G	£3,837	£213	£4,975	£226	£220
Site H	£3,332	£278	£3,384	£241	£260
Mean	**£3,230**	**£175**	**£3,740**	**£191**	**£183.03**

For Level 1 courses in the sample, the number of participants ranged from 12 to 25 (mean 16.4). There were on average a few more participants on Level 2 (mean 19.3) with a range of 9 to 25.

The cost of individual participants' time varied very considerably; for example, from over £1,100 for GP in site H to less than a tenth of that, £90, for a support worker on the same course.

The two sampled courses in Site E were much more expensive in the cost of staff time because they had both the largest number of participants (25 each) and because many of these were head teachers. In contrast, the Level 1 course in Site D was much smaller (16 participants) and involved a large contingent of relatively low paid workers in a voluntary youth project. In general, the participants in Level 2 courses were more senior in their organisations and employed in higher paid positions than those on Level 1 courses.

13.4. Discussion

As explained in the introduction, we had no model on which to base this investigation of the costs of training and the methodology, findings and conclusions will benefit from review. However, if the methodology does have merit, we can suggest some tentative conclusions from this exploratory costing exercise.

First, we should remember that there were no statistically significant differences between the outcomes of the training courses provided by the eight sites which were included in this study. This was clear from the regression analyses, which controlled for differences between the participants in terms of professions, experience and so on. We have not (yet) carried out an analysis of the comparative cost effectiveness of courses on particular topics; disaggregating the data and attributing it fairly and robustly is a very time consuming endeavour. Nevertheless, it seems fair to make the interim conclusion that, in general, courses which cost more per participant are less cost-effective than others; of course, the picture may be more complicated when analysed at the level of individual courses. It would therefore be sensible to be cautious at this stage, given the caveats noted earlier in relation to the methods and items surveyed in the costings.

It is also tempting to draw the conclusion that two-day courses are less cost-effective than one-day courses because they did not produce better outcomes in the analyses reported in the preceding chapters. However, as we pointed out, this may be a consequence of the insensitivity of the measures we developed to deeper learning which may be achieved over

a longer period of time. It also ignores secondary gains which are difficult to measure, such as improved networking and better joint working to safeguard children.

So, why is there such a variation in the costs provided by the different LSCBs in the sample? The cheapest average cost was 60% of the highest average cost. Some of these variations were attributable to the costs of external trainers and a small amount to venue costs. However, the main difference concerned the numbers of course days mounted in each LSCB: the more days provided, the cheaper the unit cost; in other words, certain sites are achieving economies of scale by delivering more courses and training more staff.

How do these costs compare with the prices charged by commercial and voluntary sector providers for similar courses? We have estimated the full economic cost per head/day at between £102 and £119, depending on the level of the course and the number of participants. We counted only attendees, not those actually registered; if they had been registered for a course with a commercial company no doubt non-attenders would have still had to pay. (Some LSCBs had levied an administration charge to agencies for non-attenders, mainly as a deterrent to dropping out at short, or no notice.)

Courses in the commercial sector vary considerably in price. For example, the cheapest one-day course in outer London was offered for £130 (including VAT)[25]; this was for a Level 1 introduction to child protection course. A Level 3 course was offered at nearly £150 by the same company. Another company's prices were £230 (incl. VAT) for both Level 1 and Level 2 courses[26]. Agencies wishing to pay for their staff to attend such courses would have to take into account the possible additional cost of travel and accommodation. For comparison a two-day Level 2 course at the NSPCC was £345 including overnight accommodation at its national training centre[27].

In making these comparisons, it should also be remembered that the commercial costs do not include the infrastructure costs to the agency that, in the case of the LSCBs are bourne in part by the training coordinator and staff and by the training sub group: someone has to identify the training need and promote the training opportunities and evaluate whether the course was effective in meeting the training needs of both participants and partner agencies alike. Of course we have no evidence concerning the *quality* of the commercial courses; they may or may not be as effective as those evaluated in this study. Additionally, even if courses in the commercial sector are of good quality, they tend to recruit participants from many different LSCB areas. If one of the important dimensions of LSCB training is to allow networking opportunities amongst staff working in a given locality, then clearly commercial courses, however well designed and delivered, are restricted in their ability to provide such opportunities.

We have shown that using in-house experts to provide interagency training is not cheap when you take into account the opportunity costs and make allowances for the time required to develop new teaching, refresh previous material and make the necessary preparation. So, is it more or less expensive to bring in a freelance trainer to provide the teaching? The answer is, not surprisingly, that this depends on the fee and expenses required by the freelance trainers. These varied enormously: some were very cheap and others very expensive: to a large extent, this reflected the expertise of the trainer and the geographic location of the LSCB. Some external trainers and consultancies being used had national reputations for excellence in specialist areas, such as young people who sexually abuse. The LSCB may not have been able to draw on the services of someone with comparable status.

[25] http://www.abeltd.co.uk (accessed 26.2.09)
[26] http://www.graffhamconsulting.co.uk/childprotection.html (accessed 26.2.09)

[27] http://www.nspcc.org.uk/training (accessed 26.2.09)

Further, 'expensive' external trainers may be brought in for other less obvious reasons, such as boosting the prestige of the LSCB's programme and attracting more applications from its agencies' staff. These considerations aside, it would seem that the mean cost of an internal trainer was similar to engaging a typical (modal) external trainer. Having said that, the more training on the same topic an internal trainer undertakes, the lower the cost per day because the development costs will not be incurred. It is clearly in the interests of the LSCBs to keep these staff engaged, enthused, well supported and well trained. As the findings of the interviews with Trainers in Chapter 3 showed, although there was a lot of enthusiasm shown by trainers, there was varying degrees of support provided by LSCBs.

There is considerable variation in the proportional contributions of the partner agencies to the costs of delivering training, as the members of the training sub groups had told us (Chapter 2). The analysis confirmed the substantial "in-kind" contribution made by, in particular, health care trusts, on top of their contribution to core funding of the LSCB. Nevertheless, this pattern of unequal contributions remained the case, even after the in-kind contributions had been added to core funding (Figures 2-9). Local authority children's services make easily the biggest contribution through direct and indirect costs. At one level, this is in itself is not surprising because the extent of involvement (but not the responsibility) of different agencies for safeguarding children is not equal. For example, safeguarding children is not the 'core business' of probation, even though it is also their responsibility; they would not be expected to contribute as much as education. What is surprising is the ways in which different partner agencies in the different parts of the country have interpreted this issue and determined their direct and indirect financial contributions to the task of safeguarding children.

Estimating the costs to agencies of their staff participating in training proved to be much more time consuming than had been anticipated. This was largely because of the plethora of new jobs and agencies for which hourly costs have yet to be estimated. The sample of 16 courses from the eight LSCBs is too small to draw definitive conclusions. A larger sample, and a lot of time would be required to develop this further. Nevertheless, the findings do give an indication of the level of expenditure required if the outcomes we have seen from the courses evaluated in this study are to be achieved. And that brings us to a final point: training *is* properly seen as a long-term investment. Its outcomes go beyond those immediately assessed in evaluations such as this study Salas and Cannon-Bowers (2001). Changes in attitudes to service users and to other professions engendered on the courses may be expected to generalise to other contexts. The networking opportunities taken may well lead to improved interagency working at a personal level, as when one former trainee phones another about a case, precisely because they had begun to get to know each other on an interagency course. Although these outcomes cannot be quantified, they certainly should not be undervalued. The benefits of training are, therefore, potentially long lasting; however, a methodology for distributing the costs of these benefits over a relevant period of time remains to be developed.

13.5. References

Beach, M., Price, E., Gary, T. et al. (2005) Cultural competence: a systematic review of health care provider educational interventions *Medical Care,* 43(4): 356-373

Brown, C., Belfield, C. and Field, S. (2002) Cost effectiveness of continuing professional development in health care: a critical review of the evidence, *BMJ,* 324: 652-655.

Carpenter, J., Milne, D., Lombardo, C. and Dickinson, C. (2007) Process and outcomes of training in psychosocial interventions in mental health: a stepwise approach to evaluation. *Journal of Mental Health*, 16: 505-520.

PSSRU (2008) *Units Costs of Health and Social Care*. Canterbury: PSSRU, University of Kent.

Salas, E. and Cannon-Bowers, J. (2001) The science of training: a decade review of progress, *Annual Review of Psychology*, 52: 471-499.

14. Conclusions and Policy Recommendations

14.1. Introduction

The purpose of this study was to develop an evidence base for interagency training to safeguard children. As a systematic review of the international research literature had recently demonstrated (Carter et al., 2006), evidence is sorely lacking, not just of the effects of interagency training, but of any kind of training in this field. The authors of this review, acknowledging the difficulties of mounting meaningful randomised controlled trials with adequate follow-up, called for new approaches to develop "best evidence" of outcomes.

Developing "best evidence" required first, the development of suitable measures to assess knowledge, attitudes and self-efficacy in the context of safeguarding. Specific measures were developed to assess the outcomes of both generic and specialist courses on such topics as "Introduction to safeguarding" and "Safeguarding disabled children". These measures generally performed reliably and were sensitive to change.

In addition to assessing outcomes, the project sought to describe the context and mechanisms through which interagency training is planned and delivered and also to estimate the direct and indirect costs to partner agencies.

Interagency training is of course not an end in itself but should be seen as a necessary and vital component of the safeguarding children process.

14.2. The organisation of interagency training

The context of interagency training

Interagency training for safeguarding children is an unusual example of partnership working in that it is mandated by central government but not resourced via ring-fenced funding; it therefore relies very significantly on the good will of partner agencies and professional and personal relationships developed parochially. There are obvious strengths to this approach, but also weaknesses; the system is vulnerable to changes in personnel and highly dependent on a few people, specifically the training coordinator and their support staff.

Mechanisms for the delivery of training

Interagency training is organised by a training coordinator, generally employed by the Local Safeguarding Children Board, and support staff, and working with a training subgroup (TSG) of partner agency representatives. In many respects, the TSGs were good examples of effective partnership working, with members believing that their agency's and the partnership's goals with respect to interagency training were interdependent and mutually beneficial.

14.3. The content and delivery of training

Content of training

The interagency training programmes are very substantial and offer training on important safeguarding issues in accordance with the guidance in *Working Together.* The courses are short, the great majority being for one day only.

An analysis of the content of these courses showed that that interagency training makes a substantial contribution to learning the skills and knowledge of the *Common Core* and therefore to the training of children's workforce in general.

Delivery of training

The courses are led by enthusiastic, skilled and experienced trainers using participative educational models. However, they need more recognition and initial and on-ongoing support than is currently received by the LSCB. In-house and freelance trainers alike would also benefit from increased opportunities for on-going and specialist training (which is funded by the LSCB) and regular networking events with other safeguarding house trainers.

14.4. Overview of findings on the outcomes of interagency training courses

The findings from the series of evaluations of the range of courses included in this study are remarkably consistent in a number of ways.

- First, the overall pattern of learning outcomes is consistent across different types of courses: in line with the study hypothesis, there were no statistically significant changes in scores between registration on a course (T0) and its start (T1). At the end of the course (T2), the objective and subjective scores we measured: knowledge of the substantive topic; attitudes to service users; and self-efficacy in relation to knowledge of safeguarding policies and procedures as well as in working with service users and other professionals, all increased.

  Further, these improvements were not simply highly statistically significant, but the 'effect sizes' (a more informative measure of the strength of an effect) were "large" or "very large" across the range of scales produced for the evaluation. It is worth emphasising this point: effect sizes of this magnitude are very rarely found in 'real world' studies as compared to psychological laboratories. This means substantial, observable change.

- Second, the positive outcomes were found consistently in all the eight study sites (LSCBs) in four parts of the country. In other words, these are not local effects and we can generalise from the findings with a degree of confidence. Overall, the numbers of courses (139) and participants (nearly 1,500) studied is unprecedented in this area and these add weight to the conclusions.

- Third, detailed analyses showed that the effects were, in almost all cases, consistent across participants. In other words, there were positive outcomes, irrespective of the participants' gender, age, ethnicity, service experience and even when they had been 'required' rather than volunteered to attend the course.

- Finally, the opportunity to learn together to work together was very highly valued by participants, even more so at the end of the course than at the beginning. By the end of the course there were very substantial improvements in their self-reported understanding of the roles of different professionals who engage in work to safeguard children and in their confidence and comfort in working with these colleagues.

14.5. Value for money?

Training is a major investment for the delivering and participating agency and incurs indirect as well as direct costs. An approach to the estimation of these costs was developed and used to compare the contributions of LSCB partner agencies to the costs

of delivering interagency training under the auspices of the Board. This analysis demonstrated how, through supplying their own professional staff to act as trainers, by sharing the use of their training facilities and by the time spent as members of training support groups, some partner agencies were making substantial in-kind contributions in addition to their "annual subscription" to the Board.

A comprehensive analysis of these direct and indirect costs led to estimates of the costs of a day's training per participant in the region of £100. This compares favourably to the fees charged by commercial organisations for training on safeguarding children and local courses have considerable advantages in terms of creating opportunities for networking. They were seen by partner agencies as good value for money.

14.6. Practice and Policy implications

Practice

- In terms of the content of training and the achievement of learning outcomes, there is one key area to consider. The research evidence on some topics was not well understood and there were no improvements in assessed knowledge at the end of the course. This was especially true of knowledge about the effects of parental mental health problems on children, but also relevant for courses on domestic abuse and female genital mutilation. The evidence-based content of these courses should be reviewed.
- In order to evaluate the outcomes of training rigorously, training coordinators and trainers could consider using the measures developed in this study to evaluate the pre- post- outcomes of their courses.
- There is a large degree of overlap between single- and multi-agency training courses offered in-house by larger partner agencies such as health and education. However, the extent to which the content of courses varies between agency providers needs further examination in order to avoid duplication of delivery and better use of available resources. The content and evidence-base of these courses should be reviewed.
- The pool of generic and specialist trainers needs to be expanded. An internal audit of training capacities in both the LSCB and partner agencies would help identify areas in which recruitment is needed and where training staff secondment could alleviate undue training pressures on a few dedicated trainers.

Policy

- There should be a more robust system nationally for prioritising and disseminating key training issues for individual LSCBs. In many places, training programmes are planned for the most part by training coordinators with training sub group and partner agency input varying from site to site. There is clear evidence that *Working Together* priorities are highlighted in most programmes. Specific issues, for example as arising from local Serious Case Reviews are also included in some programmes, but what about national priorities or training implications of cases? There remains a potential vulnerability in a system where training priorities for a large number of staff in a LSCB are prioritised by so few people.

- A more robust and shared interagency arrangement for providing training is needed to ensure that the whole programme does not 'collapse' in the absence of one key person. In each of the eight sites included in the study, a skilled and experienced Training Coordinator is critical in ensuring the effective operation of the training programme, including its planning, structure and delivery. We have noted the

benefits and risks of substantial reliance on one individual. TSCs should plan in advance and develop contingencies in order to ensure that programmes are not halted by staff sickness or loss.

- There is an urgent need to address the overwhelming lack of rigorous evaluation of courses provided by LSCBs. As most courses across LSCBs had very similar learning outcomes, there would be benefits of producing a standardised approach to evaluation nationally which would enable comparisons about the functioning and performance in relation to interagency training across LSCBs. The approaches to evaluation, as well as the measures developed and employed in this project, could form the basis of a shared evaluative strategy to interagency training.

- Better and more transparent arrangements for funding interagency training are needed for LSCBs to be able to invest strategically in its training programme and to expand their range of courses beyond basic level training to more complex safeguarding issues. Structural differences in the way in which programmes are delivered are perhaps inevitable, given the variance in organisational arrangements across local areas. However, funding arrangements for training in many LSCBs are currently hidden and costs are unclear. As funding for interagency training is currently taken from the LSCB and single agency budgets, it would be preferable for ring-fenced central government finance to be allocated to LSCBs specifically for training purposes.

- An expanded programme of 'training for trainers' is needed, including standards and accreditation. A very wide variety of trainers is used, both from partner agencies within LSCBs and external trainers. There is little standardisation about the support or training offered to trainers from the LSCB. A minimum set of standards, which specifies experience and training competence, should be considered. A national system of accreditation for people training on interagency training courses to safeguard children would be desirable. This would enable better quality control and consistency between areas and would also allow LSCBs to share and exchange trainer. Wider 'training for trainers' is particularly important if a more rigorous approach to evaluating courses is to be taken nationally.

- Consideration should be given to building LSCB interagency courses into the postqualifying professional development frameworks for different groups of professional staff. This would both raise the status of courses and also help to draw in professional groups who are currently under-represented in the programmes, such as more experienced workers (over 5 years in service), doctors and staff working in adult services.
- One of the essential content areas inherent in all the courses evaluated was the need to inform practitioners of the evidence base within specific areas of practice. As the evidence base is continually developing, findings taught in many courses may therefore have a relatively short shelf life. Practitioners should not be reliant on intermittent and infrequent LSCB courses to keep up-to-date with the latest research, however this is a difficult task for busy practitioners, whatever their professional designation. We were struck by the lack of any core courses which taught staff about the importance of, and processes involved with, evidence based practice. For many practitioners, access to up-to-date and emerging research evidence is limited. Interagency training coordinators or TSCs could provide a role here, through the provision of regular research briefings to all staff who are part of the LSCB in addition to the provision of direct training courses. In this way, we believe that TSCs have a direct role to play in shaping the research mindedness of the whole LSCB.

14.7. Future research into Interagency training for safeguarding children

Although the research identified and subsequently filled a much needed gap in the empirical evidence-base of interagency training across a number of disciplines, it also identified other areas of potential research interest for government and LSCBs.

- The first is in relation to comparing the outcomes of face-to-face training courses with those staff completing courses on-line. Such an evaluation should measure other outcomes considered to be important in safeguarding, especially interprofessional relationships and confidence and knowledge about working together.
- Second, research in this field would benefit substantially from interviews with service users from a range of agencies whose staff have participated in interagency training. This could gauge the influence that interagency training has on the primary outcome of safeguarding children; better child protection and increased well-being. The difficulty of this task should not be underestimated however.
- Third, the exploratory costing exercise can be developed further by carrying out an analysis of the comparative cost effectiveness of courses on particular topics by disaggregating the data and apportioning it in a more robust manner.

Appendix: Evaluating Training - a Toolkit

The evaluations of training courses reported in this report were carried with the help of LSCB training co-ordinators and administrators. The researchers designed the evaluation methods, developed the instruments and analysed the data. Each LSCB took responsibility for administering the questionnaires on the selected courses and collecting and returning the various surveys.

It would be quite possible for a LSCB training subgroup to undertake an evaluation using our methodology. The only technical skills required are in analysing the data (comparing responses at different time points); these skills will be possessed by social science graduates in e.g. psychology and sociology who are familiar with data analysis packages such as SPSS or Minitab. It is also possible to carry out such comparative analysese using MS Excel, but this is a bit more involved process.

Two levels of evaluation are feasible. The simplest involves distribution of the measures at the beginning and end of each course and comparing matched responses (T1 and T2). This requires participants to generate an individual code number so that their responses can be compared. Demographic data may also be collected (but is not imperative, particularly in instances where anonymity is not required).

A more complex evaluation involves administration of the questionnaires at registration (T0) as well as T1 and T2. The logic is that if there is no change between T0 and T1, but there is change between T1 and T2, this may be attributed to the effects of the course with greater certainty. Given the additional costs in terms of administration, sites may wish to simply compare learning outcomes before and after the training.

In order to assess whether learning had been retained, participants can be followed up after 3 months. In practice this is not easy. In our study, response rates at T3 were quite low, but they varied noticeably between sites. The most successful approach involved the trainer making a personal appeal to the participants and extracting a verbal commitment from them to respond later. Email reminders certainly help. The provision of a CPD certificate to those who completed at T3 was not very successful; a prize draw or comparable incentive might be more so.

The following procedure and materials are designed for the more complex evaluation and is based on the methods employed in the study reported here.

Cover letter and Information sheet for Course Participants

Dear Colleague,

I am writing to invite you to take part in an important evaluation of inter-agency training programmes for Safeguarding Children for the ……LSCB.

Official investigations into the deaths of children from abuse and neglect repeatedly emphasise difficulties in interprofessional and interagency working; consequently the government's policy "Working Together to Safeguard Children" promotes training programmes to address these issues. It's obviously important to know whether these programmes are effective and how they can be improved. By assisting us in this project you could play a part in shaping the future in this very important area.

Your participation is, of course, voluntary but we would **very much** like you to take part. Participation simply involves completing a short confidential questionnaire on three (plus one) occasions, designed to assess your knowledge and skills before and after the course for which you have applied. We will not in any circumstances pass on any information about your personal responses to your employing agency or the LSCB.

We have attached an Information Sheet which contains answers to frequently asked questions. We will happily answer any other questions you might have about the evaluation.

Thank you for reading this letter and thank you in advance if you chose to participate in this research.

Yours sincerely,

Information for Participants

You are invited to take part in an evaluation of a training programme provided by ….LSCB. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like to obtain more information.

- **Why have you been chosen to participate?**

The LSCB Training Subgroup has decided to evaluate a number of interagency Safeguarding Children courses this year. You are selected together with all your fellow-trainees because you have applied to attend one of the courses we are evaluating.

- **Do you have to take part?**

No. It is up to you to decide whether or not to take part. If you agree to participate, you are still free to withdraw at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect at all the quality of your training.

- **What are the possible benefits of taking part?**

The objective of the study is to evaluate Safeguarding Children training programmes. More importantly, however, the aim is to improve interprofessional work and to spread good practice in the field of interagency training.

Participation in the research may also be beneficial for you personally. You will be invited to reflect upon the development of your ideas, skills and knowledge gained in the course of the training. Such an exercise will allow you to reflect upon your own professional abilities in relation to the aims and content of the training. Your training experience will become more embedded and the exercise will help you to identify what you have learnt as well as possible gaps in your knowledge. In other words, it's more than a standard end of course smiley faces questionnaire.

- **How long will it take?**

We estimate that it will take an average 10 minutes to complete each three (or four) questionnaires. We will ask you to complete two questionnaires, one at the beginning and one at the end of the training session for which you have registered. This will happen during the training session itself, so it will not take an extra time. We will also ask some of you to complete one questionnaire at registration to the course. Finally we will invite all of you to complete one follow-up questionnaire in about 3 months time.

- **Why are we asking you to complete a questionnaire at registration and then again in the beginning of the course?**

The logic of the evaluation is that in the absence of training, there should be no or little difference between questionnaires completed at registration and at the beginning of the course. A similar pattern of answers given by a group completing questionnaires at both registration and in the beginning of the course and by a group completing questionnaires only in the beginning of the course will prove strong support for the hypothesis that training has an effect on the answers given at the end of the training session.

- **Why do we do a follow-up survey?**

The evaluation aims to measure not only the immediate impact of training sessions. We are also interested in the development of your ideas and knowledge through practice following the course. We would like to know whether you are able to put your new skills and knowledge into practice a few months after the course. If you agree, the third follow-up questionnaire will be sent to your work address in about 3 months time.

- **Why do we ask for your personal details?**

We ask you to generate a personal code number so that we can match your responses at the different time points. It will not be possible to identify you from this code.

- **What will happen to the results?**

Results have a meaning for us only when it comes to measuring differences between groups rather than individuals. We are interested in the average learning and behavioural impact of a particular training session; we are not concerned with individual answers and individual results will be confidential.

Your name and responses will be strictly confidential. The questionnaires you receive will have a code number which will be used to match your responses at different times. The questionnaires completed during the training session will be put in a sealed envelope and will be sent to us right away.

- **How will the results be used?**

The LSCB training subgroup, which comprises representatives of all the partner agencies together with the LSCB training co-ordinator, will write a report for the LSCB. The LSCB will use the results to inform its decisions about the funding of training and the commissioning of courses.

Contact

If you have any questions or concerns about the study or your participation in it at any stage of the process please contact the LSCB training co-ordinator or Chair of the Training subgroup.

Evaluation Procedure

TIME	RESPONSIBLE PERSON	ACTIONS
Annually	LSCB training subgroup	Agree which courses should be evaluated, select the relevant measures and agree responsibilities and support.
Before start of course	LSCB training co-ordinator	Brief course trainer and explain the course is being evaluated anonymously for the LSCB Ask them to plan 15 minutes for participants to complete the evaluation forms at the beginning as well as 10 minutes the end of the course.
At Course Registration (T0)	LSCB course administrator	Send training participants via post or email: **Information sheet for participants** Short **cover letter** written by LSCB encouraging their participation in the evaluation. **Demographic form** and one copy of **the relevant evaluation questionnaire.** Ask them to complete and return the forms when confirming their acceptance of a place on the course.
At Start of course (T1)	Course trainer	If participants forgot to complete the **demographic form** – ask them to complete one on spot. Distribute, collect: one copy of **evaluation questionnaire** (T1) Check that they have self-coded the questionnaire.
At the end of the course (T2)	Course trainer	Distribute, collect: one copy of **evaluation questionnaire**. Collect the completed forms in an envelope which should be sent to the LSCB training administrator
After the course	LSCB course administrator	Separate questionnaires completed at different times. Clearly mark title, date of course. Put all the completed forms in a sealed envelope.
After 3 months (T3)	LSCB course administrator	Send training participants via e-mail (post, if necessary): one copy of **the relevant** questionnaire. Also include **cover letter** and (if sending by post) **empty stamped envelope** addressed to you. Ask training participants to send/email completed forms back to you. Send a polite reminder after 2 weeks
After followup	LSCB course administrator & co-ordinator (with advice as necessary)	Use personal code numbers to match participants responses at the four timepoints. Enter data on EXCEL or SPSS spreadsheet (template available) Analyse differences (protocol available) Draft report for LSCB training subgroup
Annually	LSCB training subgroup	Review results and report with recommendations to the LSCB.

Measures and scales

LEVEL 1 INTRO. TO SAFE-GUARDING	LEVEL 2 WORKING TOGETHER	DOMESTIC ABUSE	PARENTAL MENTAL HEALTH	DRUG USING PARENTS	FEMALE GENITAL MUTILATION	DISABLED CHILDREN	YOUNG PEOPLE WITH SEXUALLY HARMFUL BEHAVIOUR
Defining child abuse scenarios (CAS)	Inter-professional working to safeguard children (IPW)	Domestic abuse and child protection (DA)	Parental mental health and child protection (PMH)	Drug misusing parents and child protection (DMP)	Female genital mutilation and child protection (FGM)	Disabled children and child protection (DC)	Attitudes towards young people with sexually harmful behaviour (AYPSAS)
9 case scenarios	Inter-professional learning (9 items) Inter-professional interaction (9 items) Inter-professional relationships (8 items)	28 items	Reduced attitudinal scale (9 items) Knowledge test (7 items)	15 items	10 items	14 items	21 items

The questionnaires will available to download from the Safeguarding Children Research Initiative www site http://tcru.ioe.ac.uk/scri/. They may be used with due acknowledgement.

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