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Torfaen County Council

Evaluation of 'Don't Walk By' Deeper Dive

Report

March 2017

OXFORD BROOKES UNIVERSITY

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Evaluation of 'Don't Walk By' Deeper Dive Report

1 Introduction

The Institute of Public Care (IPC) at Oxford Brookes University has been asked to provide an in-depth evaluation of the 'Don't Walk By' arrangements designed to provide multi-disciplinary support to families with additional needs in Torfaen. The report complements and builds on data recently collated by the Torfaen Families First Team, of which headlines include:

- Growing demand for Don't Walk By / Families First arrangements between 2015 and 2016
- A corresponding reduction in demand for statutory Child in Need Plans (from 728 in March 2015 to 537 in March 2016[1])

The IPC deeper dive evaluation has included:

- A case file analysis – involving a randomly selected cohort of 33 families who have received support commencing between early May and mid-July 2016
- A series of semi-structured interviews with professional stakeholders – 12 of these interviews were conducted in February 2017
- Interviews with 6 families whose files were analysed and who agreed to talk with evaluators about their experiences in February – March 2017

The report is organised as follows:

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[1] 2017 numbers not yet available

2 Findings from the Case File Analysis and Family Interviews

2.1 Cohort Features

IPC examined the files of a total of 33 families who had recently received a 'Don't Walk By' or Families First intervention (families had been referred into these arrangements in early May to mid-July 2016). 6 of these families subsequently agreed to a one to one interview.

2.1.1 Geographical location

In 4 cases, the location of the family was unclear. Of the others, most (55%) were from the Cwmbran area. A full breakdown is provided in the table below:

Area	Number	Percentage
Cwmbran	16	55%
Pontypool	7	24%
Blaenavon	4	14%
Sebastopol	2	7%

2.1.2 Referring Organisation

Referrals had been received mostly from primary and secondary schools (42%) or social services (12%).

Organisation	Number	Percentage
Primary schools	7	21%
Secondary schools	7	21%
Social Services	4	12%
Bron Afon	3	9%
Action for Children	3	9%
Self-Referral (Parent)	3	9%
Health Visiting	2	6%
Community Nurseries	1	3%
PMHCT	1	3%
Flying Start	1	3%
Healthy Babies Advisory Service	1	3%

2.1.3 Age of Key Child and Ethnicity

The arrangements have been involved in supporting children of a very wide variety of ages from under 1 year to 18 years and a fairly evenly spread of ages in between. However, the mode (most common) age of the key child is 14 years and the mean (average) age is 9 years.

The children were almost all White British / Welsh with just one child of White British/Other European origin. In some cases, ethnicity wasn't recorded.

2.1.4 Family composition

There were a number of large (4+ children) families, as illustrated in the table below:

Number of children of the family living at home	Number of families	Percentage (approx.)
1	5	15%
2	10	30%
3	7	21%
4	7	21%
5	4	12%

A high proportion of families with 4-5 children had a significant history of involvement with Social Services (see below).

2.2 History of Involvement with Social Services

- A large proportion of the families (11/33 or one third) had a significant history of involvement with Social Care Services
- 11/33 or one third of families had some involvement with Social Care Services
- 11/33 (one third again) had no previous involvement with Social Care Services

2.2.1 'Significant History' Families

- These were mostly (7/11 or 64%) families with 4-5 children living in the family home
- At least 1/11 families had older children already in care
- At least 1/11 families included children who had spent some time in care
- At least 4/11 families (36%) included children who had been on the Child Protection Register
- 7/11 (64%) families had signs of at least two out of three of the 'toxic trio' (domestic abuse, substance misuse and mental health problems:
    - 5 of these 7 families had evidence of domestic abuse and parent mental health problems
    - 2 of these 7 families had evidence of domestic abuse and substance misuse problems

- 2 other families had signs of domestic abuse only
- 1 other family had signs of substance misuse only
- 1 other family had no signs of toxic trio issues – this family had a long involvement with Children's Disability Services to support their significantly disabled child
- There were signs of child neglect over time in 4/11 (36%) families
- There were concerns relating to possible physical abuse of the children in 6/11 (55%) families. In almost all (5/6 or 83%) of these cases, there was evidence of both domestic abuse and parent (Mum) mental health problems.
- There were concerns relating to possible sexual abuse of the children in 4/11 (36%) families. In all (100%) of these cases, there were also concerns about possible physical abuse. In all (100%) of these cases, there was also evidence of both domestic abuse *and* parent (Mum) mental health problems. In most of these cases, there were also concerns about neglect.

Example cases:

Case 5

This family of 5 children was referred to Families First by Social Care Services in May 2016. The key teenaged child was living with grandparents, the other children with Mum and (Step) Father. The children had previously been on the Child Protection Register in another part of the UK, and some of Mum's older children had been adopted. The family had been known to Torfaen Social Services since 2010 including:

- At least 7 referrals 2010 to 2015 regarding domestic abuse, substance misuse, alleged neglect, child sexualised behaviour, and neighbourhood disputes – none of which resulted in an intervention
- The most recent referral (2016) relating to one child who was alleging physical abuse and displaying challenging behaviour at school, stealing from shops - resulting in NFA and referral to Families First

Case 28

This family of 3 children living with Mum and Dad and referred to Families First by the Secondary School were known to Social Services from 2005 including:

- 2009 concerns that Mum has mental health problems and children arriving to school dirty, very low school attendance, missed health appointments. Results in a CIN Plan closed in 2011 although parents didn't engage with the Plan
- 2011 referral regarding an injury to a child taken to hospital outside the area, family delayed seeking medical assistance for 24 hours. Subsequent referrals that year for child aggressive behaviour and children tired / grubby uniform at school and low attendance. NFA as child receiving anger management support in school
- 2013 referral child grubby and very tired, receiving support in school for bed wetting and has nasty wound to his hand child unclear how it happened, NFA
- 2014, anonymous referral regarding poor home conditions and animal waste in the house, threatening behaviour in the home involving knives, children not getting meals at home. Announced visit results in no concerns, NFA

- 2014, subsequent referral from a project worker that an older sibling isn't eating at home and another sibling has bruising to face. An older child is now in supported accommodation due to poor relationship with parents. Younger child found with small mark to face, NFA
- 2015 referral from older sibling Dad is very controlling and family frightened, NFA

In at least 5/11 of the 'significant history' cases, it appeared that neither the referring agency nor the key worker allocated to the case had knowledge of the previous history – and in many of these cases, this was highly relevant to ongoing work with the family. IPC is aware that there are procedures in place to alert lead workers to a social services history and to provide them with the right contact within social care services. However, it would appear that the follow up contact doesn't always happen.

2.3 Presenting Needs (at the time of referral to Families First)

2.3.1 No history of referrals to Social Services Cohort

There were 11 families in this cohort. (Sometimes overlapping) characteristics of this cohort included:

Characteristic	Number	Percentage of cohort (approx.)
Child behaviour problems (and problem boundary setting by parents)	6	55%
Diagnosed or possible ASD	5	45%
Child learning disability	3	27%
Parent mental health issues	2	18%
Family financial / benefits issues	2	18%
Family housing issues	2	18%
Recent (multiple) bereavement	1	9%
Child emotional health and wellbeing issues	1	9%
Family fleeing domestic abuse	1	9%

At the point of referral, the estimated level of need within families in this cohort was as follows:

- One family (9%) at level 4-5 (borderline requiring a Social Worker led intervention)
- Two families (18%) at level 3 (multiple additional family needs requiring coordinated family support)
- Five families (45%) at level 2-3 (multiple additional family needs)
- Three families (27%) at level 2 (with some additional needs requiring targeted single agency / issue support)

Therefore, at least 27% of families in this cohort didn't seem to require a coordinated (Don't Walk By) response, although they probably required some form of single agency targeted response.

2.3.2 Some referral history with Social Services cohort

There were 11 families in this cohort. Their characteristics included:

Characteristic	Number	Percentage of cohort (approx.)
Child behaviour and problems with boundary setting	6	55%
Child significant emotional health and wellbeing issues	5	45%
Parent mental health problems (mostly significant)	5	45%
Domestic abuse recent or current and/or high level family conflict	5	45%
Probable or diagnosed ASD	3	27%
Young person at risk of sexual exploitation	2	18%
Caring responsibilities for extended family members living at home	2	18%
General parenting problems	2	18%
Parent substance misuse	2	18%
Attachment issues	1	9%
Housing issues	1	9%
Finance issues	1	9%
Child substance misuse	1	9%
Child on a modified timetable at school	1	9%
Some evidence neglectful home conditions	1	9%
Parent learning disability	1	9%
Parent physical health problems	1	9%

A number of these characteristics were overlapping including in particular: ASD and problems with child behaviour / boundary setting; adult and child mental health problems; child behaviour problems and child emotional health and wellbeing problems.

At the point of referral, the estimated level of need within families in this cohort was as follows:

- One family (9%) at level 4-5 (borderline requiring a Social Worker led intervention)
- One family (9%) at level 4 (complex additional needs requiring a coordinated family support)
- Two families (18%) at level 3-4 (multiple additional family needs requiring coordinated family, bordering complex)
- Five families (45%) at level 3 (multiple additional family needs requiring coordinated family support)
- Two families (18%) at level 2-3 (multiple additional family needs)

2.3.3 Significant history of referrals and interventions with Social Services cohort

There were 11 families in this cohort. In addition to the significant referral and 'toxic trio' history outlined above, the (often overlapping) characteristics of this cohort at the point of referral included:

Characteristic	Number	Percentage of cohort (approx.)
Child challenging behaviour and (parent) difficulties in establishing boundaries / empathy with the child	9	82%
Child emotional health and wellbeing issues	5	45%
Parent mental health issues	5 (including some significant)	45%
Child disability (LD and PD)	5	45%
Possible ongoing risk of physical abuse	4	36%
Poor school attendance / truancy	2	18%
Risk of child sexual exploitation	2	18%
Probable ongoing domestic abuse	2	18%
Family finance issues	2	18%
Housing issues	1	9%
Child substance misuse issues	1	9%
Sexually abused child	1	9%

At the point of referral, the estimated level of need within families in this cohort was as follows:

- Three families (27%) at level 5 (needs indicate a Care and Support Plan)
- Three families (27%) at level 4-5 (very complex needs bordering the need for social worker involvement via a care and support plan)
- One family (9%) at level 4 (complex additional needs requiring coordinated family support)

- One family (9%) at level 3 (multiple additional family needs requiring coordinated family support)
- Two families (18%) at level 2-3 (multiple additional family needs)
- One family (9%) at level 2 (some additional needs requiring targeted single agency support)

2.3.4 Levels of presenting need in the overall cohort

Level	Description	Number	Percentage
2	Some additional needs requiring targeted single agency support	4	12%
2-3	Multiple additional family needs	9	27%
3	Multiple additional family needs requiring coordinated family support	8	24%
3-4	As above, bordering complex needs	2	6%
4	Complex additional needs	2	6%
4-5	Very complex additional needs bordering the need for social worker involvement via a care and support plan	5	15%
5	Needs indicate a care and support plan	3	9%

Therefore, most of the families referred into this pathway (88%) had needs that indicated more than a targeted single agency support.

Approximately 24% had very high level and complex needs suggestive of the need for intensive family support delivered by highly skilled professionals with sufficient time (including caseloads) to deliver this form of support.

9% had needs and risks suggestive of a Care and Support plan facilitated and coordinated by a social worker.

2.4 Lead Workers and their Initial Engagement with Families

2.4.1 Who were the Lead Workers?

Lead Workers were mainly from Families First funded services, as illustrated below:

Service	No. from the 'no history' cohort	No. from the 'some history' cohort	No. from the 'sig history' cohort	Total and %
FAP	3	3	5	11 (33%)
Bron Afon	2	3	4	9 (27%)
Early Years	4	1	2	7 (21%)

Service	No. from the 'no history' cohort	No. from the 'some history' cohort	No. from the 'sig history' cohort	Total and %
Disabled children service	2			2 (6%)
Communities First	1			1 (3%)
Healthy Babies Adviser		1		1 (3%)
Action for Children		1		1 (3%)
Family Focus		1		1 (3%)

2.4.2 How well did the lead workers engage initially with families?

Type of engagement	No history cohort	Some history cohort	Sig history cohort	Total and %
Impossible to see from the file, but obviously quite well, as the family did engage	3	2	2	7 (21%)
Lead worker already involved with the family, thus straight forward engagement	1	1	2	4 (12%)
Good, including timely, tenacious and involving several techniques	4	2	2	8 (24%)
Quite good, some limitations	3		1	4 (12%)
No real opportunity to engage as case stepped up to Social Services quickly		2		2 (6%)
Unsuccessful in spite of good attempts (probably inappropriate referral)			1	1 (3%)
Poor including delayed		4	3	7 (21%)

Most lead workers engaged well and in a timely way with families allocated to them or already involved with them. However, 21% of early engagement activity was considered by evaluators to be poor, including some delays or insufficiently pro-active engagement with families with high level needs and/or a significant history of involvement with social services.

2.5 Whole Family Assessment

2.5.1 Type of Assessment

There were 6 instances where an assessment hadn't been completed – mainly because the case had been closed before this was appropriate and/ or stepped up to Social Services. In one case, there was no record of the assessment on the file for other reasons.

For the remaining 26 families, workers had completed a Family Support Assessment with the families concerned, including the 'scoring' section in all bar one case.

2.5.2 Quality of the assessment

Where an assessment had been completed, these were almost always (in 23 out of 26 or 88% cases) of good quality including holistic, strengths based and focusing on the key family issues. In 3 cases, the assessment wasn't judged to be sufficient, particularly with reference to relevant areas of family functioning that remained unexplored.

2.5.3 Timeliness of the assessment

- For the 'no history' cohort, the average time between referral and completion of the assessment (where one was done) was **4.5 weeks**. The time varied between 2 and 8 weeks
- For the 'some history' cohort, the average time between referral and completion of the assessment was **7 weeks**. The time varied between 2 and 12 weeks
- For the 'significant history' cohort, the average time between referral and completion of the assessment was **6 weeks**. The time varied between 1 and 12 weeks

These average timescales seem appropriate, with the proviso that some, particularly vulnerable, families were waiting quite a long period of time between referral and the first visit / assessment. This seemed to contribute at least to the likelihood of them disengaging with the support.

2.6 Quality of Plans

All 26 families who had an assessment also had a Family Support Plan. The table below illustrates the varied quality of these plans:

Qualities	No History Cohort	Some History Cohort	Sig History Cohort	Total
Good, comprehensive plan including outcomes-focused	3	0	3	6

Qualities	No History Cohort	Some History Cohort	Sig History Cohort	Total
Fair, but not outcomes-focused – focused more on outputs	3	4	3	7
Fair, but not sufficiently multi-agency plan	2	0	0	2
Fair, but insufficiently clear about what will be done, by whom and when	2	4	1	7
Fair, but not addressing some of the key issues or proposing support that is likely to be insubstantial	2 (particularly not tailored to child ASD needs)	0	2 (particularly insufficient lead worker support)	4

2.7 Interventions and Outcomes

2.7.1 Did Team around the Family Meetings take place?

	No history cohort	Some history cohort	Sig history cohort	Total
Several TAF meetings	1		1	2 (6%)
One TAF meeting	3	3	3	9 (27%)
Didn't need a TAF meeting or N/A	4	3	4	11 (33%)
Didn't have a TAF meeting but the family might have benefitted	3	5	3	11 (33%)

- In one third of the reviewed cases, there was at least one TAF meeting – although about a half of this sample had late or very late TAF meetings (with reference to the referral date and/or assessment)
- In one third of the reviewed cases, there was no TAF meeting but evaluators judged that the family might have benefitted from one
- One third of the sample didn't require a TAF meeting, either because the nature of need or because circumstances changed before one could be arranged (for example, step up to Social Services)

2.7.2 Interventions and outcomes for the 'no history with social services' cohort

- In the majority (7/11 or 64%) of the 'no history with social services' cohort, the interventions and outcomes were largely very positive including a good well-received intervention, a clear plan that was delivered thoughtfully and responsively, and evidence that the key issues or problems for the family were improving. There were a variety of levels of need within this cohort (from 2 to 4/5) and a variety of lead workers involved.

Examples of these successful cases are provided below, including family member verification of the experience and outcomes:

Case 13 including reference to family interview

This level 2 case concerns a 3 year old male child living with Mum and Dad. The child was already on a 'School Action Plan' for general learning difficulties and the health visitor initiated a referral to Families First for dietary (nutritionally incomplete) and child behaviour (frustration) issues. Parents believed the child might be on the autistic spectrum.

The plan included: MEND messy play sessions for the child; tests for vitamin deficiency; and lead worker-led work to increase the variety of foods he would eat.

Whilst there was no 'team around the family' approach, the family appreciated:

- Lead worker involvement once a week for 8 weeks, providing support, advice and ideas about food and activities *"This was really practical help. She really helped him"*
- Some speech and language therapist involvement

Mum thinks that:

- Her child will now touch different foods
- She will persevere with the approach to food – as she can see the progress he is making already
- She is doing more positive activities with her child

"He is now making things with me, cakes. Beforehand, I would put stuff in front of him and he would just scream"

Case Study 22 including reference to family interview

This level 3 case concerns a female child aged 4 years referred with an older sibling and living with Dad and a grandparent. The child was in the process of being diagnosed with autism. She also has physical disabilities and can't walk far. She was becoming upset easily and Dad was struggling with boundary setting. The family had some financial problems.

"I was struggling with the kids and living arrangements. I wasn't used to being a single parent"

The lead worker engaged very well with the parent and family. She organised regular TAF meetings with the Educational Psychologist, teachers and SENCO at school. Dad felt 'completely involved' in these meetings and found them very helpful. *"My opinions (matter) – everybody listens"*.

The aspects of the plan that Dad found particularly helpful were:

- Support to access more appropriate housing (although the family is still waiting to be re-housed)
- The parenting course – which Dad is accessing weekly *"I enjoy it, it's valuable, has helped me in a lot of areas"* – although it's not specifically for ASD children *"It's been more helpful for my (older child)"*
- Lead worker support for emotional wellbeing *"I was depressed, I need to work"*
- The coordination activity provided by the lead worker *'X is my single point and is fantastic. I can ring her whenever"*

As a result, this Dad feels more confident in the overall parenting task and is more relaxed and able to cope, the older sibling is doing well in school.

"This was good timing, changes are now happening"

Case 21

This case concerns a 5 year old girl and younger sister aged 6 months living with Mum who had been forced to flee domestic abuse elsewhere and was living with parents. The 5 year old had been diagnosed with global development delay including delayed speech and had typical ASD traits and behaviours.

The Lead Worker completed a strong assessment with the family and formulated a joint plan including help with accommodation, benefits, child health needs, education and respite needs, support for Mum to become independent and to engage the child(ren) in activities.

By the time of the first review, the family had secured a property locally, the children were happy and settled, Mum was receiving appropriate benefits, and Mum reported being much happier and less anxious and was attending a 'Freedom Programme' to explore her vulnerability to abusive relationships.

- In 2/11 cases, the interventions appeared to be partially successful and outcomes partially positive. These were families with level 2-3 needs and included evidence of some good including persistent Lead Worker activity to access the right resources for the family, but also:

  - key parent becoming reluctant to engage in group or 1:1 parenting work
  - reluctance from specialist services to undertake diagnosis work
  - evidence of drift in implementing some of the plans

- In 2/11 cases, there was no discernible progress for the families concerned. These were families at level 2-3. In both of these cases, the Lead Worker appeared to have failed to engage sufficiently well with the family, either initially or on an ongoing basis. The interaction of the Lead Worker with the family was at arms' length (for example almost entirely over the 'phone). An case study example is provided below, including reference to the family interview:

Case 30 including reference to family interview

This level 2-3 case concerns a female child aged 8 years referred with a younger sibling and living with Mum (pregnant) and Step Father. Mum was looking for help with this child's behaviour (frustrated and angry at home). Mum has done a Family Links Programme before but said 'nothing's working'.

"I thought I might get somewhere, I was hopeful"

However, although there was an assessment and plan (to reduce anxiety through parenting support techniques) and Mum engaged initially, the school-based course tailed off. The case drifted towards single agency support and was eventually re-referred into Families First.

"In school, there was a meeting and things were agreed. At first I thought they were listening but they did not follow up"

"She suggested a sticker chart and brought charts the following day. We did it for 3 days but it didn't work. One worker was going to do 1:1 work with us but then passed the buck to another worker. They promised the world then didn't deliver. I think the worker may have been ill, we were left in the lurch. Nothing has changed"

2.7.3 Interventions and outcomes for the 'some history with social services' cohort

- In 2/11 of these 'some history with social services' cases, there was evidence of largely positive outcomes. These were both level 3 cases:

Case 11

This level 3 case concerned a key male child aged 4 years living with Mum and two older brothers referred to Families First after Mum and Dad had separated acrimoniously.

Mum was struggling with this child's challenging including controlling and violent behaviour at home. The house was cluttered and unclean. The Lead Worker co-produced an excellent holistic assessment and outcomes focused plan with the family. Since then:

- The child has received an ASD diagnosis
- There has been progress with his self-care skills, understanding and reasoning, and participation in school
- Mum's basic care has improved including boundary-setting
- Mum's mental health has improved

- In 2/11 of these cases, there was evidence of a partially positive intervention. These families had needs at level 2-3 or 3:

Case 17

This level 3 case concerned a key male child aged 11 years with diagnosed global delay living with an older brother, Mum, Dad and Grandfather. There had been historical concerns about possible physical abuse of this child who has a very low academic ability and self-care skills, and is vulnerable socially. Mum was struggling to cope with the children's aggressive behaviour at home and was caring for Grandad.

The key worker demonstrated good, persistent early engagement with both Mum and the child, and a strong assessment was co-produced with the family.

Although family life and the children's behaviour appeared to have stabilised after a few months and this child had been successfully referred to a youth club:

- No work had been done with the parents on their parenting techniques, particularly parenting of aggressive teenagers
- Mum wasn't getting any support with her carer role in relation to this child with additional needs / grandad
- The youth club attendance was perhaps only partially successful as this young person was beginning to 'stand out' as having a learning disability

All communication with the family post-assessment was undertaken over the telephone rather than face to face, which may have limited the worker's ability to work 1:1 with the family on some of these issues, or to encourage them into more appropriate services and supports.

- In 4/11 of these cases, there was no evidence of progress or a deterioration in family conditions and outcomes. The level of need was mixed for this group, from 2-3 to 3-4. These cases were characterised by:
  - Plans that didn't acknowledge significant family needs – for example very poor family communication and high level conflict; significant child anxiety issues; domestic abuse; or parent mental health issues
  - A resultant lack of focus on the key issue or issues (as above)
  - Lead worker insufficiently engaged or pro-active with the family to explore the key issue(s) – lead working instead at arms' length, for example by sending check-up texts. Overall, insufficient time with the whole family and insufficient attention to escalating needs
  - The organisation of a Team around the Family only very late in the intervention – when an early TAF could have helped to explore the issues and develop more effective plans
  - In one case, significant drift in lead worker communication with the family

Case 1

This level 3 case concerned a key male child aged 12 years referred with 3 siblings, living with Mum who was finding it difficult to show warmth towards them and to put in place boundaries. Mum has mental health problems relating to a traumatic childhood experience.

The case records indicated that several lead workers may have become involved sequentially, which led to a significant (4 month) gap between referral and a substantive intervention. Although the finally allocated lead worker eventually made considerable efforts to re-connect with Mum and to put together a fresh plan:

- Mum is now distracted by a new partner and pregnancy and hasn't therefore sought help with her mental health issues (had just been encouraged to go to the GP by the first lead worker)
- One child's schooling has deteriorated and he has left school as a result
- The children's behaviour at home has deteriorated
- This family needs more intensive support than appears to be on offer

- In 3/11 of cases, there has been a further referral to Social Care Services between allocation and a Families First (Don't Walk By) intervention commencing – in all cases, this resulted in a Section 47 investigation

2.7.4 Interventions and outcomes for the 'significant history with social services' cohort

Families in the significant history cohort were mostly at level 4-5 or 5, but there were also some at level 3 or even 2-3 (at the point of initial referral).

Evaluators noted that the chronic and complex nature of many of these families' issues is likely to have made them largely unresponsive to anything other than very persistent, intensive, and evidence-based lead worker activity not offered through the current Torfaen model for TAF.

- In 1/11 case there was evidence of a largely positive outcome:

Case 24

This level 2-3 case concerned a male child aged 10 years living with Mum, Step Father and 3 younger siblings. The child had previously been on the Child Protection Register for physical abuse by their natural father. This child then made allegations of physical abuse against the Step Father. The case was closed to Social Services and referred to Families First by the school. The child has dyspraxia and presents as very anxious, not coping well with change, and with low self-esteem. Mum was struggling with the child's behaviour at home.

The Lead Worker contacted the family 6 weeks after referral and engaged effectively with them. The holistic assessment co-produced with the family was strengths- based and thorough. This led to a good outcomes-focused plan including:

- Youth work support for the child
- TAF meeting at the school
- 1:1 work with Mum to ensure safety and boundaries in place at home

3 months into the intervention, the review noted:

- Significant improvements to the child wellbeing and behaviour
- Child no longer running off
- Child much calmer
- A very good parents' evening

- In 3/11 of the significant history cases, there was evidence of some positive change and outcomes of the plan being addressed, but also some key issues that hadn't been addressed.

Case 2 including reference to the family interview

This level 3 case concerns a male child aged 9 years referred with a younger sibling and living with Mum and Dad. The family had previously had some (respite) support from specialist disability services in relation to this child with significant developmental delay / learning disabilities.

Mum believes that they were 'stuck in a rut for many years' as there was no diagnosis. *"I didn't want a social worker so they referred us to (Families First)"*

This referral came to Families First via school who were concerned about this child's demanding behaviour including controlling with Mum, aggression, obsession with routines.

The lead worker engaged well with the family initially and completed a strengths based assessment and plan with them. However, there was a significant gap in contact between the worker and the family subsequently.

Whilst the child has now received a referral to the 'Serennu Centre' in Newport and other supports including play, the needs of the family appeared to have escalated during the gap in contact with their lead worker.

Mum found completing the Families First assessment quite difficult, even though it was handled sensitively, *"as the scaling was difficult – doesn't fit my child, as he can be) or 5 on different days".*

Mum has found the Lead Worker's involvement very positive *"With Y, I have something now that I didn't have before"*. She has particularly appreciated:

- The lead worker's coordination skills and availability *"I can contact her at any time. She does go quiet sometimes, but rang me and said sorry"*
- The TAF meeting in school
- The lead worker's attention to Mum's emotional health and *wellbeing "She rings me to see if I'm OK"* - Mum has now accessed counselling support
- Parenting classes at the Serennu Centre
- That the school is now referring the child to CAMHS

Mum still finds it difficult that there is no diagnosis, is waiting for a (ASD) diagnosis. The school are saying this is difficult because they can't access an assessment.

Case 15

This level 4-5 case concerns an 18 year old female child referred with siblings and living with Mum and Step Father. There was a long history of involvement of the family with social care services over 15 years including significant parent mental health problems, child self-harm, non-school attendance, poor home environment, parents not complying with CIN Plans. The family had also been known to local community services for several years. The key child was referred in relation to self-harm, anxiety, depression, poor sleep, involvement in abusive relationship(s), risk of sexual health problems and pregnancy, Mum distracted, poor family relationships, home overcrowding.

The strong outcomes-focused plan concentrated on the right things and supported the key child to: attend positive activities groups, attend a health and wellbeing project. Mum was also supported in relation to welfare benefits.

However, the plan and lead worker activity didn't address the child's emotional health and wellbeing and broader family (communication and conflict) issues in particular. This child has subsequently become pregnant.

- In 6/11 of significant history cases, there was no evidence of progress or a deterioration in family conditions and outcomes. These families were mostly at level 5 or 4-5 but two were considered to have level 2-3 needs at the point of referral.

Case 31 including reference to the family interview

This level 2-3 case concerns a male child aged 15 years living with Mum. There was a significant history of involvement with social services over 12 years including for parent substance misuse, and concerns about physical abuse. The child had been diagnosed with ADHD and also has additional learning needs and behaviour problems. Mum has significant mental health issues. The child was arriving late for school sometimes and had attendance issues.

Whilst the assessment was full and strengths based, the plan wasn't holistic (no mention of Mum) and wasn't clear about outcomes.

"The assessment was very good. She was thoughtful, down to earth. She engaged with (my son)"

After the assessment, most of the contact between the family and the lead worker was by telephone. The intervention didn't really get going and the child, then Mum, disengaged.

"There were no meetings. When the worker came, he felt positive, she was on his side. What was promised was helpful, but it's not been followed up yet. I am (still) waiting for them to get in contact. I suffer with my nerves and don't feel I can ring"

As a result, Mum says that:

- Her child is still not going to school (regularly) even though she's now threatened by court action
- The child has possibly even lost confidence in people who offer support (but don't deliver) *"He needs someone who he feels is looking out for him"*

He is not leaving the house to socialise now

Case 16

This level 2-3 case concerns a 15 year old male child and 3 siblings (1 unborn) living with Mum and Step Father. There had been a history of referrals to social services over 9 years and a previous child protection investigation regarding physical abuse. This child has mild learning difficulties.

More recently, the child had begun to truant from school and the Education Welfare Officer had given Mum a formal warning for poor school attendance.

Resultant planned Families First support helped the child perhaps to engage with college initially. However:

- No work was undertaken with Mum on parenting (Mum doesn't appear to have been referred to or accepted a referral for 'Talking Teens' and there has been no 1:1 work either)

Overall, child attendance issues don't appear to have been addressed

Case 10

This level 5 case concerns a 14 year old female child referred with a 10 year old sibling, both living at home with Mum and Step Father. There are 2 older siblings also living at home.

- The older siblings were on the Child Protection Register some years ago for suspected physical abuse (including significant fractures and bruises)

- The key child was sexually abused as a younger child leading to all children being placed in care, although the care order was subsequently discharged
- This child then had a fractured skull and there were several other child protection investigations leading to case closure in every subsequent year: these relating to domestic abuse, children going missing and out of control, Mum self-harming in front of the children, Mum alleging Step Father assaults the children, poor living conditions
- There was one CIN intervention approximately 8 years ago, and one Child Protection Conference after one of the brothers alleged an assault by Step Father, who was temporarily excluded from the house. Mum was also sectioned at this point
- There is a history of poor school attendance for all children of the family and a history of Mum being dependent on alcohol during both recent pregnancies
- At the point of this referral to Families First (Don't Walk By) by their school, this child was: struggling and had poor school attendance; having counselling but self-harming and attention seeking in school; heavily dependent on on-line relationships, has anxiety issues, GP recommending a PRU anxiety group rather than mainstream school. Mum says she was abused as a child and needs support. Mum suffers from depression and anxiety and struggles to maintain boundaries at home, Dad does this. The younger sibling has additional learning needs and limited social skills – she is verbally abusive to the parents.
- The family are known not to engage in support - they have a history of this.

The Lead Worker did make contact with Mum and undertook an assessment of the family needs but, before the support was implemented, there was a crisis with this child punching her younger sibling and Mum describing herself as suicidal. Although the lead worker demonstrated good case coordination skills (including good chasing of the PRU) the family disengaged after 3 months after a change of worker was proposed, with no engagement in change.

Case 18

This level 4-5 case concerns a female child aged 8 years and 4 siblings living with Mum and Step Father and referred by the school to Families First (Don't Walk By). The long history of involvement with Social Services included:

- Historical concerns about neglect including poor home conditions and care workers denied access to the home, partner aggressive
- Historical concerns about possible sexual abuse of this child – unsubstantiated
- Significant family conflict and violence reported by this child
- Mum then asking for help as expecting another baby, not coping with this child's behaviour which she accepts is a result of witnessing domestic abuse. Health Visitor has significant concerns about Mum's ability to cope. Results in a CIN Plan followed by a brief period in voluntary care
- Later concerns from a midwife about the unborn child's father, not a clear outcome
- Recently, this child alleging in school that Mum smacks her
- A history of Mum avoiding support

- This referral suggests: Mum not managing children's behaviour; children not sleeping well, fighting and rude to Mum; Mum recently bereaved; Mum has anxiety and depression and hasn't accessed any support for this

The Lead Worker did well to engage the family and undertake an assessment with them, but possibly didn't ask sufficiently probing questions to understand the children's behaviour issues. It looks like this worker didn't access the history before undertaking the assessment and plan – which therefore looks completely inadequate as Mum not offering up the possible reasons for child behaviours. The intervention never got off the ground and no-one was undertaking the intensive therapeutic and practical support likely to be required for this family.

- In 1/11 significant history case, the case was stepped up to Social Services before the Families First (Don't Walk By) intervention could get going. This was a worrying case involving patterns of injury to the children and background ongoing neglect, many referrals over time but limited support offered to the family.

3 Findings from the Stakeholder Interviews

A total of 12 managers of relevant local services were interviewed for this project. They completed a semi-structured interview with evaluators aimed at exploring the extent to which:

1. the existing 'Don't Walk By' model is clear and fit for purpose
2. the existing supports for the model are effective
3. the model fits with the strategic direction of travel locally
4. performance management and governance arrangements are fit for purpose

Their responses in relation to these areas are explored below:

3.1 Is the existing 'Don't Walk By' model clear and fit for purpose?

- All stakeholders agree that the model for working with individual families is now clear to most agencies and practitioners
- Professionals and agencies tend to refer to:
  - the underpinning strategy and ethos as 'Don't Walk By' (sometimes 'Don't Walk on By'!
  - the model and way of working with individual families as either 'Families First' or 'Team around the Family (about 50/50)
- All stakeholders agree that the existing model (a hybrid of an Everybody's Business model combining some allocated Lead Worker arrangements) is the right one for Torfaen

"It's working very successfully now"

"I don't think we should go to an extreme end of either a refer in or everybody's business now"

"It's absolutely the right model for us now, it's developing and becoming more efficient"

"It feels intuitively right, particularly the TAF model"

"Yes in theory, in practice it's difficult to get workers to see that they're the right one to take the lead worker role"

"It's the right model, but all people we're asking to contribute have other priorities and agendas. Families First employed people can give a bigger commitment"

- Most stakeholders believe that agencies and services are engaged now in the model, although not all agencies are thought to be well engaged. Positive progress in this respect has been particularly marked with schools recently
- Most stakeholders think that the model is working with a very high level of need in terms of family complexity

"Families referred in are quite high level: including many that have had a significant social care involvement in the past"

"We're getting some families with chronic issues – where the child is perceived to be the problem. It's difficult to draw out the harder issues"

"These cases are sometimes so complex, we don't have the skills to deal with it"

Stakeholders recognised the risks of this trend – particularly that the most needy or complex families disengage or that workers are effectively being asked to 'start again' on a limited resource with families where earlier efforts have failed

- Most stakeholders think that the pathway and its key stages are working well now. Most think that the overall pathway has improved and become more responsive (faster to allocate) in recent times. The elements of the pathway that are considered to be working well now are: the referral systems and the holistic assessment and planning stages. The elements of the pathway that are thought to be weaker include:

  - Information sharing (particularly with regard to families with a history of involvement with services and high level needs)
  - Reviews – which people can still forget to do – although with the 'RAG reporting' system, it was felt that this is improving significantly
  - TAF meetings – which are highly valued when they happen, but aren't always consistently used even where the family might benefit. Some lead workers are more reluctant than others to draw these together
  - Some lead working – there appears to be inconsistency in what people perceive this role to include, including some workers who consider this only to involve signposting after an assessment. Other lead worker activity is considered by stakeholders to be excellent

- All stakeholders think that the model actively promotes or has the potential to promote effective multi-agency working

- Whilst there are other pathways for children and families that are potentially overlapping, these are not considered to be problematic. Essentially, professionals in close contact with children and families select the most appropriate pathway and there is limited duplication

3.2 Are the existing supports for the pathway effective?

3.2.1 Documents and Templates

All stakeholders believe these supports to be of good quality, including:

- Much better compared to the original documentation
- Family-friendly

"Don't change it – it's about right now!"
"We all like it and are committed to it"

3.2.2 Central Coordination Function

This function is considered by all stakeholders to be a real strength of the existing arrangements in Torfaen and critical to the success of the model.

"It's absolutely brilliant, communications are extremely good, they're always there and there are clear coordination roles"
"It's the engine room"
"Fantastic, I've been able to build a relationship with people there, which is very important. I can trust them"
"It's a good team, committed to getting it right"

3.2.3 Panel Arrangements

These arrangements are thought to be working well now, particularly with the incorporation of a 'pre-panel meeting' to triage families and ensure swifter access to lead worker support.

"(The Panel) has helped to bring people together – it has real structure and people understand the process"

3.2.4 Training and Workforce Development

Whilst stakeholders acknowledge the availability of training specifically on the model and lead worker function, not all agencies and relevant workers are availing themselves of it, particularly where they don't want to engage in this role.

Other stakeholders mentioned the practitioner and manager meetings that have been recently implemented and that have been very well received.

Other forms of lead worker training that are relevant to the task (for example: motivational interviewing, solutions focused therapy, positive parenting, domestic abuse) are described as being patchily available or taken up across the services mainly providing lead workers in Torfaen.

3.2.5 Services to support the pathway

Although most stakeholders acknowledge that there are generally wide-ranging family support services in Torfaen and recent sharing of some key ones (such as parenting programmes), there are thought to be some crucial gaps including:

- Behaviour support for families with more complex needs – including behaviour that results from attachment issues or child/family trauma
- Emotional health and wellbeing support for children and young people
- Mental health support for parents

It is interesting to note that these are the three 'top' issues for families referred into existing arrangements, as identified by the case file analysis.

3.3 Does the model fit with the strategic direction of travel locally?

Most stakeholders acknowledge that the Don't Walk By Strategy and Families First / Team around the Family arrangements fit well with the local and national strategic direction of travel including with:

- the principles underpinning the Social Services and Wellbeing Act
- other Anti-Poverty priorities and work streams
- the Additional Learning Needs Act
- the 3 corporate priorities (particularly vulnerable people and education)
- recent developments in Children's Social Care Services

However, there is an element of uncertainty about the strategic direction of travel, in part because of the uncertainty over some aspects of national policy.

Some stakeholders are concerned about the sustainability of the arrangements, particularly as the model is so heavily reliant on families first (grant) funded lead workers and/or because worker skills need to grow and develop quickly to accommodate levels of family need being referred into the model.

3.4 Are the performance management and governance arrangements fit for purpose?

These are mostly considered fit for purpose, with clear reporting lines. However, it is thought by many stakeholders that leaders of key agencies have struggled to hold each other fully to account in relation to the development and embedding of the strategy and model. Elected members may also be under-aware of the model.

3.5 How would stakeholders like to see the model develop?

There was a high level of consensus that the model should remain 'as is' but continue to embed and develop to bring the quality up to the highest standard.

"Leave it alone – no radical change – we've made huge progress"
"Embed further – including networking meetings and drawing others in gradually"

In terms of embedding, the following emerged as particularly significant themes:

- The need to develop key (including lead) worker skills further, in particular to meet the demand coming through the door
- The need to embed the principles of the model across a greater range of agencies – this to be achieved in a supportive way (pulling not pushing)
- The need to address Information, Advice and Assistance issues including information sharing and how, across the authority including at the 'front door' into council services, families are directed to the right help at the right time
- The need for greater accountability for the embedding of the model at a senior level
- The need to draw early help and children's social care services into a more streamlined continuum of family support – including in particular to benefit families at the high end of early help / on the edge of social care

"It's an exciting time – a brilliant process for some families to help them change"

Institute of Public Care
March 2017