Institute of Public Care
Evaluation of 3 new 'edge of care' services for children and families

Briefing Paper

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1 Context

Numbers of children going into care are rising. In the year ending 31st March 2021 there were 80,850 looked after children in England (Gov.Uk, November 2021)[1] – an all-time high. In response to these UK figures, the Chief Executive of Barnardo's, quoted in Children and Young People Now (November 2021)[2] said this was partly due to:

> "Family breakdowns and other issues faced by children during the pandemic such as mental health issues, special educational needs and disabilities (SEND) and families just not coping".

Not only have numbers been rising but the complexity of need seems also to have become more acute. Local authorities have reported that more children with emotional and behavioural difficulties and challenging and risky behaviours linked to their Adverse Childhood Experiences (ACEs) are coming into care. Family characteristics typically include:

- Domestic violence in the home.
- Parental mental health problems.
- Parental substance misuse problems.
- Offending or anti-social behaviour by the child.
- Child not attending or excluded from school.
- Poor or inconsistent parenting.

Given that the upward trend in risk factors is predicted to continue, the question of how best to support families to be resilient and resourceful to prevent children coming into care remains a high priority for the sector.

The existing research literature (IPC 2020)[3] suggested that features of effective support for families with more complex or chronic needs include:

- More intensive interventions (but with broader base of multi-disciplinary support).

[1] Gov,Uk (November 2021). Available at: https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions/2021. Accessed 25th March 2022
[2] Children and Young People Now (November 2021) NUMBER OF CHILDREN IN CARE AT HIGHEST LEVEL ON RECORD, LATEST FIGURES SHOW. Available at: https://www.cypnow.co.uk/news/article/number-of-children-in-care-at-highest-level-on-record-latest-figures-show. Accessed 25th March 2022
[3] IPC (2020) Rapid Research Review for Cornwall Council. Unpublished

- Interventions with a good evidence base and even more importantly, delivered with a high degree of fidelity.
- A longer period of intervention is usually required overall – i.e. 12-18 months, but this can include an element of ‘step down’ to less intensive support after a period of intensive intervention.
- Assertive, persistent key workers with lower caseloads and high levels of skill in working with families.
- Significant attention to helping parents or carers to develop internal motivation to change and to address their issues that are likely to get in the way of considering or making changes for example, substance misuse, domestic abuse or parent mental health issues.

2 Three new ‘edge of care’ services

In the context of this relatively established evidence base and between 2020 and 2022, IPC has undertaken three evaluations of new ‘edge of care’ services established to work with families where there is a risk of breakdown. A brief outline of each service is provided below:

Gweres Teyluyow (GT) (Helping Families Service) was set up by Cornwall Council in January 2020 to work with children aged 5-11 and their families. Typical presenting issues include anti-social behaviours, child to parent violence, poor school attendance and low levels of emotional health and wellbeing. 3 area based multi-disciplinary teams were established for the county each with: 2 social workers, 2 family support workers and 2 therapists. The latter provide the **Functional Family Therapy Child Welfare** (FFT CW) programme. A key aim for the service is to intervene at both an early age and stage (before problems have escalated). Most children are referred through Section 17 and are not yet at the level of statutory intervention.

North-East Wales Multisystemic Therapy Service (MST), started working with families in Flintshire and Wrexham in May 2020 and is the first MST standard programme in Wales. The service was developed as part of the Early Intervention and Intensive Support for Children and Young People Transformation Programme, 2019 – 2022, funded by Welsh Government. The service targets children and young people aged 11-17 at risk of entering care or custody, and their families. There is one team covering Flintshire and Wrexham with 4 therapists and a supervisor/team manager who have a mix of professional backgrounds including social work, health, and therapy.

Bwthyn Y Ddol (BYD), is a ‘bespoke’ model with a strong emphasis on psychologically informed assessment and formulation, established as part of the North Wales Early Intervention and Intensive Support for Children and Young People Transformation Programme. A multi-agency team consisting of 2 social workers, 2 family workers, a clinical psychologist and team manager delivers a service to young people aged 11-17 living in Denbighshire and Conwy who are at the high end of complexity. At the point of referral, some children may already have become looked after in emergency alternative care settings including hospital due to the high level of safeguarding need, often linked to serious mental health issues. They are discharged home when the service commences.

Both North Wales services will be opening local residential facilities soon to complement the intensive community-based support services and for those young people that need a short period of time out of the family home to stabilise a crisis situation. During this time, intensive assessment and support will be provided with the aim that they will return home and prevent the need for longer term out of area placements.

3 IPC's evaluation approach and key areas of inquiry

IPC's approach to all 3 evaluations can be defined as 'realist' or 'realistic' i.e. that asks not just whether things are working, but for whom, in what circumstances, in what respects and how (Pawson and Tilley, 1997[4]). A mixed method approach was also applied, incorporating quantitative as well as qualitative research methods. These included case file analysis, interviews and surveys with families and professionals and analysis of management data collected by the service itself.

Key areas of inquiry that were common across all three pilot evaluations included:

- Whether families had engaged well with the service and if so what had enabled them to do so.
- What aspects were different about these models and made them stand out from other family support services (and makes them interesting for others to consider/replicate).
- What had been the outcomes for children and families – in particular had children been prevented from entering care, did they have improved emotional health and wellbeing, were parents better equipped to safely support and meet the needs of their children and were families more resilient and resourceful.
- Key service implementation challenges.

4 Findings

From our analysis of how each service was operating, we identified a number of 'key 'features that appeared to have helped families to engage and commit to the interventions which resulted in a high level of completion and few drop outs. These 'key features' which could be replicable elsewhere maybe of interest to the sector as a whole.

A preventative approach – the starting point for all 3 services was to prevent family breakdown and children coming into care. The differences between them highlight that prevention can happen at different points in the spectrum of need (see windscreen model, IPC 2020)[5] and all have value in enabling families to develop protective factors that will help to prevent their needs from escalating.

Voluntary participation: these services were offered not imposed, and families had choice about whether to engage.

[4] R Dawson, N Tilley (1997) - Evaluation for the 21st century: A handbook. Available at: https://books.google.co.uk/books?hl=en&lr=&id=woH3oHF_egEC&oi=fnd&pg=PA405&dq=pawson+and+tilley+1997&ots=cvuulqSxls&sig=Q75Pktbt1rFXkiEZAVZyeQrvjhM#v=onepage&q=pawson%20and%20tilley%201997&f=false. Accessed 29th March 2022.
[5] IPC (2020) Op cit

Multi-disciplinary teams: having a mix of roles within the teams was felt to be a real strength both by staff, in terms of the opportunities to broaden their professional knowledge and skills and by families who benefitted from the different viewpoints.

> "Having a therapist and the social worker together was very good…… It is good to have two professionals giving different types of insights". (GT parent)

A therapeutic model which is evidence based: Both MST and FFT CW are well established, evidence based, manualised models, delivered under licence. The BYD model incorporated established psychological therapies such as Dialectical Behaviour Therapy (DBT), motivational interviewing and the RAID (Reinforce, Appropriate, Implode, Disruption) approach.

Structured sessions with clearly defined goals: all 3 services offered 'a programme' or process to work through with regular reviews of progress and a beginning, middle and end, as well as **responsive support** when needed.

> "The best thing for me was that I could ring them at any time. If he was having a challenging moment, I could pick up the phone and it didn't have to be the Police". (MST mum)

Facilitative methods were used by staff to encourage families to draw on their strengths and assets and find their own solutions.

> "We teach parents to problem solve for themselves" so that "they are empowered to manage by the end". (MST staff member)

> "We would talk about what happened, how he was behaving, what I could do differently. We put in strategies to combat that behaviour. It was a bit like parental coaching… It was more aimed at me about how I could parent my son". (MST mum)

The quality of the relationship between professionals and family really stood out in all three services. It was clear that staff were skilled in establishing a good rapport from the outset, using empathetic, non-judgemental approaches to engage family members and build up trust.

> "She made me feel comfortable…. I felt I could be very open and honest with her .. She would ask questions, listen and then change strategy when needed". (MST dad)

Intensive support – was provided and this approach was markedly different to what families had experienced before. This included more frequent contact, that incorporated all members of the family including step-parents, grandparents and siblings and lasted for a longer period. Staff spoke about going 'above and beyond', 'whatever it takes'. Parents appreciated this and for partner agencies this was one of the most valuable aspects of the service.

> “They supported the young person through crisis and were involved a lot longer than they usually would be… There was daily support at times when she was unsettled, and there were daily multi-disciplinary mtgs”. (BYD partner agency)

Flexible delivery – typically, staff arranged sessions to fit around the family’s schedule and preferences to enable everyone to participate. This became even more important during the pandemic and all three services offered a range of options including telephone, text, WhatsApp, Zoom as well as ‘in person’ (Covid safe) contacts to keep the support going.

> “(worker) fitted in around us in the evenings when I was home from work and x (child) wasn’t in school. She came to the home”. (GT parent)

Partnership working – health and social care services have long been criticised for ‘working in silos’ resulting in families experiencing un-coordinated and disjointed support. A key aim for these services was to develop a more integrated, and coherent offer, for example by communicating and building relationships with other agencies and drawing them into a coordinated plan of support. Our evaluations demonstrated that information sharing had improved, stronger links were in place and families were benefitting.

> “We are more connected now. She made sure we had a multidisciplinary assessment. We knew my son needed to be assessed for lots of things, but it hadn't happened. She was instrumental in getting the multidisciplinary side of things moving”. (GT parent)

5 Outcomes

As is frequently the nature of pilot evaluations, it was more difficult to determine the extent to which these target outcomes for services had been achieved. The evaluations were carried out at a relatively early stage of implementation, and it has been suggested that “it takes between 2 and 3 years for a social care intervention to reach full implementation and that is it likely to happen in stages” Lushey (2017)[6]. As already noted above, families often engaged with these services for long periods and therefore the number of children and families who had completed interventions was relatively small. However, by using a range of methods to gather evidence including family interviews, case file sampling and standardised outcome measures, we were able to identify very positive early signs of promise in all 3 service settings. For example:

Data gathered from case file analysis in the GT service

85% of parents who participated in FFT CW had improved their knowledge, understanding and skills quite or very well in relation to child development and parenting.

69% of parents in the FFT CW cohort had taken on board the learning and were working together using effective strategies for managing or preventing difficult behaviour either very much or quite a lot.

69% of parents in the FFT CW cohort had improved levels of self-esteem and emotional wellbeing and were feeling more hopeful and positive about the future.

69% of children in the FFT CW cohort and 72% in the social worker/family support worker led model were experiencing fewer incidents of aggression or anti-social behaviour at home or at school.

68% of children in the FFT CW cohort had improved emotional health and wellbeing.

71% of families in the FFT CW cohort and 79% in the social worker/family support worker led model were found to have improved relationships and communication.

Only 5% of children had been stepped up to Child Protection or Looked After Child during the intervention.

[6] Lushey C. (2017) No Wrong Door. Available at: https://www.gov.uk/government/publications/no-wrong-door-innovation-programme-evaluation

The following case studies from our evaluation of the MST service focus on what the change for one family looked and felt like:

MST case study

The young person was going missing and at risk of Child Sexual Exploitation (CSE) and been out of education for 2 years. She had alleged that she'd been raped but mum hadn't believed her. There had been self harm incidents 2 months prior to the referral. Relationships at home were very strained. There was physical and verbal aggression from the young person to her mother. Mum & step dad very negative about the young person. Mum had told her she didn't want her and didn't care if she became homeless. Mum had called children's social care out of hours asking for her daughter to be accommodated and saying she felt like hitting her. It was noted that mum has had multiple brain tumours over the last few years, she had a poor relationship with her daughter, ineffective discipline and ignored her for weeks as punishment.

Engagement in MST by mum, dad and step dad was very good. Mum commented as early as the second week that she had never had support like this with someone at the end of a phone whenever you want. 1 to 1 sessions mostly with mum looked at FITs and sequential thinking for verbal aggression, poor school attendance, breaking curfews, positive school attendance, partner's lack of engagement, anti-social peers, absconding, low mood, and positive verbal aggression. A genogram was completed looking at family ecology. The worker completed 38 hours over 16 weeks, 2-3 sessions a week.

At case closure, the support was said to have been very successful. Young person felt loved, felt safer and more secure. Now had positive relations with all adults in her life and more affection and less verbal aggression towards her mum (sustained for 7 weeks at closure). There was no absconding. She asks mum if she can go out & tells her where she is going and who with. Curfews have been kept and sustained for 7 weeks. Mum realised that "when I show my daughter warmth & I am positive she can't kick back at that." There were no anti-social friends now, only pro-social activities with approved friends. Relationships at home had vastly improved. The young person was reciprocating warmth to her mother and getting on with her stepfather. School had offered her a place in the school hub & were pleased with her engagement and academic progress.

BYD outcomes: lessons learnt

The cohort of young people accessing the BYD service were described as being 'at the high end of complexity' and included some that had already had to leave the family home and were being cared for in hospital or the local residential home. In these cases, the service became involved as part of the discharge plan.

In our case file analysis and through interviews with parents and professionals we found evidence that suggested some progress had been made. For example, in one case there had been no reports of self-harming for several months and no further hospital admissions. In another, there had been a reduction in absconding/going missing and Police involvement.

> "It helped build relationships… The young person was displaying significant violent behaviour…. The reflection and the impact of traumatic life events on them all that they may have not fully appreciated before was a big shift for them & helped enormously". (residential unit manager)

> "The young person was so complimentary of the support and intervention she had had. She noticed so much difference in herself. She was talking about school and going back and the problems she felt. Before she would see a problem and that would be it. But in this conversation she identified the problem and then talked through solutions". (residential unit manager)

Comments from parents we interviewed tended to be more cautious about the degree to which they felt young people had changed and hinted that whilst the intervention may have helped 'at the time', it wasn't necessarily going to be enough to sustain long term improvement, given the high level of complexity. For example:

> "He had a good 2-3 weeks when his behaviour wasn't so bad. Emotional and behavioural difficulties reduced a bit in this time… He's no better off at the minute. That's just him". (mum)

> "They didn't understand the complexities of my daughter as a whole. My daughter would play lip service. They would give her calming techniques but she's not that type of person. She would do the 1:1 sessions but nothing outside". (mum)

What this indicates, is that there is not likely to be a 'quick fix' for this cohort of children and young people who are at the high end of complexity. Progress is likely to fluctuate and it can be more helpful to measure outcomes as small steps in the right direction rather than wholesale change. The BTD team use distance travelled tools like outcome star which can be helpful in documenting the journey incrementally and sharing this with young people and families to highlight achievements, however small and encourage ongoing change.

6 Lessons learnt for the sector as a whole

For children's services in other areas that are considering piloting new approaches to address the growing number of children with complex needs on the edge of care, our evaluation of these three services points to some key implementation challenges as follows:

Staff recruitment was problematic, particularly for roles that required clinical expertise for the delivery of therapeutic interventions - reflecting the bigger picture of staff shortages across the health and social care workforce. However, in talking to staff in the newly established teams, we heard very positive feedback about the uniqueness of the roles, opportunities for personal development and the high level of job satisfaction. It might be helpful to feature these positives in recruitment drives.

Capacity was stretched – the growing number of families needing support was exacerbated by the Covid pandemic and more recently the cost-of-living crisis. Small teams can quickly become overwhelmed. Having tight eligibility criteria might be one way to control this that might include an assessment of whether the family is ready to benefit from an intensive and potentially demanding intervention.

Gaps in other services - unmet need that was beyond the scope of the service risked having a detrimental effect on families and cancelling out the gains that had been made. The most frequently mentioned services that were difficult for families to access were CAMHS, other specialist support for children with additional needs and adult mental health. This can only be addressed by partner agencies taking a whole system approach to explore how capacity in other services can be boosted.

Conversely, the things that supported implementation included:

Partnership working by senior managers and leaders – a shared agreement about the need / target group, a willingness to try something new and a shared commitment to resource the pilot.

Partnership working at operational level – new teams worked hard to establish open, honest and trusted relationships and ensure that what they were offering complemented (not duplicated) the work of other agencies.

Support for staff – induction and training for new staff to ensure they had the right skills and approach to deliver a high-quality service and were able to adapt to new ways of working. Regular clinical supervision, enabling staff to develop reflective practice.

Smaller caseloads - so that staff could work more intensively with families.

Adaptability – being creative and changing methods of delivery if necessary to keep families engaged. For example, all 3 services offered remote and digital options as well as keeping in person (Covid safe) visits going through the pandemic.

Continuous review – reflection and review by practitioners – is what we're doing making a difference to families? as well as by senior managers and steering groups - checking against delivery plans, asking themselves – are we doing the right thing?

Evidence based approach – for example in the case of MST, and FFT CW, adherence to the model is seen to be critical to its success; also using evidence from interim evaluation and reviews to re-shape the model if necessary.

Our findings are complemented by the existing research literature (IPC 2019)[7] which suggests that the characteristics of successful project implementation include:

- A culture of leadership embedded in the system.
- Being clear about the model - motivating staff around a shared ethos with clear objectives.
- Strong multi-agency commitment.
- Alignment of processes such as IT and recording systems and good use of data for planning and performance monitoring.
- Staying focused on the intended group of children and their needs, being flexible enough to focus on their needs and not select children based on their fit with the service offer.
- Recognising that creating changes in practice across services is challenging. Training is not enough; staff need ongoing input and time to adapt and change their practice.
- The creation of interagency KPIs to enable engagement and manage performance and accountability.
- Understanding that implementation is a process and not a single event. Existing implementation science literature suggests that it takes between 2 and 3 years for a social care intervention to reach full implementation, and that it is likely to happen in stages.
- Ensuring that employment arrangements i.e. secondment time limited contracts do not undermine implementation by creating instability in the staff team.

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[7] IPC (2019) North Wales Early Intervention and Support for Children and Young People Transformation programme. Initial literature Review. Unpublished.