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Evaluation of the Integrated Family Support Service - Final Year 3 Report



Evaluation of the Integrated Family Support Service

Final Year 3 Report

February 2014

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Executive Summary

SQW, supported by Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick, was appointed to undertake an evaluation of the Integrated Family Support Service (IFSS) model in August 2010. **This Executive Summary presents the findings from the third and final year of the evaluation, covering the period April 2012 through to March 2013.**

Detailed information on the IFSS model and the background to the evaluation process is contained in the First Interim Report¹, which was published in May 2012. In addition, a Second Interim Report was published in February 2013.

Key evaluation findings and issues for consideration

Developments during the third and final year of Phase one

The strategic and operational contexts for the three Phase one sites have changed significantly during the last 12 months. This was predominantly as a result of the roll out of IFSS across the whole of Wales, which has created some disruption locally, not least with some IFST members leaving to take posts in the new teams and uncertainties about future local arrangements and funding beyond March 2014.

The IFSTs at sites 1 and 3 have reduced in size significantly during the final year of this phase. Over the same time period, the size of the IFST at Site 2 has remained unchanged. Although some skills and capacity has been lost from the sites as a result of the staff churn, **the remaining IFST workers have continued to develop and become increasingly experienced and expert in delivering IFSS.**

IFSS Boards and Operational Groups have continued to meet and were seen as effective, even though attendance has been mixed. In one case the Operational Group was put on hold as it was felt there were insufficient issues

¹ Separate reports covering years 1 and 2 of the evaluation process have been published and can be accessed via the Welsh Government website: <http://wales.gov.uk/statistics-and-research/evaluation-integrated-family-support-service/?lang=en>

or interest to require it to meet now that the set up phase had passed. IFSS Board agendas have focused heavily on post Phase one funding and regional roll out strategic planning issues, with a reduced emphasis on day-to-day operational issues.

Section 58 agreements have been developed in all three sites, but to date there has been no cause to use these as partners have generally bought into the IFSS model. Indeed, the evidence suggests that operationally at least, partner awareness levels and commitment to IFSS has grown, mainly due to the relationship building work of the IFST members.

In year 3, the number of referrals to IFSS fell slightly compared to the volume recorded in year 2. However, the **monitoring data indicates that the quality of the referrals in year 3 has improved, as a larger proportion of these cases (92%) progressed to Phase 1.** This reflects improved awareness of and buy-in to the programme by referring Social Worker teams.

In two of the sites, **IFSTs had to operate a waiting list due to demand exceeding capacity**, although in one case this reflected a significant decline in the scale of the IFST. Waiting lists caused some frustrations given the importance of making a timely intervention. Cases were accepted on the basis of the most appropriate, predominantly in terms of the families' willingness or motivation to change, when capacity became available.

There is a high degree of consistency in terms of the volume of cases recorded as being accepted onto Phase 1 of the IFSS programme (47-49 across the three Phase one sites) in year 3. This consistency contrasts with the contextual data which shows a variation (645 – 2,435) in the number of registered Children in Need across the areas.

The volume of cases accepted onto Phase 1 represents an increase in throughput of around 50% relative to performance in year 2. This has been delivered with significantly smaller teams in two areas. It suggests that there may have been excess capacity at these two sites in previous years.

IFSTs in all sites have had to review when they accept cases and how many they can process at any one point in time. Some sites have moved towards

practitioners having two cases at a time, with one finishing and one starting, to deal with demand. This approach seems to be working.

There is **continued variation and flexibility in how IFSS has been delivered across the Phase one sites, although the general approach and ways of working are very similar**. At Site 1 and Site 3, the intensive period usually lasted for six weeks, whereas at Site 2, it tended to be shorter at four weeks, although some work could be carried over to the first week of Phase 2.

In addition, **there have also been some structural changes to how the model is implemented**. For example, at Site 1, a new resource panel approach to referrals was introduced part-way through the year, and at Site 2 IFST workers were assigned to build networks in particular geographical areas. The sites have also sought to provide greater structure and clarity to wider services during Phase 2. At one of the sites, a phased reduction in IFST worker inputs has been introduced as part of wider efforts to help manage the transition from Phase 1 to 2.

Key successes and achievements

A considerable amount of evidence has been generated and analysed as part of this evaluation process. Taken in the round, it shows that **the IFSS approach appears to improve short-term outcomes for a good number of families**, as has been observed with similar intensive family support interventions implemented elsewhere.

The general trend with the Goal Attainment Scores across the sites was consistent, with an initial spike in progress after the initial intensive period, followed by slower progress between one month and six months, and a second spike observed at the 12 month review stage. The extent to which these positive outcomes will persist into the future is unknown currently, but it will be interesting to explore this over the coming years.

The programme is perceived to have worked well for certain types of families, although for others the story has been a less positive one. There was a broad consensus among the IFSTs about who should receive

IFSS and for which types of family the approach worked best. Although only one site has sought to document this, all three IFSTs used broadly similar phrases around: **crisis point; the importance of timing; and the motivation to engage or change their behaviours.**

Across the three Phase one sites (amongst IFST staff, IFSS Board and Operational Group members, as well as referring social worker teams) there was almost **universal support and praise for the programme.** In particular, the **tools and techniques, and multi-agency style of delivery used were seen as being highly effective.**

Most of the families interviewed felt the IFSS programme had been largely successful. In the majority of cases, families explained that a number of the issues they had faced such as substance misuse, acute mental health problems, problems with parenting, housing, gaining employment, children's truancy and problematic/abusive relationships had been either fully or partly resolved following their engagement with IFSS.

Similarly, most families **described IFSS as a considerable improvement on the support that they had previously received.** IFST practitioners were felt to be more willing to get to know families and were described as less judgemental than traditional social workers; something which has helped families to feel more comfortable about opening up and sharing their problems.

In addition to the reports of effective access to services, many parents talked about **feeling significantly more confident in their ability to manage their own problems and challenges in the future, and also now felt motivated to do so.**

They were also better able to understand some of the causes of the issues that they had experienced (including long-standing mental health problems, addictions and/or trauma as a result of difficult childhoods, bereavement or other past events). Most of the families taking part in the research believed that they were making progress (to differing extents) to overcome these problems through the support of their IFST practitioner and suitable referrals

to additional support and counselling services. In the longer term, further support may be needed to ensure that families with long standing difficulties are able to continue to manage well in the future.

Key areas for development going forwards

IFSS was perceived to have been **less successful where families had very chaotic lives and serious multiple issues to address at once**. The timing of the intervention and the level of motivation within the family also appears to be very important.

Issue 1 for consideration: as highlighted in the interim evaluation reports, the evidence suggests that IFSS appears to be an effective policy intervention for supporting families to move away from a potential 'crisis' or 'tipping point'. However, the programme may not really tackle the existing stock of families who have gone through a crisis in the past or whose lives are extremely chaotic and they are not motivated to turn things round. A different intervention, perhaps over a longer period and focussed on building motivation to change, may be required in order to engage families from this cohort and to make them receptive to IFSS-style support.

When families did not think they had benefited, they most often related this to: **lack of continuity of service; phase 1 being too short; the IFST lacking specialist skills; gaps in wider service provision; and to some extent, family members not fully engaging**. However, each issue was reported by fairly small numbers of families.

Issue 2 for consideration: the evidence suggests that for some cases the length of the programme is too short or the transition from Phase 1 to 2 is overly severe. An additional stage of support may be required after Phase 1, during which IFST work with the family continues but is gently tapered over time as part of a managed process. It is clear from the evaluation that it is difficult to generalise in terms of the needs of different families. However, it may be sensible to pilot this additional phase of the model and it would make sense to do this at the Phase one sites given that they have the most experience.

It is evident that **IFSS is only as good as the IFST workers who are delivering the intensive support to families**. The importance of having staff with the right experience, expertise and skills cannot and should not be underestimated. Professional judgements are required during all stages of the process.

Issue 3 for consideration: considerable learning and development has taken place over the last three years at the Phase one sites. The current IFSTs have built up their experience over time. However, at the start they relied heavily on the experience they brought from other fields. The need for newly recruited members to be similarly experienced is important alongside any IFSS training that they may be offered.

Some **uncertainty remains about how best to get most value out of the CSW role**. Concerns have been raised that the role is becoming increasingly focused on management and training activities, at the expense of research and case handling elements.

Issue 4 for consideration: whilst it is not problematic for CSWs to take on more IFST team management responsibility, it is essential that the balance of their activities is reviewed on a regular basis. It is imperative that the CSWs retain their professional credibility which comes from having a recognised caseload.

IFSS is **heavily reliant upon the volume and quality of the referrals that come through from the social worker teams**. Progress has been made in this area during year 3 but ongoing challenges remain.

Issue 5 for consideration: the evidence from the Phase one sites demonstrates how much resource must be invested in raising awareness of IFSS, building effective relationships with the social worker teams and wider partners (in order to embed IFSS tools and practices). Furthermore, given the significant level of staff churn seen across the referring social worker teams, there is likely to be an ongoing need for this work to continue into the future.

In terms of throughput, performance during last year with reduced capacity suggests that **IFST workers might be able to handle two cases at one time (where one is entering and one exiting the intensive phase)**.

Issue 6 for consideration: reflecting on the increased throughput with reduced capacity, there was support from across the sites to explore the option of IFST workers taking on two cases at any one point in time. The situation would need to be monitored carefully as some of the more complex cases or the work with larger families will require additional IFST worker time. It could be appropriate to pilot this approach at one of the Phase one sites.

Monitoring activity across the sites remains inconsistent.

Issue 7 for consideration: A more structured and systematic approach across all sites, in terms of monitoring, target setting and evaluation, would be beneficial and would aid strategic planning decisions. More specifically, the scale of the demand for IFSS intervention locally should be considered when funding and other decisions such as the size and shape of the IFSTs are taken. Additionally, beneficiaries should be tracked over time so that the sustainability of IFSS impacts can be assessed robustly.

1: Introduction

- 1.1 SQW, supported by Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick, was appointed to undertake an evaluation of the Integrated Family Support Service (IFSS) model in August 2010. This *Final Report* presents the findings from the third and final year of the evaluation, covering the period April 2012 through to March 2013. Detailed information on the IFSS model and the background to the evaluation process is contained in the *First Interim Report*², which was published in May 2012. In addition, a *Second Interim Report* was published in February 2013.

Year 3 of the evaluation

Approach

- 1.2 As with previous years of the evaluation, a mixed methods approach was used and the focus remained on the three Phase one sites. The following strands of research activity were conducted:
- A third wave of an online survey of the three Integrated Family Support Teams (IFSTs) was carried out during the summer 2013. The purpose of the survey exercise was to capture staff views on job satisfaction levels, how they use their time, and to identify any common issues or lessons for the future
 - Analysis of data collected from families using the Warwick Edinburgh Mental Well-being Scale and Strengths and Difficulties Questionnaire tools, showing 'before' and 'after' intervention positions
 - Analysis of Goal Assessment Scale score data collected by the sites, indicating the 'distance travelled' by beneficiary families in terms of working towards their agreed goals

² Separate reports covering years 1 and 2 of the evaluation process have been published and can be accessed via the Welsh Government website: <http://wales.gov.uk/statistics-and-research/evaluation-integrated-family-support-service/?lang=en>

- At one of the sites, educational attendance data³ for 30 school-age children within beneficiary families were collected and analysed. Unauthorised absences were used as a potential proxy for an unstable home environment
- In-depth discussions with stakeholders at each of the three Phase one sites (see Table 1-1 for details), including IFST members, IFSS Board and Operational Group members, and representatives from referring Social Care Teams
- Beneficiary families were interviewed to increase understanding around the processes and outcomes of the programme, the family members' perceptions of the services provided for them, and their suggestions for improvements. The interviews took place over three waves from July 2012 – September 2013 (further information is provided in Annex B).

Table 1-1: Consultee mix across the three Phase one sites

Site	Total no. of people consulted	No. of individual interviews with IFST	No. of people attending staff focus group	No. of interviews with Board & Operational Group staff	No. of responses to staff online survey	No. of interviews with Social Care Team leads	Other e.g. IRO & wider services etc.
Site 1	21	6	3	7	1	2	2
Site 2	26	5	5	3	9	1	3
Site 3	15	5	N/A	3	5	1	1

³ Analysis of these data revealed that the number of absences varied widely between the different families and across school terms, and no clear overall trends were evident. The small size of each cohort that went through the programme also meant that meaningful analysis was difficult due to the sample sizes. For these reasons, the attendance data has not been included within the report.

Structure of this report

1.3 The remainder of this report is structured as follows:

- **Section 2** provides an update on the changing policy context for IFSS at a programme level as well as a summary of some of the key related developments elsewhere
- **Section 3** describes any key changes to the three Phase one sites, focusing specifically on the IFSTs, the Operational Groups and the IFSS Boards
- **Section 4** explores the issue of IFSS referral routes and approval processes, as well as looking at the volume of throughput in year 3
- **Section 5** presents an overview of the different types and mix of support available during different phases of the IFSS 'journey'
- **Section 6** sets out an assessment of IFSS outcomes and impacts, over both the short and long-term for families, and more widely in terms of influencing service provision
- **Section 7** summarises the main findings and lessons from this third and final year of the evaluation.

1.4 In addition, there are two supporting annexes:

- **Annex A** presents further background information on key policy developments and the emerging evaluation evidence on similar family support interventions in the UK
- **Annex B** describes the approach used for selecting and conducting the beneficiary family interviews.

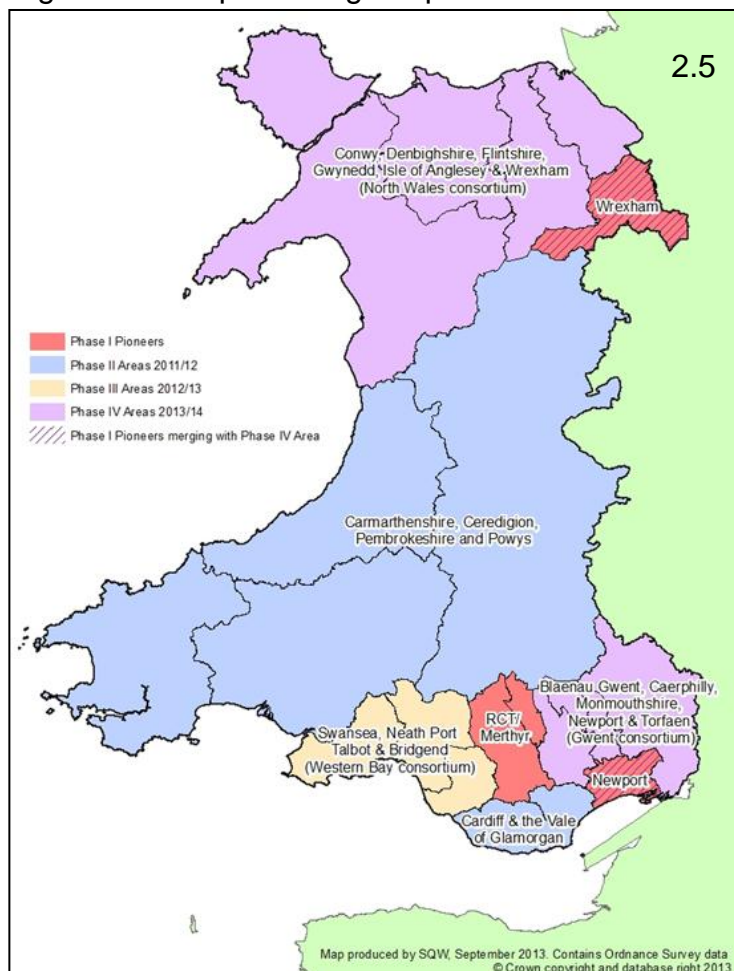
2: Context

- 2.1 This section of the report presents an overview of the key relevant policy developments, including the continued rollout of the IFSS intervention across Wales. Headline messages from a wider review of the evidence base in relation to comparator family support interventions are also provided (more detail is provided in Annex A).

Phased implementation and rollout of IFSS

- 2.2 The IFSS Phase one sites of Newport, Wrexham and Merthyr Tydfil/Rhondda Cynon Taf began operating in September 2010. They have now accrued three years' of delivery experience and learning. Since the IFSS programme's inception there have been some important wider developments – some of which have impacted on the Phase one sites. These contextual issues are explored below.
- 2.3 The three Phase one sites were followed in February/March 2012 by the following Phase 2 areas: a regional consortium of Hywel Dda University Health Board, Powys Teaching Health Board, with Carmarthenshire, Ceredigion, Pembrokeshire and Powys local authorities; and a consortium of Cardiff and Vale University Health Board and the Cardiff and Vale of Glamorgan local authorities. Through the Phase 2 rollout, five new IFSTs were established, bringing the IFSS coverage to 10 local authority areas across Wales.
- 2.4 The final two phases of the IFSS rollout were announced in March 2012 by the Deputy Minister for Children & Social Services. The third phase covers the geographical areas of Swansea, Neath Port Talbot and Bridgend, through the development of three new IFSTs. The expansion of the programme into North Wales and Gwent forms the final phase of the rollout, meaning that IFSS will become operational nationally across the whole of Wales in 2014.

Figure 2-1: Map showing the phased rollout of IFSS⁴



Discussions with members of the IFSTs and wider stakeholders across the three Phase one sites reveals that the roll out of IFSS has impacted on their work during year 3 in a number of different ways. For example, several staff from these sites have successfully applied for jobs in the newly formed IFSTs, as promotion and career progression opportunities have

emerged. Whilst on one level this is a welcome development, with knowledge gained through the pilot work being shared across Wales, it has compounded staff retention issues at some of the Phase one sites.

- 2.6 Additionally, the post-Phase one funding agreements have provided some significant challenges to the Phase one sites. This has contributed towards increased uncertainty and instability amongst some IFST staff about the long-term security of their existing roles, as well as giving rise to the cessation of some of the specially commissioned services that were extremely popular e.g. the tailored counselling work from Action for Children during Phase 2 at Site 3, which stopped at the end of March 2013. These issues started to be resolved towards the final quarter of year 3. Nevertheless, as set out in detail in Section 3, the size and capacity of Site 1 and Site 3 was scaled back

⁴ Further details on the phased implementation of IFSS can be found on the Welsh Government's IFSS website: <http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst/implementation/?lang=en>

significantly during year 3, which in part reflected the lower levels of funding anticipated post Phase one.

- 2.7 At a more strategic level, IFSS Operational Groups and Boards have been reshaped or merged to represent the enlarged geographies. At Site 1, six months prior to the inaugural meeting of the enlarged Board, a shadow board operated. Various meetings of these new structures as well as more informal events with Service Managers have been held to agree and define a shared vision, as well as strategic and operational plans to underpin the roll out.
- 2.8 Above and beyond the geographical rollout of IFSS provision, the Welsh Government has recently announced⁵ the aim of extending the focus and targeting of the programme to cover families where there are:
- parental mental health problems
 - parental learning disabilities
 - domestic abuse concerns.
- 2.9 This is an interesting development and covers a key topic that was raised within the year 2 interim evaluation report. The change should enable the reach of the service to cover a potentially larger cohort of families. The important issue of IFSS eligibility and targeting is revisited later in this report.

Understanding 'local demand' across the Phase one areas

- 2.10 Table 2-2 presents the latest figures available on the total number of children in need within each of the three Phase one areas, and Wales as a whole. These data should be treated with caution as the numbers will change throughout the year as well as from one year to another. Additionally, there will be a significant level of local demand for IFSS type provision that is not captured through these published datasets. However, even allowing for the limitations of these data, they do provide a useful snapshot of the indicative scale and nature of demand across the three sites.

⁵ <http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst/implementation/?lang=en>

- 2.11 Across the whole of Wales, just over 20,000 children were classified as being in need as of March 2012, which equates to 320 per 10,000 of the population aged 0 to 17 years. In Site 1 (1,090 children) and Site 2 (2,435 children), the rate was higher, particularly so in Site 2, where 388 per 10,000 of the population aged 0 to 17 years were categorised as children in need. Site 3, with a total of 645 children in need, had a much lower rate at 222 per 10,000.
- 2.12 The variation in scale across the three areas is significant and has been evident since 2010, when the initial funding allocations were agreed. This is important as all three Phase one sites were given the same resource with which to deliver IFSS. Furthermore, when looking across the three years of data that are available through the Children in Need Census, it is evident that in some areas, need fluctuates significantly from one year to the next. This highlights one of the key practical challenges that the IFSS sites face in terms of their annual planning processes.
- 2.13 Given that the delivery capacity of the sites is dependent on the size of the IFSTs, it is difficult for areas to respond quickly to changing levels of demand on an annual basis. However, IFSS Boards should ensure that they are using the best available evidence to track local need effectively and use this intelligence to guide their strategic decision making so as to take account of changing trends and deliver a flexible, tailored local service at the appropriate scale.
- 2.14 The Phase one areas also contain some particularly deprived communities, though this varies considerably across the three areas. Some 53% of wards in Site 2 fall within the 30% most deprived wards across Wales, whilst in Site 3, the equivalent figure is 28%. Similarly, employment rates also differ significantly across the three areas, with Site 2 having an employment rate of 63%, whilst Site 3 has a rate of 73%, better than the national average (68%). Deprivation and employment levels are not necessarily good proxies for demand for IFSS provision but they do once again demonstrate the importance of the sites having sufficient flexibility to be able to robustly tailor their interventions around the specific needs of the beneficiary families and to adequately take into account the local socio-economic environment.

Table 2-2: Children in Need, March 2012

	Site 1	Site 2	Site 3	Wales
Total Children in Need	1,090	2,435	645	20,240
Rate per 10,000 population aged 0-17 years	328	388	222	320
Parental substance/alcohol misuse	280	645	80	5,035
<i>% of cases with substance abuse as a factor</i>	<i>26%</i>	<i>26%</i>	<i>12%</i>	<i>25%</i>
Domestic abuse	165	710	390	5,080
<i>% of cases with domestic abuse as a factor</i>	<i>15%</i>	<i>29%</i>	<i>60%</i>	<i>25%</i>
Parental learning disabilities	100	160	*	1,570
<i>% of cases with learning disabilities as a factor</i>	<i>9%</i>	<i>7%</i>	<i>N/A</i>	<i>8%</i>
Parental mental ill health	210	595	25	4,945
<i>% of cases with parental mental ill health as a factor</i>	<i>19%</i>	<i>24%</i>	<i>4%</i>	<i>24%</i>
<i>Employment Rate (March 2013)</i>	<i>70%</i>	<i>63%</i>	<i>73%</i>	<i>68%</i>
<i>% of wards in 30% most deprived in Wales (2011)</i>	<i>43%</i>	<i>53%</i>	<i>28%</i>	<i>N/A</i>

Source: SQW analysis of Statistical Directorate, Welsh Assembly Government Data and ONS Mid-Year Population Estimates, published February 2013

The wider evidence base

Informing the development of IFSS

- 2.15 In the First Interim IFSS Evaluation Report, the context for IFSS at its inception was outlined. In short, the IFSS model was designed to reform health and social services delivery for vulnerable children and their families in Wales. Initially, those families with parental substance abuse issues were targeted, although there was some flexibility as to how the model was implemented on the ground.

- 2.16 The IFSS approach was informed in part by the emerging lessons from other similar family intervention services, specifically the Option 2 service and the Reclaiming Social Work (RSW) approach.
- 2.17 The Option 2 Intensive Family Preservation Service is a crisis intervention programme aimed at supporting those families where serious child protection concerns are related to parents' use of alcohol or drugs. It is an adapted version of an American model, called 'Homebuilders'. The Option 2 service was focused geographically on Cardiff and the Vale of Glamorgan, although different versions have emerged in other parts of the UK⁶.
- 2.18 The Reclaiming Social Work (RSW) approach was designed by Steve Goodman and Isabelle Trowler. It was originally implemented in the London Borough of Hackney and was initiated in 2007. The so-called 'Hackney' model is based on the establishment of social work 'units' comprising multiple social workers and clinical workers. Importantly, the social workers operate within a small multi-skilled team, thereby creating an environment in which more than one professional works with the child and his/her family. These teams comprise a Consultant Social Worker (CSW), a Social Worker, a Child Practitioner, Clinical Therapist and an Administrator.

Similar models have emerged in other parts of the UK

- 2.19 Over recent years there have been other significant developments across the UK policy landscape in relation to interventions designed to support families with complex needs. One of the most high profile was the launch of the 'Troubled Families' agenda in England. That programme aims to help 120,000 troubled families turn their lives around by 2015. The primary focus is on supporting children in these families to have the chance of a better life, as well as reducing costs to the taxpayer. It was estimated by the Department for

⁶ An adaptation of the Option 2 model, named 'Families First' was set-up in Middlesbrough in 2006 (see Woolfall et al. (2008)). Although the scheme was based on the Option 2 model, there were some important differences e.g. Families First was jointly funded from child and adult services, the service held case responsibility for families and included six social workers who had statutory responsibilities that enabled them to remove children from the family home if necessary. It did not operate a 24 hour service but offered out of hours support if that was needed. The initial intensive intervention lasted up to eight weeks with additional services available for up to four months, after which the case was transferred to mainstream provision.

Communities and Local Government⁷ that the cost to the public sector associated with the 120,000 Troubled Families across England would be in the order of £9 billion per annum over the period 2010-2015. It was reported that some £8 billion of this would be spent on reacting to the problems of these families and only £1 billion would be focused on targeted interventions designed to improve outcomes.

Early evaluation evidence indicates that these schemes are working

- 2.20 The evaluation evidence on these interventions is generally rather patchy. However, the main conclusions to date have been broadly positive in terms of the impact of these services on improving family outcomes and in some cases, reducing costs to the public purse. Specifically, it has been reported that the Option 2 model has significantly reduced the need for children to enter into care, is likely to generate substantial cost savings for local authorities and other social care, health and criminal justice agencies, and overall, helps to improve family well-being and parental welfare. In relation to RSW, it is claimed that the model has been very successful in contributing towards a reduction in the number of looked after children and reducing the overall cost of children's social care in Hackney. An evaluation report⁸ by the National Centre for Social Research shows that intensive intervention to support and challenge troubled families can be effective in turning round their lives. It was claimed that a family receiving intensive support and challenge is twice as likely to stop anti-social behaviour as one not getting the intervention.

Key lessons for IFSS

Several important lessons have emerged from the evidence base in terms of the key success factors associated with these interventions. These issues are summarised in Table 2-3.

⁷ DCLG, The Fiscal Case for Working with Troubled Families, Analysis and Evidence on the Costs of Troubled Families to Government, February 2013, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/79377/20130208_The_Fiscal_Case_for_Working_with_Troubled_Families.pdf

⁸ Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011, Department for Education, December 2011, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184031/DFE-RR174.pdf

Table 2-3: Key lessons from comparator programmes

	Reclaiming Social Work approach (Hackney model)	Troubled Families	Option 2
Key lessons	<p>Multi-agency working leads to better communications between partnership agencies</p> <p>It is important for the families to get a sense that they are being listened to fully</p> <p>A more open and supportive team structure can help staff to cope more effectively with the emotional demands of the job and reduce staff costs in terms of low levels of retention and high levels of sickness.</p>	<p>Much of the success of family interventions are derived from the skills of individual workers, both in building an effective relationship with the family, and in encouraging other services to assist the family in an effective manner</p> <p>The provision of quick, practical support is a useful first step in building the relationship with a family</p> <p>A family should be considered as a whole</p> <p>Ensuring professionals and agencies work collaboratively towards common goals for the family.</p>	<p>Providing support at the right time is vital - when it is needed most</p> <p>Development of achievable plans for families to work towards</p> <p>Recognising the strengths of the family</p> <p>Workers building effective relationships with families to help them understand their problems.</p>

Source: SQW review of the available evaluation evidence (see Annex A for details).

Key points

2.21 The key points covered in this chapter are as follows:

- In addition to the three Phase one sites which are the focus of this evaluation, it is intended that the final phase of the IFSS roll out will be completed during 2014 so that the programme will cover the rest of Wales
- This has created some issues in the three sites as staff have sought employment in the new areas, there have been concerns about continuity of employment and funding, staff have been engaged to deliver training to other areas and Boards have often focussed their attention on future arrangements
- A review of the Children in Need register suggests on-going high numbers in each Phase one site, well above the current scale of IFSS delivery and capacity. IFSS Boards should ensure that they are using the best available evidence to track local need effectively and use this intelligence to guide their strategic decision making
- Emerging evidence from elsewhere suggests on-going support for the approach which underpins IFSS.

3: Key developments across the Phase one sites

- 3.1 This section of the report explores key operational and structural developments across the Phase one sites during the last year. Specifically, issues around the IFSTs, Operational Groups, IFSS Boards and Section 58 agreements are covered.

The IFSTs

IFST size and composition

- 3.2 Table 3-1 shows that as of March 2013, the three IFSTs varied in size, with six full time equivalent members of staff in Site 1, seven and a half in Site 3 and nine and a half in Site 2. The IFSTs at Site 1 and Site 3 have reduced in size significantly since September 2012, when data for the second year of the evaluation were collected; Site 1 has scaled back from 15 to 6 FTEs and Site 3 from 11.5 to 7.5. Over the same time period, the size of the IFST at Site 2 has remained unchanged.

Table 3-1: IFST composition in March 2013

	Site 1 ⁹	Site 2	Site 3
IFST Manager	0	1 (50% FTE)	1 (50% FTE)
Consultant Social Worker	1	2	1
IFST multi-disciplinary professional	4 ^a	6	5
Admin Support/ Performance Management	1	1	1
Total (FTE)	6	9.5	7.5

^a(including 2 CPNs who shared some of the management responsibilities with the CSW)

Source: SQW analysis of data provided by the sites

- 3.3 At Site 1, the most noticeable shift is in relation to the overall team size, which has decreased as secondments have come to an end and a team member has moved on to a new IFSS related role. In addition, the team manager

⁹ These figures include four new members of the Site 1 IFST (including one CSW) who form part of the sister Family Assessment and Support Service (FASS).

position was vacant for nine months between September 2012, through to May 2013. This has meant that since 2011, at Site 1, the IFST has had three different team managers. According to consultees, this has created some instability and disruption, which in turn has had a detrimental impact on the IFST and the service as capacity has been reduced in the transition period and experienced staff have been replaced by less experienced people who will take time to get fully up to speed.

- 3.4 The reduced size of the team has significantly impacted on the team's capacity to deliver the service. This resulted in a waiting list for IFSS and prompted discussions with colleagues in the front line teams in relation to more effective targeting of the limited IFST resource.
- 3.5 A decision was made by the Operational Group at Site 1 to delay recruiting to the IFST manager position in recognition that the new post holder would need to be engaged with the wider IFSS roll out process in some form, and these regional details were still being worked out. However, the absence of a manager and inconsistencies between the supervisors appears to have created some unrest and instability amongst the team members.
- 3.6 Following the Team Manager's departure at Site 1, day-to-day operational line management and leadership responsibilities fell to the CSW or two CPNs (Community Psychiatric Nurses), who were supervised by the Service Manager. It was reported that the CSW and the two CPNs had broadly similar remits during year 3, acting as trainers, mentors and line managers. However, it was felt that this structure had resulted in some inconsistencies in the decision-making by supervisors. These arrangements came to an end following the recruitment of the new IFST manager in May 2013, as part of the wider IFSS roll out process.
- 3.7 Another important factor that contributed towards some of the seconded staff feeling unsettled was the fixed term nature of their employment contracts. It was subsequently agreed that permanent contracts should be issued to staff at Site 1. This has assisted in allaying some fears of individual staff members, and will aid future recruitment.

- 3.8 Through the shrinkage of the IFST, it was reported that the complement of skills and expertise had been reduced. This issue was compounded further by the fact that some of the staff that left had been responsible for training new members of the IFST.
- 3.9 There was no net change in the size of the IFST at Site 2 during year 3, although there was some staff churn. Two of the original social workers secured promotions to Consultant Social Work posts in new IFSS areas. These IFST members were replaced by two social workers, both from a child protection background.
- 3.10 At Site 3, the IFST has endured some notable changes during year 3. In terms of staff make-up, one spearhead worker retired, the seconded worker from the Probation Service left in November 2012 as he gained employment elsewhere, the Health Visitor left in February 2013 to take up a post with the local Flying Start team and the Senior Administrator retired in September 2012. The Head of Service at Site 3 also left during the final quarter of the year. The seconded CPN and Parenting Worker have both had their contracts extended for another 12 months.
- 3.11 Following an evaluation of the Family Aid Worker role (after the staff member left in February 2012), it was decided that Action for Children should take responsibility for employing this post going forwards. It is worth noting that the Parenting Worker (part of the IFST) is employed by a local support organisation for voluntary and community organisations.
- 3.12 The IFST at Site 3 relocated into a different building in early 2012 to be co-located with all of the children's social care teams. The new location has worked well and has resulted in enhanced linkages and collaborative working between the different teams. During year 3, the IFST moved for a second time, this time within the same building, to a smaller office on the ground floor.
- 3.13 Overall, three key issues emerge from a review of the structural changes observed within the Phase one IFSTs during year 3 in terms of how potential impacts on service delivery can be effectively managed:

- Staff churn within any team environment is likely to be problematic and damaging, particularly so when highly experienced and skilled staff leave. It is often extremely difficult to prevent staff turnover and high levels of staff churn can be very challenging to manage.
- As staff secondments come to an end this can also be highly disruptive for teams. However, managers should be able to take account of such developments as part of their annual planning process and therefore, potential impacts on IFST capacity and capability can be anticipated and minimised.
- If an IFST manager leaves their post and appropriate interim or replacement arrangements are not put in place quickly and effectively, this can give rise to instability within the wider team.

The CSW role

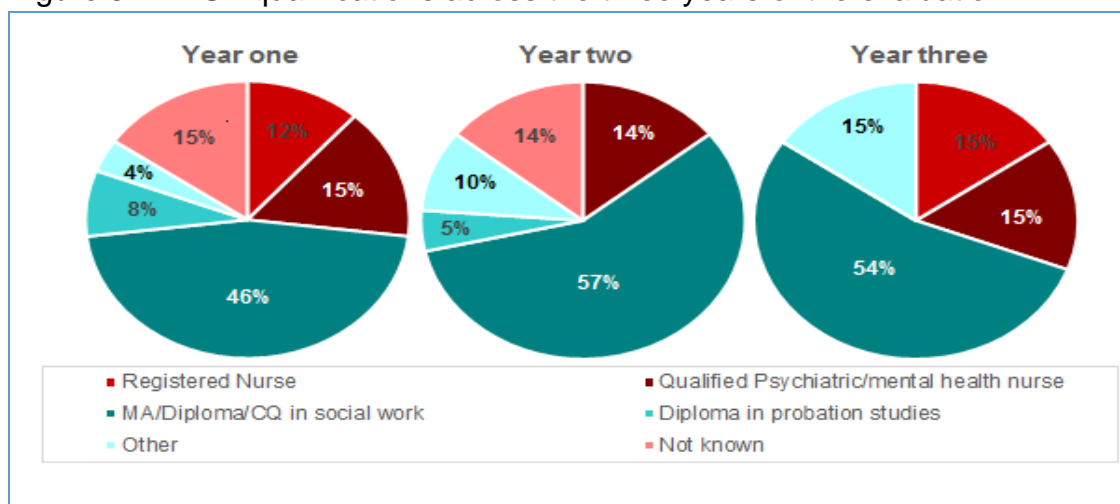
- 3.14 The three Phase one sites have different numbers of CSWs in post as part of their IFST: in Site 1, there is one formal CSW (plus two CPNs who have also provided some important management and leadership support); in Site 2 there are two; and in Site 3 there is one CSW. Across the three sites, it was reported that the CSW role had increasingly covered management and training responsibilities at the expense of research and family case work.
- 3.15 It was also evident that some of the issues associated with the role that had been identified during the second year of the evaluation remained. Specifically, that the CSW role needed to be more tightly defined from the outset so as to ensure that the added value of the post could be maximised. A perceived lack of clarity in terms of the expected balance between management, leadership, training (including some undertaking MSc qualifications) and delivery activities had given rise to some problems and tensions across the sites. For instance, it was widely reported that the CSWs were expected to be experts in the delivery of the service to families and they should play a key role in supervising and supporting the ongoing development of other IFST members.

3.16 However, as part of the role, they also had to facilitate training and undertake research. This meant that CSWs often ended up spending less time face-to-face with families than other team members and were ultimately not best placed to supervise delivery. Many consultees were of the view that CSWs should be operating at the vanguard of IFSS practice and undertaking work with the most challenging families, with a view to developing and disseminating good practice materials.

Staff survey analysis

3.17 As demonstrated in **Error! Reference source not found.**, a substantial proportion of IFST respondents to our online staff survey across the three years held social work qualification. This remained the case in year 3, even after the turnover of staff reported above.

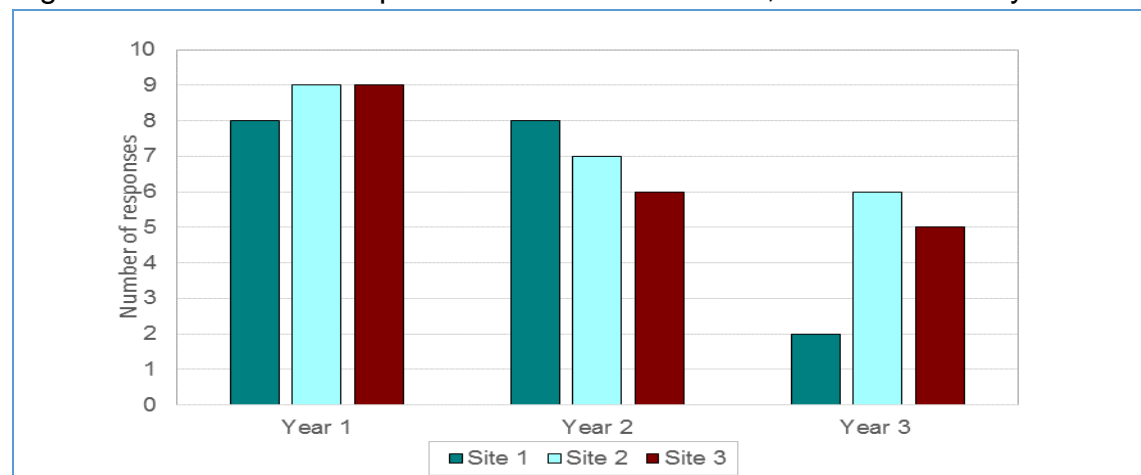
Figure 3-1: IFST qualifications across the three years of the evaluation



Source: SQW online survey of IFST staff

3.18 The total number of responses fell over the three years of the survey (Figure 3-2), with almost half of all responses coming from Site 2 in year 3, and only two responses coming from Site 1 in year 3 (33%). In part this reflects the high level of staff churn and the notable shrinkage of the IFST at Site 1.

Figure 3-2: Number of responses from all three areas, across all three years

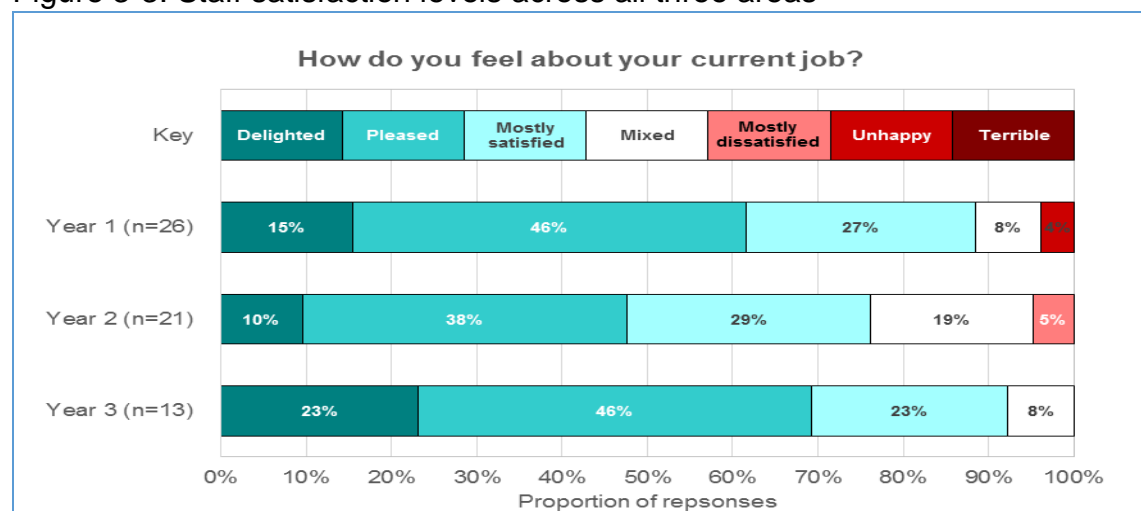


Source: SQW online survey of IFST staff

3.19 Figure 3-3 reveals that staff satisfaction levels amongst IFST workers increased between years 1 and 3 of the evaluation. In year 1, 61% of respondents stated they were delighted or pleased with their job and this figure increased to 69% in year 3.

3.20 The rise in satisfaction levels between year 1 and year 3 may in part be explained by staff turnover, where those staff who were dissatisfied with their jobs have managed to find alternative employment (leaving behind an apparently more satisfied but also smaller number of respondents). Nevertheless, no respondents were dissatisfied in year 3, with 92% mostly satisfied with their role.

Figure 3-3: Staff satisfaction levels across all three areas¹⁰

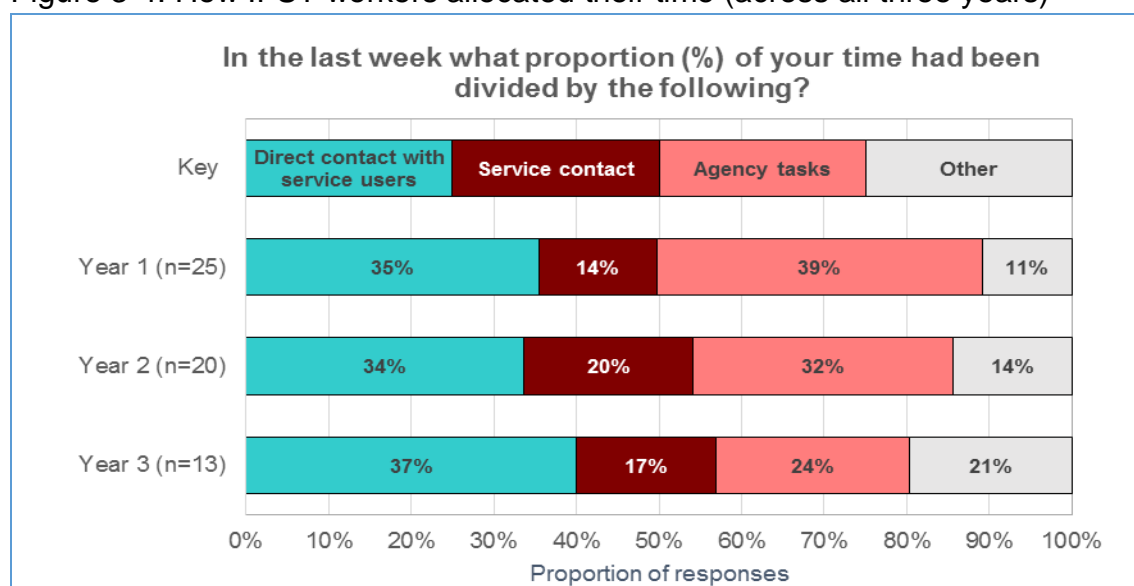


Source: SQW online survey of IFST staff

¹⁰ Note that the base n varies from year to year.

- 3.21 Figure 3-4 indicates that as a proportion of time spent, IFST member time has decreased in agency tasks across the three years from 39% to 24% of total staff time. While the proportion of time spent with service users has remained relatively stable across the three years of the evaluation period, the proportion of time spent on 'other' tasks has nearly doubled (increasing from 11% to 21%). In part this may be explained by increased management and training responsibilities for some of the respondents.

Figure 3-4: How IFST workers allocated their time (across all three years)



Source: SQW online survey of IFST staff

Net change analysis – the situation in year 3 versus year 1

- 3.22 Analysis of the net change in staff perceptions of their role across three years of the IFSS programme shows that staff opinion has improved in terms of the psychological demands of their IFST roles and access to organisational support. However, according to the survey evidence, the situation has worsened in terms of the respondents' ability to influence decision-making and cross-working, as well as some of the physical demands associated with their jobs.
- 3.23 Drilling down into specific issues that underpin these broad themes, it is clear that there is considerable variation *within* these classes, just as there is between them.

- 3.24 Overall, the criteria with the largest positive swing (that is, the largest positive total for the proportion of respondents reporting improvements minus the proportion reporting worsening positions) were the extent to which respondents' jobs required them to work hard, and the extent to which their job required them to learn new things. The largest negative swings were noted in relation to whether respondents had enough time for each case, and for whether they worked regularly with colleagues from criminal justice.

The IFSS Operational Groups

- 3.25 The IFSS Operational Groups have continued to function across Site 1 and Site 3. At Site 2, it was decided during the year that the full group would no longer meet formally, although regular ad hoc discussions amongst some members did take place. These structures have played key roles in supporting the main IFSS Boards and IFSTs in tackling operational issues such as boosting levels of throughput, raising awareness amongst wider services, case management reviews and on-going team development challenges.
- 3.26 Several key issues that have been addressed through the Operational Group meetings were reported by consultees:
- Due to the holistic nature of IFSS, some practitioners had to work outside of the remit or comfort of their 'home' service area. Whilst this issue was more problematic during years 1 and 2 of this phase, staff churn has meant that this has remained a concern in year 3, with some IFST members feeling unsure about how to proceed on some cases. The Operational Groups became useful fora for discussing such issues
 - Effectively managing capacity constraints, recognising that flows of referrals and throughput were irregular throughout the year. This issue has been compounded in year 3 with the reduction in capacity across Sites 1 and 3. Some discussions have taken place around the practicalities of IFST workers taking on more than one case at a time, whilst ensuring that the team does not become overly stretched
 - Challenges associated with managing the transition from Phase 1 to 2 in IFSS have also been raised at the Operational Groups

- Issues around the 'drift' of some families during Phase 2 or problems with wider service engagement on certain cases have been debated and creative solutions sought.

- 3.27 At Site 1, as part of the IFSS roll out process, the Implementation Group was extended so that it became representative of the wider region. The frequency of meetings changed from bi-monthly to monthly. The Implementation Group was supported by a sub-group of Service Managers from across the region, which was tasked with taking responsibility for advancing the roll out project plan. This group also met on a monthly basis.
- 3.28 The Implementation Group at Site 1 had 21 members in total, although attendance was reported as having been mixed across the different organisations. For instance, representatives from Housing, Barnardo's, Education, Resource & Strategy, the Wales Probation Service, Adult Mental Health and Social Care did not attend any of the sessions during year 3. Attendance data also reveal that only three members of the group attended all six sessions: the Head of Children and Families; the Service Manager with responsibility for the IFST; and the Business Support and Development Manager for the IFST.
- 3.29 The Operational Group at Site 2 remained consistent throughout the pilot phase, with its primary aim to provide operational and developmental direction to the delivery of IFSS locally. The group had 26 members, representing a wide range of services. Consultees indicated that attendance levels had, on occasions, been rather disappointing and the need for the group had been questioned by a small number of stakeholders. It was suggested that the case for the continuation of the group had reduced as the initial set-up phase had successfully been completed and the experience of the IFST had grown.
- 3.30 At Site 3, the Operational Group is referred to as the IFSS Steering Group and has 18 members. The group has proved an effective mechanism for resolving operational issues as well as raising awareness of IFSS amongst wider services. Until the benefits of the Steering Group were fully realised, some of the initial meetings were poorly attended. However, this has improved over time, with operational managers appreciating the benefit of

attending this forum, providing an opportunity to share information about IFSS families and improve delivery processes.

The IFSS Boards

- 3.31 The evaluation evidence gathered for year 3 suggests that the IFSS Boards have continued to function effectively, focusing on high-level strategic planning matters. These included issues such as post Phase one funding, regional roll out plans including IFST shape and governance arrangements, modifications to Section 58 agreements, referrals and throughput, development and delivery of effective multi-agency working, and information sharing.
- 3.32 The size of the IFSS Boards and the frequency of meetings varied across the three sites in year 3: Site 1 had 25 members and met every two months; Site 2 had 12 members and met quarterly; and Site 3 had 22 members and also met quarterly.
- 3.33 Generally, representation was thought to have been pretty good across the Boards, although key gaps such as Adult Social Care and Mental Health were raised at Site 3. Similarly, at Site 2, efforts were made to strengthen the Board by inviting a representative from the National Probation Service to join.
- 3.34 Attendance levels tended to be mixed and inconsistent, although a core group of members were present at most meetings across the three sites. Poor attendance by the Police, Housing and Jobcentre Plus were specifically identified by consultees. It was suggested that these attendance issues could in part be explained by significant changes occurring within these partner organisations during the year. Whilst it was disappointing that these agencies had not engaged consistently at board level, it was reported that this had not impacted on operational level working relationships, which in the main, continued to be effective.
- 3.35 At Site 2, it was evident during the consultation visits that a review process had commenced, focusing on how best to reinvigorate the IFSS Board going forwards. This was designed to ensure that the Board and all future meetings were fully fit for purpose.

- 3.36 More generally, it may be useful for IFSS Board members to think creatively about how best to use their time on IFSS matters. Issues for consideration are likely to centre on engagement with IFSS decision making, annual planning processes, ongoing problem solving and wider strategic and managerial activities as Board members seek to meet their statutory objectives. If attendance levels drop on a regular basis, the Chair of the Board should explore options for re-energising the Board and he/she should seek to understand what can be done to effectively re-engage members.

Section 58 agreements

- 3.37 The three IFSS Phase one sites were tasked with developing Section 58 agreements, which detail the services that will be included within the 'Family Support Functions' available to the IFST in each site. The Section 58 agreement is a record of the services being provided by partners, the level of resources, and objectives for the IFST. Section 58 agreements have now been produced and formally signed-off by partners across all three Phase one sites.
- 3.38 At Site 1, individual Service Level Agreements (SLAs) have been agreed and signed between the local City Council and relevant partner agencies. Each SLA contains information on the management of IFST staff through their 'home' agency. This covers issues such as line management, managing sickness levels, processing expenses and working protocols etc. At Site 2 and Site 3, high-level Section 58 agreements were produced, containing signatures from key partners, including a broad range of statutory and voluntary organisations.
- 3.39 To date, there has been no cause to use the agreements as partners have generally bought into the IFSS model. Furthermore, issues have been resolved satisfactorily through the Implementation Groups and/or escalated to the IFSS Boards (usually via the Heads of Service). However, at Site 1, it was reported that there had been an ongoing issue around cultural differences with health partners. More specifically, it was suggested that health organisations tended to find it difficult to prioritise IFSS families above other clients/service users. The health lead in the area has sought to address this

issue by raising awareness of the difference between clinical and social models of working and the need to combine the two effectively.

- 3.40 Overall, the general consensus amongst consultees across the Phase one sites was that it was difficult to determine the true value of these agreements because they had not yet been used or 'tested' legally. Some stakeholders also suggested that whilst the agreements may have limited currency in terms of committing agencies to specific actions on the ground, the process of developing them has proven to be a useful one, not least in terms of strengthening local partnership working and raising awareness of IFSS.
- 3.41 Additionally, it was stated that these agreements might prove to be helpful in the future if there are key personnel changes at operational levels and new staff are recruited who are less familiar with IFSS. Nevertheless, it was felt that on balance, case-specific decisions taken by service providers in relation to prioritisation, and level of service were likely to be negotiated at the time. In this regard, the strength of individual person-to-person relationships (more so at an operational rather than strategic level) and the level of trust between these partner agencies were likely to play more important roles than the Section 58 agreement. Overall, consultees were of the view that the development of the Section 58 agreements had to date, not impacted significantly on service delivery.

Key points

- 3.42 The key points covered in this chapter are as follows:
- The IFSTs at Site 1 and Site 3 have reduced in size significantly since September 2012, when data for the second year of the evaluation were collected; Site 1 has scaled back from 15 to 6 FTEs and Site 3 from 11.5 to 7.5. Over the same time period, the size of the IFST at Site 2 has remained unchanged
 - The CSW role has increasingly covered management (including filling in when a line manager left) and training responsibilities at the expense of research and family case work

- Staff satisfaction levels amongst IFST workers increased between years 1 and 3 of the evaluation (although this may partly be explained by staff turnover, where those staff who were dissatisfied with their jobs have managed to find alternative employment)
- Boards and Operational Groups have continued to meet, and were seen as being effective even though attendance has been mixed. In one case, the Operational Group was put on hold as it was felt there were insufficient issues or interest to require it to meet formally now that the set up phase had passed
- For Boards, a key issue has been post Phase one funding and regional roll out plans, including IFST shape and governance arrangements
- Engaging criminal justice services remains challenging in some sites
- While Section 58 agreements are in place, to date there has been no cause to use these as partners have generally bought into the IFSS model.

4: IFSS referrals and throughput

- 4.1 This section of the report focuses on the volume and appropriateness of referrals into IFSS and case throughput, which emerged as dominant themes of the Year 2 evaluation report. Specifically, the number of families accessing IFSS, as well as the underlying processes and systems, are explored from the perspectives of IFST workers, referring social worker teams and beneficiary families.

Referrals and throughput – performance overview in Year 3

- 4.2 During the financial year 2012/13, a total of 215 referrals were made to IFSTs across the three Phase one sites (see Table 4-1). This figure is slightly lower than the 228 recorded in the second year of IFSS and broadly in line with the volume recorded in Year 1 (210). However, the monitoring data provided by the sites suggest that the quality or appropriateness of these referrals has improved significantly. Across the three sites, 198 referrals (92%) progressed to the 72 hour assessment stage in Year 3, compared to a figure of 76% during the previous year. In addition, 20 of these cases were re-referrals (10%), whereas in Year 2, the proportion of cases progressing to the assessment stage that were re-referrals was higher at 15%.
- 4.3 During the second year of the evaluation, it was reported that the volume of referrals and assessments was broadly consistent across the three sites. The situation appears to have changed somewhat during the third year of IFSS. In Sites 1 and 3 the number of referrals dropped from 88 to 67 and 74 to 64 respectively, whereas at Site 2 the number increased from 66 to 84.
- 4.4 At Site 2, however, the IFST had to use a waiting list for the service due to capacity limits, which suggests greater demand than shown in the figures. A waiting list also operated in Site 1, but in this case staff numbers had fallen sharply from the year before. Staff felt rather uncomfortable with having to turn eligible families away. Subsequently, where appropriate, IFST staff took the decision to refer families onto wider services.

- 4.5 The number and percentage of referrals progressing to the formal 72 hour assessment stage varies across the three Phase one sites. It is evident that Sites 1 and 3 have maintained broadly similar volumes of cases moving through to the formal assessment stage compared to the previous year, but Site 2 has seen a significant uplift. This difference may relate to staff capacity, as only Site 2 did not see a significant decline in numbers.
- 4.6 The monitoring data also reveal that the level of ‘drop-off’ reported last year between the volume of referrals coming in and the number of cases progressing to the 72 hour assessment stage has been reduced across the sites in year 3. This is particularly evident at Site 1, where it had been highest (82% of cases progressing versus 56% last year). It suggests that the referral mechanisms, described below, have worked better than before and that families referred are now much more likely to become accepted cases.

Table 4-1: IFSS throughput across the three Phase one sites

	Year 2 (April 2011 – March 2012)			Year 3 (April 2012 – March 2013)		
	Site 1	Site 2	Site 3	Site 1	Site 2	Site 3
No. of referrals	88	66	74	67	84	64
No. of referrals deemed inappropriate	0	4	11	0	3	2
	0%	6%	15%	0	4%	3%
No. of referrals progressing to 72 hour assessment	49	62	63	55	81	62
	56%	94%	85%	82%	96%	97%
<i>Of which were re-referrals</i>	14	4	8	7	6	7
	16%	6%	11%	10%	7%	11%
No. of cases accepted to Phase 1	31	- ¹¹	34	47	49	47
	35%	-	46%	70%	58%	73%
No. of families having completed Phase 1 during this period	21	41	23	29	43	28
	24%	62%	31%	43%	51%	44%
No. of families having	4	6	12	16	29	16

¹¹ Data on the number of cases accepted onto Phase 1 of the Programme at Site 2 were not available.

	Year 2 (April 2011 – March 2012)			Year 3 (April 2012 – March 2013)		
	Site 1	Site 2	Site 3	Site 1	Site 2	Site 3
completed Phase 2 during this period	5%	9%	16%	24%	35%	25%

- 4.7 Given the variation in the figures observed during the referral and 72 hour assessment stages across the three sites, it is interesting to note that there is a high degree of consistency in terms of the volume of cases accepted onto Phase 1 of the programme (47-49 across the three). This represented an increase in throughput of around 50% relative to year 2.
- 4.8 The fact that this has been delivered with smaller teams in two cases is important. It suggests that there may have been excess capacity at these two sites in previous years. Additionally, all sites have had to review when they accept cases. Some have moved towards practitioners having two cases at a time, with one finishing and one starting, to deal with demand. Provided this does not impact on service quality, it should boost the economy of the service.
- 4.9 An increased number of families completed Phase 1 and Phase 2 of the programme during year 3 compared with the previous year.

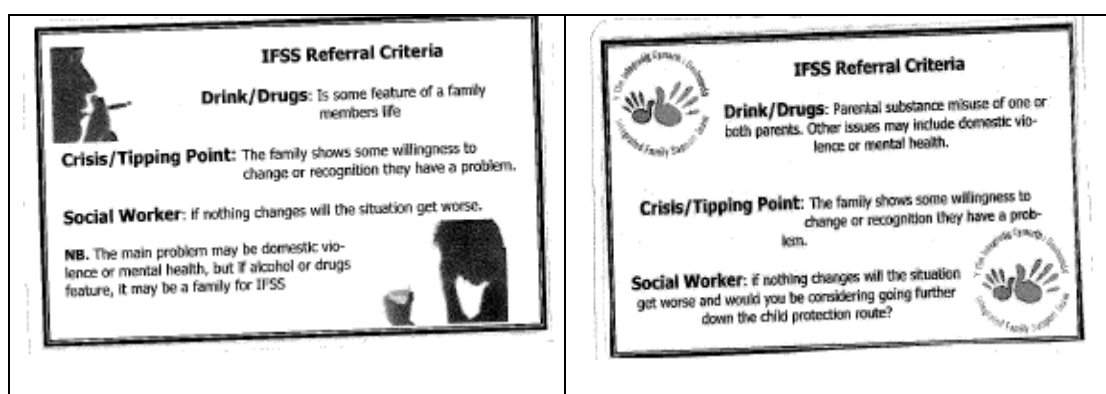
Referral

Improvements have been made to the referral processes

- 4.10 Generally, the feedback from consultees indicates that the referral mechanisms used across the three Phase one sites have improved during year 3 which led to the improved performance reported above. Awareness of and buy-in to the programme by referring Social Worker teams was reported to have increased, as IFSS had become more embedded. It was felt that support for the model had also increased, including the different tools and techniques used.
- 4.11 It was reported that the following developments had contributed towards the improvements:

- Some changes were made to the referral process at Site 1. Whilst IFSS continued to be represented through the 'Information Station' for the majority of the year, a decision was taken to **shift towards a resource panel-based** approach. This involved an email request being sent to the IFST and a response being provided within 24 hours to arrange a consultation with a CSW. If a case was assessed as being an appropriate referral, it would get sent to the resource panel, which was chaired by the Children's Services manager (and attended by the IFST manager and representatives from the other services). This panel would meet on a weekly basis to allocate cases to the relevant Family Support teams (e.g. IFST, FASS etc.) based on need and the capacity of the individual services at that point in time. However, it was reported that on occasions there had been some delays due to the fact that the resources panel only met once a week.
- One apparently minor change in Site 2 which was thought to have helped was to **assign individual members of the IFST to local areas**, and have them based in social work offices at regular intervals. Previously this had been done on an ad hoc basis, with different IFST members going. The change to having a single IFST worker who was responsible for a defined geographical area was thought to have led to better personal relationships forming (with Social Workers and wider service networks) and greater awareness of the programme.
- Site 3 tried to improve their links with other teams through a three month **placement**, delivering **training courses** to Social Workers, which were well-received, and providing summary eligibility criteria on **information cards**, which were designed to act as useful guides or prompts. Wider issues above and beyond substance misuse such as domestic violence and mental health are included on the cards.

Figure 4-2: IFSS referral criteria cards used with Social Workers at Site 3



Source: Site 3 IFST

But some important issues remain

4.12 Despite the general improvements to referral processes observed across the sites, consultees indicated that some issues remained and there was scope for further improvement. Key issues were as follows:

- **Social Care capacity constraints.** Due to capacity issues Social Care teams sometimes were not able to robustly vet all potential IFSS referrals. This had led to both inappropriate referrals and on occasions, the refusal of some families by the Social Worker that had been assessed as being 'in crisis' by a wider service but not by Social Care themselves. Additionally, at one of the sites, it was also suggested that the time needed to make a referral had increased due to the use of paper forms. It was suggested that Social Workers would prefer to be able to make initial referrals via telephone, which could then be followed-up through a formal referral form
- **Linkages to wider services.** It was reported that communication between the social care teams and substance misuse teams had not always worked well, and had often left substance misuse staff unsure of what had happened to families post their referral. This prompted the substance misuse team to develop closer working relations with both the Social Care referrers and the IFST workers. The majority of services therefore commented that they would prefer to make direct referrals into the IFST

- **Staff churn.** According to consultees, it was noticeable that the volume of appropriate referrals would drop when members of the Social Care teams changed jobs or were away from work (due to illness or regular holidays). Over time and often following targeted work by the IFST members, the 'new' Social Workers would become more familiar with IFSS and referrals would start to pick up. That said, it was reported across the sites that a relatively small number of Social Workers were often responsible for the majority of the referrals.

Eligibility and targeting

- 4.13 As demonstrated above, Site 3 produced some written guidance around eligibility. The other sites have not done so. However, it was evident from discussions with IFST members at Site 1, that eligibility was loosely based on their ability to define family goals around the substance misuse issues presented on the referral form. If this was not possible it would get passed over to the sister Family Assessment and Support Service (FASS) team. The 'trigger' for acceptance onto IFSS at Site 1 appeared to centre on the timeliness of the intervention, the family's motivation and readiness to change, as well as an accumulation of underlying factors. These considerations formed part of an overall assessment of the ability of IFSS as an intervention to be effective in turning around the lives of the family members.
- 4.14 There was agreement amongst IFST consultees at Site 2 that they were able to articulate what constituted an appropriate referral. However, when this issue of eligibility was explored in greater detail, the specific criteria identified by staff differed and their definitions were fairly general. Key words used by staff included: substance misuse; crisis point; willingness to get involved; and motivation to change and turn their lives around. These phrases are broadly similar to those used in the other sites, suggesting a consensus around the definition, albeit not in a very precise way.
- 4.15 Overall, there was some evidence that all three sites had broadened the eligibility criteria somewhat to include families suffering from wider problems to be accepted onto IFSS. This was formalised the most at Site 1 through the

continuation of the FASS scheme, but was evident (informally) at the other two sites. The three most common issues, in addition to substance misuse, were (in no particular order) domestic violence, mental health, and learning disability. Most consultees reported that in the majority of cases, multiple underlying factors were identified and so defining cases only on one issue was not really appropriate.

Social Worker perspectives

- 4.16 Social Worker consultees identified several key factors that were considered when deciding whether to refer to IFSS or not: the family's ability or motivation to work and engage effectively with the service; the level of stability evident within the family, indicating that they felt the service did not work for chaotic families, although when pressed on this issue, consultees had appeared to have formed this view over time, in response to a small number of unsuccessful cases as opposed to any systematic review of the evidence; families where there were clear concerns around child safety; and timing in relation to whether a clear crisis point had been reached.
- 4.17 At Site 1, Social Workers specifically made the point that they felt the service had worked best when families at the initial Public Law Outline (PLO) stage (pre court) had been targeted. They stated that for a number of families the intervention had created a delay at the PLO stage and they had subsequently seen an improvement in the family environment.
- 4.18 Some concerns were raised by the Social Workers at Site 2 in relation to the use of waiting lists by the IFSTs. Whilst they recognised that there had been capacity constraints during particular periods of the year, they felt that some families had been seen too late. They were of the view that the success of the IFSS programme was determined by the extent to which the IFST worker was able to intervene and 'catch' the family at just the right moment in time and often, this window was not very big. Whilst waiting lists may be necessary at certain periods of the year when demand for IFSS provision peaks, these need to be managed very carefully and any delay in taking on new cases should be kept to a minimum. If waiting lists are sustained over a longer period of time, this suggests that there could be a mismatch between the

capacity of the IFST and local demand, implying that the size of the team is too small.

Feedback from participating families

- 4.19 Participants suggested a number of motivations for agreeing to sign-up and engage with the IFSS programme. The motivations could be classified as either being positive (embracing an opportunity to 'turn their lives around'), or as negative (avoiding the threat of social services). While most families could be described as being motivated primarily by either the opportunities or the threats associated with the programme, some families described their motivations in both positive and negative terms. A further group of families had no clear idea or recollection of why they had been selected to take part in IFSS and cannot be framed in these terms.

Families motivated by perceived opportunities

- 4.20 Most families explained that they had made an active choice to sign-up to IFSS. They had accepted that they had reached 'rock bottom' and needed help. In some cases this realisation was provoked by a specific incident or crisis within the family, which marked the culmination of long-term problems. In other cases parents came to a realisation that the existing situation could not continue. Participation on the programme was viewed as an opportunity to help them overcome the difficult situations that they were experiencing.
- 4.21 In these cases, IFSS often came as a relief, and could go some way to explaining why families were particularly positive about the idea of working more closely with an IFST practitioner. Those parents who felt they had hit a low point were often amongst the most keen to engage with services, as they indicated that they never wanted to experience the same problems again.
- 4.22 Some saw the IFSS programme as a better option than the traditional support offered by social services. Many families welcomed the idea of receiving intensive support and viewed it as being appropriate to the urgency and complexity of their situations. Other families either struggled to, or in some cases were completely unable to, work with the social workers who supported them before the introduction of IFSS, and felt that they were not getting the

support they needed from this service. One mother believed that there was some stigma attached to having a social worker visit their house and was grateful to be able to refer to IFSS as being ‘family support’.

“I was relieved. Because it [IFSS intervention] wasn’t social services and the stigma that comes with it. She [IFSS worker] said ‘it is a very intense thing’... now that to me was very important”

Parent

Families motivated by perceived threats

4.23 A significant number of families perceived traditional social service support as a potential threat. In these cases, it was reported that the IFSS programme was seen as a way of avoiding contact with traditional social services. It also provided them with an opportunity to show a willingness to comply and a way of keeping social services on side.

4.24 Parents from this group often believed that taking part in IFSS might reduce the risk of their child being taken into care, or it may allow them to gain more access to their children. Others did not specify a precise threat along these lines but were clearly aware of the options available to social services if there is a belief that a child is at risk, as the following quote shows:

4.25 **“We didn’t feel we had to [take part in IFSS] but we thought it would be better for us and they [social services] wouldn’t give us as much stick if we went along with it...”**

Parent

Passive recipients

4.26 The third category of families was characterised by those who had no clear idea or recollection of why they had been selected to take part in IFSS. These families were generally less clear on the details of the referral process but were aware that something had changed and they were in receipt of more intensive help and support, as in the example below:

“All I knew at the time was that they were coming in and I thought ‘taking over’. I tried to look at it like a Nanny, a 911 situation”

Parent

Key points

4.27 The key points covered in this chapter are as follows:

- While the number of referrals has declined, the number of 72 hour assessments and cases accepted on to Phase 1 has risen across the three sites – indicating that more of the referrals were being accepted as IFSS cases
- The increase reflects improved awareness of and buy-in to the programme by referring Social Worker teams
- In two sites they have had to operate a waiting list due to demand exceeding capacity (although in one case this reflected a significant decline in the scale of the IFST). This has caused some frustrations, with cases being accepted on the basis of the most appropriate, when capacity became available
- There was a broad consensus among the IFSTs about who should receive IFSS. Although only one site has sought to write it down, they all use similar phrases around: crisis point; the importance of timing; and the motivation to engage or change their behaviours
- Participants' motivations to take part varied from being positive (embracing an opportunity to 'turn their lives around') to negative (avoiding the threat of social services), although most families reported positive reasons
- Many families welcomed the idea of receiving intensive support and viewed it as being appropriate to the urgency and complexity of their situations.

5: IFSS delivery

- 5.1 This section focuses on the different types of support delivered across the sites in year 3. It first describes how the programme has been implemented across the areas, prior to exploring issues with wider services.

IFST delivery

Continued flexibility and variation in delivery as IFSS has evolved

- 5.2 Evidence from across the three sites indicates that there has continued to be some variation and flexibility in how IFSS had been delivered on the ground. Whilst the sites have not sought to deviate significantly from the broad parameters of the model or what was set out in the original guidance, IFST workers have tailored some delivery aspects around specific family needs.
- 5.3 It was reported that larger families often required additional time with the IFST worker during Phase 1 than smaller families. Similarly, the responsiveness of the family to the intensive support was also often a key factor that influenced how much time was required with the family or the overall length of Phase 1 (in Sites 1 and 3 this was usually six weeks whereas at Site 2 it usually lasted for four weeks).
- 5.4 The sites have sought to respond to family-specific situations and to deploy different tools and/or techniques. The manner with which these have been used has also been shaped around the family situation, drawing on the expertise and professional experience of the IFST staff. For instance, one of the IFST workers described a case that involved a mother with a learning disability. The IFST worker quickly realised that she would need to adapt her delivery style. The worker sought specialist advice from a colleague as she did not have a background in this area. Her revised delivery style involved the use of visual aids and reading out the contents of reflective letters.
- 5.5 The main features of the IFSS delivery process across the three Phase one sites are presented in Table 5-1. The key headlines to note from the table are as follows:

- **Referrals:** A new resource panel approach was introduced part-way through the year at Site 1. At Site 2, IFST workers were assigned to work in particular geographical areas and each was responsible for establishing effective relationships with referring social worker teams and engaging with wider service networks in that 'patch'. With the loss of the administration resource in Site 3, all referrals subsequently came into the IFST (to the CSW and IFST manager) in paper form
- **Allocation:** all sites allocate cases primarily based on IFST member capacity, although on occasions families are assigned to workers with particular skills or areas of expertise
- **72 hour assessment:** all sites adopted a fairly consistent approach to the 72 hour assessment and assessing whether the family is suitable for progressing to Phase 1 of IFSS. Similarly, at this stage, a goals orientated Family Plan and a CYP Safety Plan would be developed
- **Phase 1:** At Site 1 and Site 3, the intensive period usually lasted for six weeks, whereas at Site 2, it tended to be shorter at four weeks, although some work could be carried over to the first week of Phase 2
- **Phase 2:** At Site 1, IFST staff would have weekly contact with a family during the first month of Phase 2 and fortnightly contact in the second month. This was introduced to help manage the transition from Phase 1. Efforts were also made to provide more structure to Phase 2 so that there was greater clarity on the specific delivery roles and responsibilities of wider services. It was reported that the Family Aid Worker had continued to play an important role in Phase 2 at Site 3.

Table 5-1: Overview of IFSS delivery across the Phase one sites in year 3

	Site 1	Site 2	Site 3
Referrals	<p>For the majority of year 3, there was a single point of referral into the Family Support Service. The referrer would book an appointment with the on duty member of the Family Support Service to discuss the case. A consultation would take place on the same day. The relevant Family Support Worker would then either offer a set of recommendations for the referrer to trial (recorded as consultation advice) or accept the referral and send it onto the IFST manager for final approval (recorded as a consultation referral). If it was deemed an appropriate referral, the social worker would write up a referral form, which would get passed to the IFST manager to check availability in the team and allocate the case accordingly.</p> <p>Towards the end of year 3, a new resource panel approach was introduced. The consultation phase worked through an IFST email inbox to request a consultation, following which a response would be provided within 24 hours to organise a consultation with a CSW. If a case was assessed as being an appropriate referral, it would get sent to the resource panel, chaired by the Children's Services manager (and attended by the IFST manager and representatives from the other services). This panel would meet on a weekly basis to allocate cases to the relevant teams (e.g. IFST, FASS, Early Intervention and Prevention, etc.) based on need and the capacity of the individual services at that time.</p>	<p>Each IFST member had been allocated their own geographical 'patch' of the local area. This meant that for the referral process, they would each visit the frontline staff in their patch twice a week to build relationships but also to be available on-site to discuss any live cases on a drop-in basis. The team felt that this had been important in giving them a strong visible presence on the ground.</p> <p>Referrals would come into the IFST via the Children's Social Services team.</p> <p>A referral would be followed by a consultation with the referring social worker/team to discuss the family and to check their eligibility for participation on the programme.</p>	<p>During the first part of the year, referrals came into the team administrator via telephone, email or through team drop ins in Social Services. The administrator would then pass referrals on to the IFST manager and CSW for allocation.</p> <p>However, following the loss of the IFST administration resource, the referral process changed. All referrals had to be sent to the IFST manager and CSW in paper form.</p> <p>A consultation meeting would be held with the referring social care worker and these usually lasted for between 30 and 45 minutes.</p>
Allocation	<p>Under the Information Station referral system, cases were allocated by the IFST manager based on capacity and where possible specialism.</p> <p>Under the new resource panel system, the panel allocated cases on a weekly basis to the IFST based on the overall capacity of the team and the IFST would subsequently meet and case allocation would be undertaken at this internal meeting.</p>	<p>In the main, the allocation of cases within the IFST would be done on a capacity basis, though on occasions, cases were assigned to staff due to their specialist skills or professional background.</p>	<p>Generally cases were allocated on a capacity-basis but where circumstances allowed, some cases allocated within the IFST based on the skills and expertise of the team members.</p>
72 hour assessment	<p>Following referral, the relevant IFST member would arrange a meeting with the family. This meeting would occur within two weeks of the referral. Following this, the</p>	<p>The allocated team member would contact the social worker and meet with them to discuss the case, prior to meeting the family. This would then give rise to the 72</p>	<p>The 72 hour assessment would follow an initial meeting with the family (often using solutions focused behavioural therapy and motivational interviewing techniques) and a</p>

	Site 1	Site 2	Site 3
	<p>three day initial assessment would be conducted. This sought to explore what the motivations of the family were at the time, what could be done, and what family outcomes (or goals) could be achieved, and the resultant assessment (the Family Plan) would get passed to the social worker. At this point, the family would enter the 4-6 week intensive IFST intervention (Phase 1), if it was clear that the family wished to change and it is judged that any children and young people would remain safe. A CYP safety plan would also get developed at this stage.</p>	<p>hour assessment, which would focus on defining broad parameters of family goals and reviewing the family's situation to determine whether or not they should proceed to Phase 1.</p> <p>Generally, if a family was accepted onto IFSS, there would be a seamless move into Phase 1. However, on occasions there were slight delays (for up to one week) due to holidays or a family member attending court etc.</p>	<p>family safety plan would be developed (usually on day 2, using a common template).</p> <p>On average, between 7 and 10 hours would be spent with the family over the three days. However, this could take longer depending on family circumstances (i.e. how big the family is or the complexity and nature of need). After the assessment had been completed, a decision would be made with the social worker and the family as to whether they should progress to Phase 1.</p>
Phase 1 (4-6 weeks)	<p>IFST staff would spend Phase 1 developing a goals based plan, engaging relevant services and seeking to begin making the required changes to achieve the goals. If other services were already involved with the family, they would continue to work with them. Additional services were added if required e.g. medical treatment.</p> <p>A maintenance meeting would be held at the end of Phase 1, at which goals were reviewed and the family would progress onto the next phase, with the family getting passed back to their social worker.</p> <p>On average, during year 3, Phase 1 lasted for six weeks.</p>	<p>The Phase 1 intervention would usually involve around 10 hours of intensive work with the family per week, although this sometimes went up to 20 hours depending on the size/nature of the family. The process would be determined by the review, which would be scheduled for between 21 and 28 days from the start of the intervention.</p> <p>In reality this meant that the intensive phase of the intervention would usually be completed within four weeks. However, if longer was needed then the review would be used to report on progress and discuss next steps with a range of professionals.</p> <p>Generally other services could also be involved at this stage, unless it was felt that the IFST worker was spending a significant amount of time with the family. If this was the case, other agencies would be asked to delay their work until after Phase 1.</p>	<p>The intensive work with the family during Phase 1 could last for different periods of time depending on the size of family or complexity of the issues. However, the majority of cases involved around 40-50 hours in this stage (usually two hours would be spent with the family per day).</p> <p>On average, during year 3, Phase 1 lasted for six weeks.</p> <p>The IFSS programme commissioned Action for Children to provide a solution focused counselling service as well as cognitive behaviour therapy for families in Phase 1 (and Phase 2).</p>
Phase 2	<p>Reviews would be held after 1, 3, 6 and 12 months. IFST staff would have weekly contact with a family during the first month of Phase 2 and fortnightly contact in the second month to enable a managed step down from the initial intensive phase.</p> <p>There were some important developments during the year. The new IFST manager wanted to provide more structure for Phase 2 to ensure plans would be more effective and that partners were clearer on their specific delivery elements. It was felt that this would allow the IFST worker to withdraw properly at the end of Phase 1.</p>	<p>The first week or so of Phase 2 could involve finishing off some of the work from Phase 1, which may have been agreed through the review process.</p> <p>Reviews would be held at 1, 3, 6 and 12 month stages.</p> <p>Booster sessions would also be provided to a family if required. These could be requested by the family or the social worker. These would usually take the form of a telephone call or a visit. Up to three booster sessions could be provided. If it was felt that additional boosters were needed, it was considered that more intensive support would be required and the case would be discussed with the social worker to agree what should happen next.</p>	<p>Appropriate wider service providers would be identified (and/or the Family Aid Worker would be engaged) and signposted at the review meetings (1, 3, 6 and 12 month stages). The reviews were goal focused and used to determine whether the family plan was still fit for purpose.</p>

Families have found IFSS to be very different to other forms of social care

- 5.6 The feedback from beneficiary families indicates that the IFSS model was seen as being very different to traditional support delivered by Social Services.
- 5.7 In general, IFST practitioners were highly spoken of and well regarded by families. This was often in stark contrast to families' reported experiences of 'regular' social workers that tended to be typified by less constructive and less positive working relationships. It was suggested that the non-threatening and open relationship that most families had with their IFST workers created the conditions for the families to engage effectively with the general approaches and specific tools and techniques used within IFSS.

The whole family based approach

- 5.8 Many families welcomed the family-centred approach with IFSS and saw this as being a much more effective way of working than the traditional support they had received in the past. In general terms, the family based approach opened up the lines of communication between family members and helped them to understand and empathise with each other. For many families this empathy and understanding continued beyond the lifetime of the programme, and was in stark contrast to how things were prior to their involvement with the IFSS programme.
- 5.9 Where the family based approach was fully implemented it had some benefits at both the assessment and problem-solving stages of the programme:
- Assessing the families' needs and problems - by spending time with each family member the practitioners could identify each individual's problems. This also enabled the practitioners and the families themselves to understand how the problems within the family were interrelated and which issues were having a causal effect on others
 - Problem solving - a small number of families also felt that this approach helped the problem-solving stage of the programme by ensuring that parents and older children had a clear understanding of their roles and

responsibilities in solving the families' problems. This provided family members with a sense that they needed to work together rather than apportioning blame on an individual.

- 5.10 However, some limitations of the family-based approach were reported too. For example, a minority of families felt that the benefits of the family-based approach had not been fully realised. This was either as a result of some family members refusing to engage with the programme (mostly fathers), or as a result of the IFST practitioners spending insufficient time with some members of the family (possibly because they had insufficient time available). It was felt that the family-based approach was irrelevant to some smaller families (such as a mother with a very young child) as there was only one family member who could be consulted.

Motivational and asset-based approaches have been used

- 5.11 Families rarely talked about a “motivational approach”. However, the evidence from the qualitative interviews suggests that a motivational approach was often used. This was designed to encourage families to develop their own solutions and to take responsibility for improving their own lives. This approach often had the greatest impact on parents in a depressive mind-set with lower levels of confidence or energy than others. We have included some examples of the motivational approach below:
- One mother with depression, could easily become reliant on other people, and explained that her IFST practitioner had encouraged her to manage things by herself – even through simple things such as phoning people herself
 - Another mother explained that she found it difficult to leave the house as a result of her social anxiety. She explained that the IFST practitioner had deliberately organised meetings in public spaces such as cafés to encourage her to get out and about, which over time she came to find easier.
- 5.12 Whilst IFST practitioners would normally encourage beneficiary families to help themselves, in some cases they would organise things (such as

contacting services) on behalf of individual family members who did not have the confidence or motivation to manage this. This was considered helpful and appropriate as it meant that support was available when family members needed it.

- 5.13 Some of the families also explained that they had completed exercises that focussed on helping them to think about their assets and capabilities. There is some evidence that an asset-based approach was used to encourage family members to focus and build on their assets, in particular on their character strengths and the achievements that they had made on the programme. This approach helped families to build their confidence and motivation.
- 5.14 Most families recalled exercises they had completed that allowed them to monitor the progress they had made. Participants often explained that they had reflected on these exercises at difficult periods of their lives and this had encouraged them to continue to avoid behaviours that were likely to be self-destructive in the longer-term (such as substance abuse).

The 72 hour assessment

- 5.15 Many of the participants reported having an intensive 72 hour period of support at the beginning of the IFSS programme. However, most interviewees were unsure about the precise details of the initial assessment, particularly those that had been on the programme for a longer period of time. Around half of those who could recollect this period with greater clarity, reported receiving an intensive 72 hour period of support at the start of the process, and a similar proportion recalled a 'general period' of intensive support (such as a week of one hour interviews) but did not recall a separate assessment period.
- 5.16 This early intensive period of support was often recognised by families as being about identifying the families' problems and setting achievable goals. Families from all three sites recalled exercises, such as thinking about their 'perfect day', as a way of establishing their goals for the programme, as in the example from one parent below:

“We were told it was going to be intensive. It was about setting goals and boundaries”.

Parent

- 5.17 Many family members explained that their IFST practitioner would spend three or four hours a day with the family in this early period, although this could vary considerably according to the needs of the family. Some of the families who were seen for longer sessions explained that the IFST practitioner had been able to see how the family really interacted with each other.
- 5.18 It was also common for families to be visited every day for several weeks. They explained that the use of shorter sessions had meant that their day-to-day lives were not unduly disrupted. Parents from one family explained that they had always been visited at the beginning of the day, and this had helped them to get into more of a routine, providing a consistent focal point to the day.

Phase 1

- 5.19 Many of the families reported that the early intensive phase of the programme was emotionally draining. This was because they had to spend a significant proportion of their time thinking and talking about their current problems or difficulties. This period was often most difficult for those who were using alcohol or drugs as a way of dealing with a traumatic incident or past (such as childhood abuse or bereavements).
- 5.20 Most of these families found this process to be helpful, with many indicating that the opportunity to discuss some of their problems with a sympathetic professional had been the most beneficial element of the whole programme:

“I could talk to her [practitioner] ... I admitted everything to her. It felt like I had talked for weeks or months... She wasn’t shocked by anything I said... it didn’t faze her, she was expecting it.”

Parent

- 5.21 There was general agreement that the intensity of the early period of support was necessary as it allowed family members to engage with the programme fully and to get to know and trust the IFST practitioner. It helped the families to

see the programme as being something that they would have to fully commit to if they wanted to improve their lives, and those of their family.

- 5.22 A couple of families who had little spare time available felt that the early period of the programme took too long, and placed too much of a burden on the family. A small number of families did not find the Phase 1 process helpful. There were two reasons for this. A few families explained that they had specific needs that required specialist support that their IFST practitioner was unable to provide. In other instances, families explained that they had struggled to open up to their practitioner with the result that they may not have received all the help that they needed. We have provided examples of these problematic cases below.

Specific support needs being unavailable

What happened?

A mother believed that her husband needed very specific support that could not be identified or provided by the IFST practitioner. The husband had mental health problems, autism and alcohol addiction issues that were difficult to manage. She suggested that while the IFST practitioner that had helped him was empathetic and enthusiastic, the worker didn't understand how people with his conditions process information and interact with others. She had not been able to get her husband to focus on the IFSS exercises or activities. This meant that her husband struggled when he faced difficulties after the completion of the IFSS programme.

What could have been improved?

The mother believed that her husband should have been referred to a practitioner who had been trained in helping people with autism. She suggested that a senior professional should have assessed her husband's specific needs and referred him to the relevant services.

Being unwilling to open up during the assessment phase

What happened?

A mother reported how she did not tell her IFST practitioner that she was suffering from depression during IFSS as she did not consider it his business. Although this refusal to disclose information does not appear to have affected her family's outcomes – her depression cleared as other issues were resolved - it is a useful reminder that IFSTs can only work on the problems that they are aware of.

Managing the transition from Phase 1 to Phase 2

- 5.23 Most families felt that the transition periods within IFSS had been well-managed. It was reported that IFST practitioners had taken sufficient time to inform families that each stage was coming to an end and to ensure they were

ready to progress to the next one. Most parents had explained that the intensive period had finished at the 'right time' and that they were comfortable about continuing on their own.

- 5.24 However, a significant minority of families felt that their intensive support had ended too quickly, with the result that they often experienced set-backs. Families in this position were more likely to receive booster sessions (initiated either by themselves or by their social worker). In some cases, families explained that they had learnt or worked out a number of techniques for managing the difficulties in their lives but that there had been insufficient time for these to become fully embedded or habitual, meaning that relapses occurred.
- 5.25 It was reported that the Family Aid Workers had played key roles in supporting the transition from Phase 1 to Phase 2 across the sites. Often this involved talking to the families, providing ad hoc support and reassuring family members of the progress they had made. It was felt that such contributions were key in maintaining levels of motivation and commitment, although IFST staff stated that they remained concerned that the transition from Phase 1 to Phase 2 was too severe for some families.
- 5.26 The sites indicated that they had invested more time and effort into planning and managing programme exits. It was suggested that the planning had been useful, as had the 'step down' or tapered approach that was deployed in Site 1. This involved the IFST worker meeting with the family less and less in a managed reduction, as Phase 2 progressed.

Phase 2

- 5.27 Most of the interviewed families were referred to wider services or support during Phase 2 of the programme. The most common services included: drug and alcohol support; support groups for people who have experienced domestic violence; mental health support; financial advice; access to charitable funds; advocacy services (particularly for children); employment support and training; help with applying for housing and benefits; services

aimed specifically for potentially vulnerable children such as Action for Children and Young Carers.

- 5.28 Most participants felt they had benefited from at least some of the wider services they had been referred to. Where individuals had not benefited greatly, they often explained that the services had not been able to provide them with the personalised, comprehensive support that had been made available via their IFST worker. In some cases, families suggested that they had received all the support they needed through the IFSS programme.
- 5.29 The least positive reported outcomes from referrals occurred in employment, housing and mental health support. Several families felt that the support they were receiving around employment was not sufficiently personalised around their needs and some parents with criminal records felt that they were unlikely to ever find a long-term job. Some of these findings may relate to wider economic problems associated with high unemployment levels in those areas where the families lived. Specific concerns relating to delays in accessing appropriate housing and mental health support were reported by several consultees. The main problem appeared to be a lack of capacity within these wider service providers to respond quickly when their inputs were required by the IFSS families. Going forwards, it may be appropriate for sites to explore the possibility of using Section 58 agreements to address such issues.
- 5.30 A small number of families believed that they really needed to move to a new area in order to get away from local drug dealers or ex-partners who had been physically or emotionally threatening. In a small number of cases, families explained that their IFST practitioner had not been able to help them to move to a new home quickly although they had received support in their application to move home. It is worth noting that those families who had been able to move home may have become more difficult to re-contact for follow-up interviews as a result of their change of address.
- 5.31 Although it seems that IFST practitioners had communicated to families that they can get in touch with them for support during Phase 2 of the programme, some of the parents who felt they needed further support were reluctant to do so. In some cases parents felt that they would be bothering the support

workers. In other cases, parents believed that their support workers were stretched with a large case-load and so were unlikely to be able to help them. Elsewhere, some participants explained that their 'old' IFST practitioner had left the area and they were less willing to contact the IFST as a result.

- 5.32 At the sites, it was reported that there had been an increased use of signposting to services at the various review meetings. It was felt that this had contributed towards other agencies responsible for getting services started to become more actively involved in Phase 2, thus preventing the spearhead workers from becoming default case managers.

The use of booster sessions

- 5.33 It was common for families to have booster sessions after the intensive period of support had finished and they had moved into Phase 2. Some sessions occurred after the family had faced a particularly difficult event in their lives, while others took place when families had felt they had not sufficiently resolved the underlying problems. The nature of the booster sessions varied considerably amongst the interviewed families. The nature of the booster sessions varied considerably amongst the interviewed families, emphasising the need for flexibility in how these are delivered.
- 5.34 Some family members explained that they had talked to their IFST practitioner face-to-face while others had communicated by phone or via text messages. In addition, some families had regular discussions while others held ad-hoc discussions or a single discussion. Some of the booster sessions were IFST-instigated while others had been requested by the beneficiary family. Importantly, nearly all the families valued these sessions explaining that they helped them to learn how to apply the advice and techniques they had learnt.
- 5.35 Families felt it was important that any booster sessions were managed by the practitioner who had worked with them before. This ensured that the practitioner understood their problems and the progress they had made, and that there was trust between the practitioner and the family. A number of families explained that they did not want to attend booster sessions managed by a new practitioner as they felt they were unlikely to be beneficial.

- 5.36 In the message box below, two examples of cases where successful booster sessions were used are summarised.

Benefits of the booster sessions

What happened?

One mother explained that she had asked for a booster session after coming back into contact with her ex-partner who had been abusive. Her ex-partner had come back to the house and had stolen money and been very aggressive. As a result she explained that she had lost confidence, felt depressed, and was finding it hard to avoid binge drinking. This problem was resolved through a series of intensive booster sessions organised by her IFST practitioner. The practitioner used the sessions to remind the mother of the progress she had made and to remind her of some of the techniques that she had learnt before. This helped her to rebuild her confidence.

Benefits of the booster sessions

What happened?

A family had received a booster session after the mother and father had become involved in a serious argument. This helped the family to understand and manage their problems, allowing them to learn techniques to ensure that disagreements did not escalate into major arguments that could put their child's well-being at risk.

Role of wider services in IFSS delivery

- 5.37 Most of the interviewed families indicated that they had used one or more wider services in addition to the support that they received from their IFST practitioner. A minority of families stated that they had relied on the IFST practitioner for all their support. In these cases, families felt that this was sufficient to meet their needs. In many cases families had been referred to services through their IFST practitioner, or had been encouraged to self-refer. Other families were already receiving support from wider services that continued throughout the programme or were able to find additional services themselves. Many families could not recall how they had been referred to services and who had been responsible for the referral.
- 5.38 A significant number of parents used support groups to help them with their addictions. Participants had mixed experiences of the groups, although this could be a reflection of the difficulties associated with managing addictions as much as the quality and suitability of the groups themselves.

- 5.39 Families which were experiencing difficulties with parent/child relationships were typically referred to parenting/nurturing courses to teach them parenting skills to help manage their children's behaviour. The courses were largely felt to have been successful and had helped to improve the children's behaviour and the relationships they had with their parents. However, the courses were not always entirely successful and one parent who did not live with her daughter admitted that she still had difficulties with her relationship with her daughter. This often occurred when the parent had other difficulties such as mental health issues.
- 5.40 A significant number of parents and older children discussed taking part in college courses to help them move towards work. The most common courses were around social care and child care with some parents also taking courses in other areas such as decorating and metal work. Parents were generally positive about the training opportunities they had received but many were concerned about the limited employment prospects in their areas as a result of the economic climate, and in some case, their own criminal records and employment history.
- 5.41 A small number of parents were referred to services for people who had experienced domestic violence. One mother explained that she had been referred onto a course which had helped to rebuild her confidence, and become more aware of the problems she was experiencing as a result of her relationship with a violent and abusive partner. It was clear that many of her family's problems had occurred as a result of her relationship with her partner at the time. She explained that she had made real progress since ending the relationship. She also felt that the new skills she had developed would help to prevent her from ending up in other unhealthy relationships in the future. A number of children were also referred to domestic violence groups to help them understand the problems that had occurred in their families.
- 5.42 Many of the children and young adults that were interviewed stated that they cared for others in the family. A small number of them had been able to join local young carers groups which gave them the opportunity to meet others, share their experiences and pick up skills that they had not been able to learn

at home or at school. The scarcity of places in the groups meant that a few children who felt they had a caring role and could benefit from the support, were not given a place on their local group.

- 5.43 A few children and young adults explained that they had used advocacy services to help them to make sure that their views were being represented (particularly in discussions or meetings around their care). This was particularly helpful for children who had two parents who did not live together.

Difficulties in accessing wider services

- 5.44 A small number of participants explained that they had found it hard to know which services were best suited to them after completing the IFSS programme. Additionally, a small number suggested that services were very difficult for them to access as they did not have the ability to assert their needs and complain when things had gone wrong. For example, one parent with mental health problems explained that she had been waiting for over a year to access counselling. The complexity of the referral system made it difficult for her to resolve this issue.
- 5.45 A small number of families explained that they had struggled to get the housing they needed to manage the difficulties that they faced in their lives. Those mothers who needed to move away from the area to avoid living close to an ex-partner who they had been in an abusive relationship with, explained that they had not been able to relocate. One family explained that they felt that their lives had improved to some extent through IFSS but they would never feel fully comfortable until they were able to move to an area where they felt safe.

The effects of staying in an unsuitable house

What happened?

The parents of one family explained that their house was very overcrowded (with five children and two adults in a three bedroom house), and that this was the major cause of the difficulties that the family faced. In particular, the parents had to move two of the younger children from their own bedroom to a separate bedroom to sleep so that their older siblings could have some privacy in the evenings. This meant that the parents had little privacy and often lost sleep – something that made them stressed and irritable. While the IFSS programme had helped the family they felt they could only make limited

progress while they remained in the same house.

Key points

5.46 The key points covered in this chapter are as follows:

- There is evidence of continued variation and flexibility in how IFSS has been delivered, with IFST workers seeking to develop tailored solutions to meet family-specific needs
- At Site 1, a new resource panel approach was introduced part-way through the year and at Site 2, IFST workers were assigned to work in particular geographical areas
- All sites allocate cases primarily based on IFST member capacity, although on occasions families are assigned to workers with particular skills or areas of expertise
- At Site 1 and Site 3, the intensive period usually lasted for six weeks, whereas at Site 2, it tended to be shorter at four weeks, although some work could be carried over to the first week of Phase 2
- The sites have sought to provide greater structure and clarity to wider services during Phase 2. In addition, at Site 1, a phased reduction in IFST worker inputs has been introduced as part of wider efforts to help manage the transition from Phase 1 to Phase 2
- IFSS was described by families as being very different to traditional support delivered by Social Services. IFST workers were praised by families and partner agencies, and the family-centred approach was generally seen as being a more effective way of working
- Motivational and asset-based approaches were often used to encourage families to develop their own solutions to problems and to take responsibility for turning their lives round
- Many families reported that they had found the 72 hours assessment emotionally draining. However, many families indicated that the

opportunity to discuss some of their problems with a sympathetic professional had been the most beneficial element of the programme

- Most families felt that the transition periods in IFSS had been well-managed by the IFST workers, including the Family Aid Worker. However, a significant minority of families felt that their intensive support phase had ended too quickly, with the result that they often experienced lapses, resulting in the need for booster sessions
- Most of the interviewed families felt that they had benefited from at least some of the wider services they had been referred to during Phase 2. However, some families reported that there had been issues around accessing appropriate employment, housing and mental health support
- A small number of families believed that their long-term well-being was dependent on them being able to relocate to a new area. This would allow them to get away from local drug dealers or ex-partners who had been physically or emotionally threatening.

6: IFSS outcomes and impacts

- 6.1 This section considers the impact of IFSS on family outcomes across the three Phase one sites. It draws on the qualitative evidence gathered through consultation with IFST workers and wider stakeholders, as well as the family interviews. Additionally, quantitative monitoring information in the form of Goal Assessment Scale scores plus WEMWBS and SDQ data have also been analysed.

IFST and partner perspectives

Strong support exists for the IFSS approach

- 6.2 Case study visits to each of the three Phase one sites revealed **strong and universal support for IFSS**, reinforcing many of the interim conclusions presented in the Year 2 Report. Consultees praised the use of motivational interviewing techniques, reflective letters, therapeutic work and the fact that IFST workers had adopted a long-term asset-based approach that focused on delivering outcomes for the whole family.
- 6.3 The collaborative working style of IFST members through, for example, the use of reflective meetings, and the different skill-sets that each worker offered was also highlighted, along with the use of multi-agency delivered solutions and the emphasis placed on giving the whole family a voice. Another important success factor identified was the ability of the IFST member to spend sufficient time working with a family so that he or she was able to understand their needs in detail.

However, IFSS does not work for all families

- 6.4 It is evident from discussions with IFST workers and Social Workers that IFSS has not worked for all cases. Whilst it is difficult to generalise too much in relation to the characteristics of families where less progress has been made, a number of common themes did emerge.
- 6.5 Consultees consistently commented that for certain families who had extremely **chaotic lives and serious multiple issues to address at once**,

IFSS interventions were less likely to be successful. However, as stated above, this view held by IFST workers appears to have developed over time in response to a small number of unsuccessful cases as opposed to any systematic review of the evidence. The main challenge appears to be around sustaining the improvements achieved during Phase 1, perhaps because not all of the issues had been fully addressed in the 4-6 week period.

6.6 **The timing of the intervention and the level of motivation within the family also appears to be very important.** It was felt that IFSS was more likely to be effective for families who had been on the social care register for a short period of time.

6.7 The majority of consultees reported that they felt families needed to be highly motivated in order for the approach to work. However, a few consultees questioned this view and they suggested that IFSS should be seen as more of a preventative intervention and the IFST worker should play a key role in motivating the families.

Some elements of IFSS have been adopted by wider services

6.8 It is evident that during year 3, awareness of IFSS amongst partner agencies has continued to grow. Across the sites there were various examples of Social Worker teams accessing advice and guidance from members of the IFSTs. Furthermore, the reach of IFSS has continued to spread through various channels (training courses, briefings and presentations at partner agency team meetings, secondees going back to their host organisations, etc.). At one of the sites, the Youth Justice Service has continued to use reflective letters and other partners such as the local voluntary and community support organisation has embedded IFSS thinking into its day-to-day work.

It is widely recognised that IFSS represents a significant investment

6.9 It was recognised that IFSS represented a significant investment of time and resource in beneficiary families. Whilst consultees felt it was too early to draw any firm conclusions on the longer-term impacts (or the persistence of these impacts) on families, most indicated that they thought IFSS represented a sensible 'invest to save' scheme. Linked to this, the dominant view amongst

stakeholders was that they thought over the long-term, it would offer good value for money to the public purse, although they acknowledged the lack of hard evidence around this.

Evidence from the monitoring information

WEMWBS data

- 6.10 The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) was designed to enable the measurement of well-being in adults across the UK. Adult participants in the IFSS programme were asked to complete WEMWBS questionnaires in order to assess the impact of the intervention on their mental well-being.
- 6.11 Across the three pilot areas, 46 IFSS participants completed WEMWBS forms to feed into the evaluation. Out of the 46 populated forms, five were from Site 1, 24 from Site 2 and 17 from Site 3, although some had to be discounted due to incomplete data (**Error! Reference source not found.**). Respondents completed the form at the beginning of the IFSS process and once they had finished the second phase of the programme, so that an assessment of 'change over time' (covering a period of approximately 13 months on average) could be made.

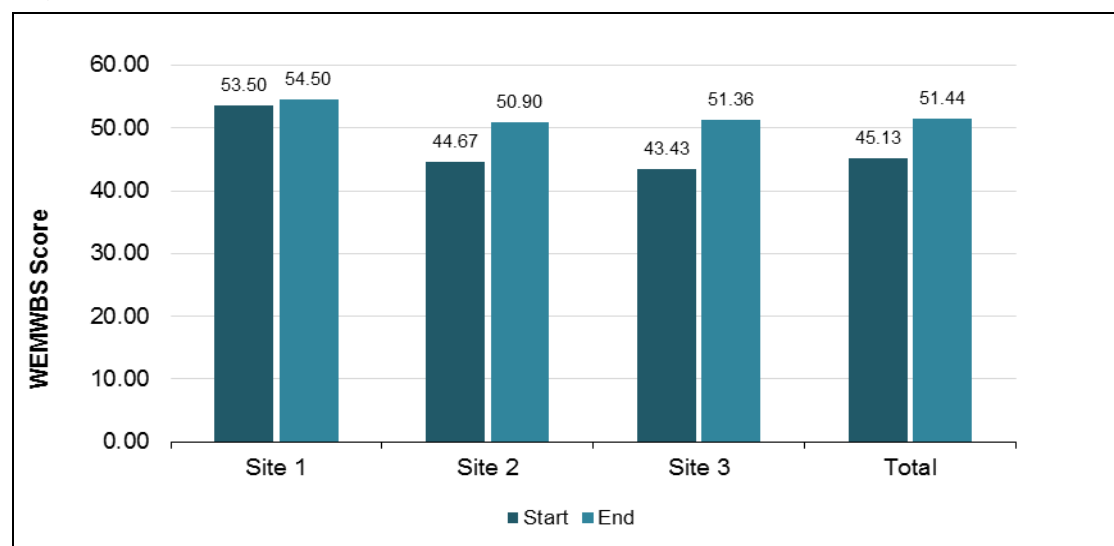
Table 6-1: WEMBWS responses by site

Site	Number of viable respondents	Number of discounted respondents
Site 1	4	1
Site 2	21	3
Site 3	14	3
Total	39	7

Source: SQW analysis of WEMBWS data

- 6.12 Positively, **there was an improvement in well-being across all three areas**, although the scale of the uplift in scores varied somewhat (**Error! Reference source not found.**). Across all areas, the mean score increased from 45.13 to 51.44. Sites 2 and 3 show relatively large increases compared to Site 1, although respondents in Site 1 began from a higher base.

Figure 6-1: Mean WEMWBS scores across the three Phase one sites



Source: SQW analysis of WEMWBS data

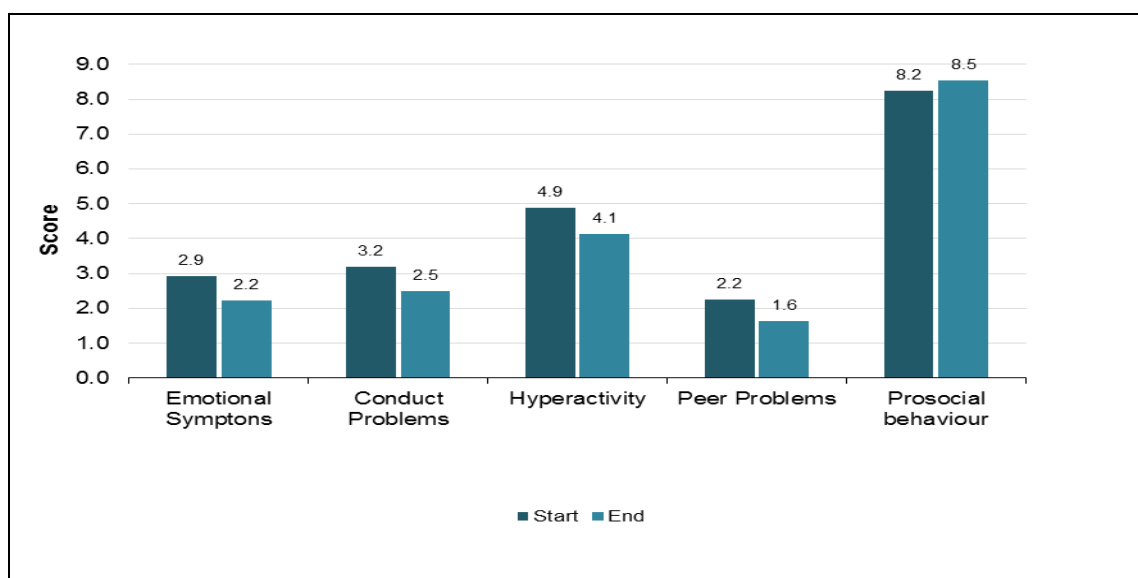
Strengths and Difficulties Questionnaire

- 6.13 The Strengths and Difficulties Questionnaire (SDQ) is a short behavioural screening tool designed for 3-16 year olds. It consists of 25 scored attributes, both positive and negative, which can be used to judge how 'normal' behaviour is in a child or group of children, as well as highlighting key changes in behaviour over time. Questionnaires were self-completed by children whose families have participated in the IFSS programme across the three Phase one areas.
- 6.14 In total, 47 questionnaires were completed across the three areas, with each respondent completing the form at the beginning of their IFSS 'journey' and at the end of the second phase of the programme (covering a period of approximately 13 months on average). Some of the questionnaires were only partially completed or had other issues, and so were discounted from the final analysis in order to ensure like-for-like comparisons across the beginning and end datasets. After excluding the questionnaires with missing data, the total number of useable responses across the three areas was 33, with four from Site 1, 14 from Site 2 and 15 from Site 3.
- 6.15 **Error! Reference source not found.** shows the mean SDQ scores across all 33 respondents, covering each of the five scales. For the first four scales on the chart (moving left to right), the scoring is inverted i.e. the lower the

number, the more positive the behaviour of the child. For pro-social behaviour, a higher number indicates a more positive behaviour.

- 6.16 The chart reveals that **across all three sites there was a small improvement against all scale categories** from the 'before' and 'after' IFSS positions. The most marked improvement can be seen under hyperactivity, which decreased from a score of 4.9 to 4.1. It is also worth noting that the mean score for all three sites lies within the 'normal'¹² banding for behavioural issues at the end of the process.

Figure 6-1: Mean SDQ scores across the five scales for all three Phase one sites

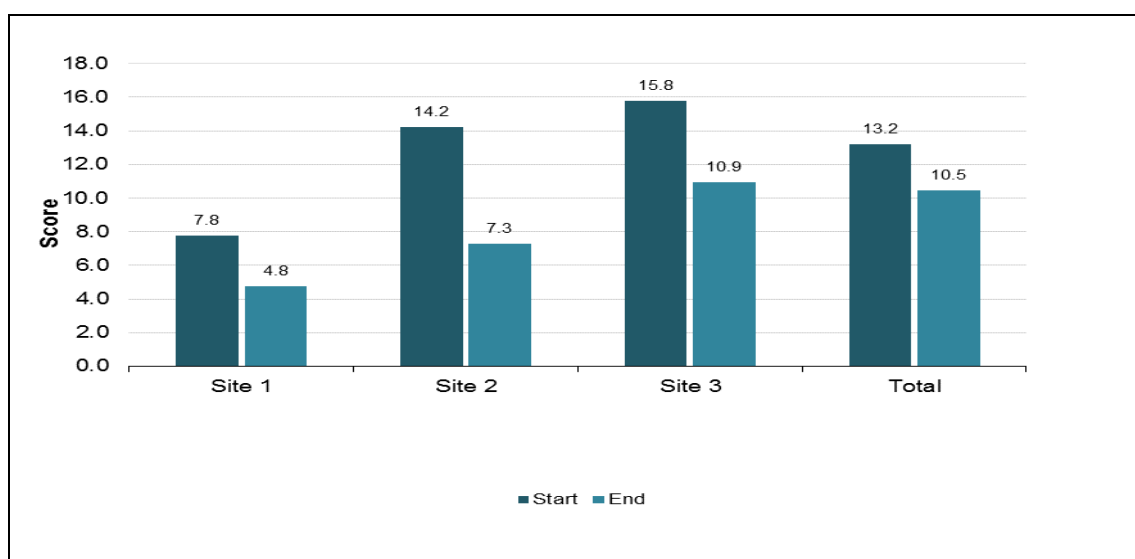


Source: SQW analysis of SDQ data

- 6.17 As shown in **Error! Reference source not found.**, the **total difficulties score across all areas has seen a fall between the beginning and the end of the programme**. The most impressive improvement was seen at Site 2, which observed a 6.9 point fall over the period, with the total across all three Phase one sites falling from 13.2 to 10.5.

¹² Within the SDQ scoring guidance, classification bandings covering 'normal' respondents, those who are deemed to be 'borderline' and those who are potentially suffering from 'abnormal' behaviour, have been defined. Further details can be found on the Youthmind SDQ website at: <http://www.sdqinfo.com/py/sdqinfo/c0.py>

Figure 6-2: Mean total difficulties scores across the three Sites



Source: SQW analysis of SDQ data

Goal Attainment Scale data

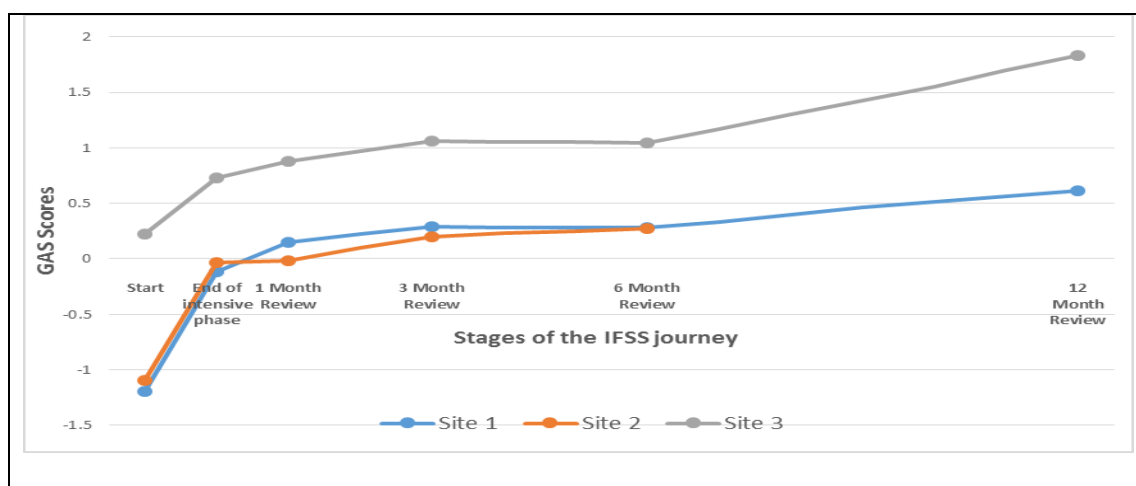
- 6.18 The Goal Attainment Scale (GAS) is a method of scoring the extent to which a participant's individual - or in this case a family's - goals are achieved throughout the different stages of an intervention. In effect, each IFSS participant has his/her own outcome measures, but these are scored in a standardised way so as to allow statistical analysis.
- 6.19 An important feature of the GAS-based approach is the 'a priori' establishment of criteria for a 'successful' outcome in relation to that individual. This is agreed with the family before the IFSS intervention starts. It is designed to enable everyone to hold a realistic expectation of what is likely to be achieved, and to agree that this is something worth striving for. Each goal is rated on a 5-point scale, with the degree of attainment captured for each goal area. If the family achieves the expected level, this is scored at 0. If they achieve a better than expected outcome this is scored at: +1 (more than expected); +2 (much more than expected). If they achieve a worse than expected outcome this is scored at: -1 (less than expected) or; -2 (much less than expected).
- 6.20 The IFSS Phase one sites measure success by considering the 'distance travelled' in terms of the scores recorded for each family's suite of individual goals. The goals are negotiated with the IFST spearhead worker. Each family

scores itself and subsequently scores at the first, third, sixth and twelve month review stages.

6.21 Figure 6-3 shows the distance travelled in terms of GAS scores across all three sites. It reveals that a **significant amount of success is achieved during the initial intensive phase across all sites, followed by a more 'steady' performance between the end of the intensive phase and the six month review**. At Sites 1 and 3, where data are available, a **second period of significant improvement in the GAS scores is evident between the six and 12 month** review stages. The dominant view from consultees was that this second spike in the scores seen towards the end of the IFSS journey could in part be explained by families being able to recognise more fully the progress they have made since the start of the intervention as they approach the 12 month review stage.

6.22 It is also noticeable that respondents at Site 3 began the process with significantly better scores than the other two sites, although there was no evidence to suggest that different eligibility criteria or targeting approaches have been used. Nevertheless, the broad trends are consistent across all three areas.

Figure 6-3: GAS scores at all sites across the IFSS Process



Source: SQW analysis of GAS data¹³

¹³ The data presented here differs slightly from that in the site annual reports due to the evaluation having access to data from a smaller cohort of beneficiary families. However, the same data trends are apparent.

Views from beneficiary families on the key benefits of IFSS

- 6.23 **Most of the families who were interviewed felt that they had benefitted from the support they had received through their participation on the IFSS programme.** Many families felt that they had made significant progress and were very confident about the future. This occurred most commonly when families had overcome a single problem such as substance misuse or domestic violence, which was considered to be the most significant problem in the families' lives.
- 6.24 A significant number of families had made some substantial progress in their lives but still experienced some on-going difficulties, such as mental health issues, that resulted in them having some concerns about the future. Finally, a small number of families had made little, if any, progress and felt that the IFSS had been of limited use. In the following section we explore the key benefits that beneficiary families experienced in more detail.

Higher levels of confidence and motivation

- 6.25 **Increased levels of confidence and motivation were considered the key benefits of the IFSS programme for many of the beneficiary families taking part.** This often led to a snow-balling of positive effects as parents were better able to address their families' needs themselves (for example, by pushing to access services) and were motivated to work towards a more positive future (by attending further education courses with the intention to find work, for example). Below we have included an example. The participants' names have been changed to preserve their anonymity.

Creating a positive cycle of change

What was the situation before IFSS?

Julie had a long-term history of violent relationships. A partner who she had just broken up with created a situation which required social services to get involved and her two children were taken into care. Julie could not get on with her social worker who believed that she was taking drugs.

The violent relationship between Julie and her partner had a negative effect on the whole family, making Julie depressed and unable to function properly. The children were introverted and afraid, and Julie turned to them for support, causing them to withdraw from family life.

Things deteriorated further, when the children were taken into care, which caused Julie to lose her job.

The children's attendance at school also suffered and her son was being bullied.

The family's rented home caused further issues, with damp and cold leading to health problems. Housing became more of a problem when the children were removed, as Julie's housing benefit was cut, leading her into debt.

What kind of help did the family receive from IFSS?

The IFSS practitioner supported Julie in getting her children back out of care. He achieved this by helping her to demonstrate that she was not taking drugs and by opening up the lines of communication between her and her social worker.

The practitioner also raised Julie's awareness of the problems within the family and helped her to develop her own solutions, leaving her feeling more "empowered". As a result of this support, Julie engaged with services offering support to victims of domestic abuse, which helped her to understand and recognise the signs when abuse is occurring.

The IFSS spearhead worker also referred Julie to a housing support service which helped her to get a grant for a new boiler and supported her in her application for Council housing. This service referred her to the CAB, which helped her to better manage her finances.

How has IFSS helped?

Julie's mental health has improved to the point where she is no longer on anti-depressants. She is feeling confident, energetic and motivated. She is also now in a happy non-abusive relationship and has had a baby with her new partner. The children are now back in her care, and her relationship with them has improved significantly. She has also been able to reassert her authority as a parent, leading to a more secure and structured environment for the children, which has increased their confidence.

The children now have a 100% attendance record at school and both received excellent school reports at the end of the last school year. They have also been able to make more friends at school and Julie believes that her son is no longer being bullied. In another positive development, they are also taking part in more extra-curricular activities.

The family have just moved into a Council house. This is nearer to their wider family who are now more able to support them with their baby. The new house is warm and well-maintained and they are already feeling the positive effects on their health.

The family's financial difficulties have not been fully resolved but are likely to improve in the future - they are paying back their housing debt, their rent is lower than previously and Julie is planning to find work in the near future.

Substance misuse issues

- 6.26 Most families believed that they had, or had previously had, on-going substance misuse issues before IFSS. In contrast, a minority believed that they had brief one-off problems as a result of a stressful time or incident, or had never had substance misuse issues.

6.27 Many of the participating parents reported overcoming or experiencing a marked improvement in their dependency on alcohol and drugs as a result of the IFSS programme. This had endured post-IFSS, although it is unclear how this issue will play out for some beneficiaries in the longer-term. There are several key ways in which IFSS helped by:

- Enabling parents to resolve the issues that triggered their addictions (for example, for one family this meant getting an ADHD diagnosis for the son)
- Referring parents to wider support services aimed at combatting the addiction.

6.28 In a small number of cases, parents' substance misuse problems improved during IFSS but they relapsed after the completion of Phase 1 of the programme. Those experiencing a relapse often explained that the support they had received during the IFSS programme had helped them to understand why they had relapsed and to start to address the underlying problems that had caused the set-back. This is explored in the following case study.

The influence of substance abuse on families

What was the situation before IFSS?

Helen, a single mother and alcoholic, lived with her daughter (Kate, 14 years old). Their relationship had deteriorated significantly as a result of Helen's alcohol abuse. Kate had anger issues and was occasionally violent towards her mother.

She also rarely attended school and Helen was unable to motivate her to go, despite her best efforts.

What kind of help did the family receive from IFSS?

The IFSS spearhead worker fast-tracked Helen onto a detox programme, with support from an alcohol support service that Helen had already used. During the detox Kate went to live with a foster family, where she has remained. The IFSS worker has also worked on rebuilding the relationship between Helen and Kate.

How has IFSS helped?

Helen successfully completed her detox and did not drink for several months. Living with foster parents provided Kate with some positive emotional distance from her mother and allowed the relationship between the two of them to improve. Kate also felt more confident and attended school, where she made new friends.

However, Helen experienced a relapse, and began drinking again. She attributed this down to

loneliness and guilt about the situation with Kate. She also commented that further face-to-face support from her IFSS spearhead worker at this time would have been more helpful than just phone calls.

Since Helen started drinking again the relationship between her and Kate has deteriorated – although it still remains better than in its pre-IFSS state. As a result, they are both finding it more difficult to implement the behaviours that their spearhead worker taught them. Kate is now likely to remain with her foster parents until the age of 16, rather than returning to live with Helen.

Helen is on the waiting list for another detox programme and plans to complete it this year. Having gone through one detox already she feels confident that she can complete the next one.

- 6.29 A significant number of families believed that they did not have addictions when they were referred into IFSS. For example, many parents argued that they had never had a drinking problem or had only had a problem on a single occasion or small number of occasions as a result of a particularly stressful experience(s). In most cases, IFST practitioners were reported to have agreed with parents' assessment of the situation while in one instance the IFST practitioner seemed to continue to disagree with the family, leading to a loss of trust between the two parties.

Mental health issues

- 6.30 Many of the families involved in the research had parents and/or children with mental health problems. For most parents, substance misuse has exacerbated their mental health problems. Many parents reported an overall improvement in their mental health and well-being as a result of the support provided within the IFSS programme. In some cases this issue appears to have improved significantly. For example, one mother with a long history of depression is now off anti-depressants for the first time in many years. In other cases it appears that their improved mental health is sustained with the help of appropriate medication.
- 6.31 There are several key ways in which IFSS has contributed to success in this area. These include the provision of counselling (provided either informally through the IFST practitioner or formally through IFSS referral to other services), supporting a reduction in alcohol consumption, goal-setting work to take medication, as well as an overall improvement in a family's situation.

- 6.32 The benefits to those individuals who had experienced an improvement in their mental health were numerous. Participants reported many changes in attitude, for example, increased confidence, increased motivation and an increased capacity to deal with problems. In many cases, wider family members had also benefitted – through better relationships and happier, better behaved children as the parent is better able to cope with the challenges facing the household.

Improved relationships

- 6.33 Many of the beneficiary families had a poor relationship with their social workers (if they had any) before the IFSS programme began. Some of the beneficiary families did not require any support from social workers after the completion of the programme. In other cases, families were able to establish a better working relationship with their social workers, leading to greater trust and better outcomes, although in a small number of cases relationships were poor both before and after IFSS.
- 6.34 One mother explained how her relationship with her social worker had broken down completely after her children had been taken into care. Her IFSS practitioner helped her to understand what the social worker was trying to achieve and how she could best meet her requirements for getting her children back. In another case, the IFSS practitioner was able to provide the family's social worker with detailed information about the family's situation which meant that the social worker had a much clearer understanding of the family and was able to work more effectively with them after Phase 1.
- 6.35 Many of the relationships between family members were poor before the IFSS programme began. In many cases, parents and children explained that they rarely spent time with each other (particularly when the children were old enough to be more independent) and often argued when they were together.
- 6.36 The IFSS programme often enabled improved relationships between family members. In the short term, many of the tools used by the IFST practitioners helped many family members to communicate more effectively and develop a shared understanding of each family member's problems and needs. For

example, some parents did not initially understand the effect that their own behaviour (such as substance misuse) was having on their children. In the longer term, the relationships between family members rarely improved unless key issues such as substance abuse, domestic violence or mental health issues had been reduced or resolved.

- 6.37 An improvement in family relationships usually led to an increase in the amount of time that family members spent with each other as well as to an increase in the activities that family members took part in together outside of the home. This, in turn, strengthened relationships further, and led to improved behaviour amongst the children. It seems that many IFST practitioners have been keen to generate this positive cycle, for example, by encouraging families to take part in activities with each other.

Other benefits of IFSS identified by the families

- 6.38 Through the discussions with IFSS families, a number of additional benefits derived from the programme were also identified. These are summarised below:
- Helping families to become more aware of their problems
 - Teaching family members techniques and strategies for managing stress, depression, anxiety and anger management issues
 - Helping families to work with other service providers on issues such as benefits, housing, debt and their children's schools
 - Helping families to manage their finances and find additional sources of income including employment support from charitable organisations and local government
 - Helping families to make and resolve complaints about other service providers
 - Helping parents to care for and discipline their children more effectively

- Working with schools to help children to increase their attendance rate, develop better relationships with other children and improve their academic results.

Views from beneficiary families on the barriers to success

6.39 **A small number of families claimed that they had not made any progress since they had first joined the IFSS programme.** A number of key barriers to IFSS success was identified by these families. These issues are explored below.

Quality of the IFSS intervention

6.40 Most of the families who took part in the interviews felt that **IFSS was of a very high standard and many struggled to think of areas where significant improvements could be made.** However, a small number of parents suggested that social workers or IFST practitioners could have provided more information about the IFSS programme at the initial referral point and early stages of Phase 1. For example, some felt that a leaflet and/or a video could be provided, setting out additional information, while others suggested that a better handover could have been arranged between their current social worker and the IFSS practitioner.

6.41 Several parents explained that a lack of information had made them less willing to be referred to the programme, while others claimed that they were nervous and confused about the programme when it started and this made it harder for them to open up to the IFST practitioner during the early stages. A small number of parents explained that they were initially concerned that the IFST support would be quickly withdrawn. These initial concerns inevitably limited the progress that could be made within the timeframe of the programme.

6.42 **A significant proportion of families believed that the transition from Phase 1 to Phase 2 happened too soon** and before key problems within the family had been adequately resolved. Many of the families believed that this had resulted in them needing further support in terms of booster sessions or wider support from different agencies. A small number of families believed

that they might have made further progress if more support had been offered at this stage. For example, in one case a mother with long-term depression and anxiety received support from an external counselling service during Phase 1 of IFSS which led to an improvement in her mental health. However, this support ended once the mother completed Phase 1 of the programme and her practitioner was unable to organise a follow-up counselling service for her in Phase 2. The mother's mental health has since deteriorated and she is struggling to link in to the appropriate long-term services herself, via her GP. She was placed on a waiting list for further support but due to high levels of demand and capacity constraints within the wider service area, she was not able to access support.

- 6.43 Other suggested barriers included a lack of IFSS staff with specialist skills in the areas of mental health, autism, and dealing with children with complex health needs, and (in the case of a few families) a lack of staff continuity.

Access to wider services

- 6.44 A small number of families felt that the wider services on offer were not sufficient to meet their needs during IFSS and beyond. The areas where **families had the greatest problems accessing services were in mental health support and housing**. This may be as a result of these services having long waiting lists due to capacity issues and IFST practitioners being unable to prioritise IFSS beneficiary families above others who are in need of support. In addition, family members were often uncomfortable about asserting their needs when told that services were not available.
- 6.45 A small number of individuals felt overwhelmed by the number of services (including IFSS, social workers and wider services) that they were involved with. This led to a lack of clarity about the roles of the individual services and to some dissatisfaction about the way services were interrupting the family's day-to-day life.

Failure of individual family members to fully engage

- 6.46 Another reported barrier facing a small number of beneficiary families was the failure of families or individual family members to engage with the IFSS programme, or certain aspects of the programme.
- 6.47 Family members often stated that it had taken some time for them to build up levels of trust with their IFST worker. Additionally, it was claimed that initially it was difficult for a small number of families to accept support through the IFSS process as they did not like discussing their problems with others or they had suffered from poor experiences with social workers and other 'authority figures' in the past.
- 6.48 Similarly, a small number of families explained that they had initially believed that they could solve some of their problems without the support of their IFST practitioner. For example, one mother refused support for her alcohol misuse during Phase 1 of IFSS. In Phase 2 she decided to refer herself to an alcohol support service but realised retrospectively that it would have been much better to have addressed her problem sooner. It is likely that a lack of self-awareness and motivation prevented her from addressing the problem sooner.
- 6.49 In a small number of cases, individual family members refused to engage with the programme with the result that the IFST practitioner was only able to work with a few members of the family, thus undermining the family-based approach, leading to less successful outcomes.

Longer term challenges

- 6.50 A small number of parents explained that they still struggled with long-standing mental health or substance abuse issues that had not been fully addressed by the IFSS programme. It is worth noting this may be a reflection of the difficulties of resolving these problems rather than a failure on the part of IFSS. As a result, a small number of families reported that they had relapsed and others felt that they could easily relapse in the future. The key reasons that were identified for this included the following:

- The difficulty of treating some individual's issues
- The family member not accepting that they have a problem or being unwilling to confront it, leading to a refusal to engage with the support being offered
- The beneficiary engaging with the support offered but this was subsequently withdrawn before the issue was fully resolved and alternative support was not provided
- Challenging circumstances arising after Phase 1 of the programme which have made it more difficult for individuals to deal effectively with outstanding alcohol or mental health issues. One example is a mother whose sister died in a car crash during Phase 2 of the programme, which led to severe depression and an increase in her alcohol consumption.

Key points

6.51 The key points covered in this chapter were as follows:

- Case study visits to each of the three Phase one sites revealed strong and universal support for IFSS, based around its techniques and ways of working
- However, IFSS was perceived to have been less successful where families had chaotic lives and serious multiple issues to address at once. The timing of the intervention and the level of motivation within the family also appears to be very important
- Overall, the monitoring data from the WEMWBS, SDQ and Goal Attainment Scale scores provide support for there being a positive impact of the IFSS programme across all three sites, although this is based on small numbers
- The general trend with the GAS scores across the sites was the same, with an initial spike in progress observed after the initial intensive

period, followed by slower progress between one month and six months, and a second spike evident at the 12 month review stage

- Most of the families who were interviewed felt that they had benefitted from the support they had received through their participation on the programme
- Increased levels of confidence and motivation were considered the key benefits of IFSS for many of the beneficiary families taking part. In addition, many of the participating parents reported overcoming or experiencing a marked improvement in their dependency on alcohol and drugs as a result of IFSS (although some had relapsed)
- For most parents, substance misuse had exacerbated their mental health problems. Many reported an overall improvement in their mental health and well-being as a result of the support provided within the IFSS programme
- Improved relationships within the family and between the family and support services were also commonly reported
- When families did not think they had benefited, they most often related this to: lack of continuity of service; Phase 1 being too short; the IFST lacking specialist skills; gaps in wider service provision; and to some extent, family members not fully engaging. However, each issue was reported by fairly small numbers of families.

7: Conclusions and issues for consideration

- 7.1 This section of the report provides a summary of conclusions from an evaluation of the IFSS model, covering the period April 2012 through to March 2013. Specifically, it presents an overview of the main achievements made in each of the three Phase one sites during the third and final year of this phase, as well as remaining areas for improvement.
- 7.2 Overall, the main findings from year 3 reinforce many of the core issues and evaluation messages identified in the first and second interim reports.¹⁴

Conclusions

Key developments during the third and final year of Phase one

- 7.3 **The strategic and operational contexts for the three Phase one sites have changed significantly during the last 12 months.** This was predominantly as a result of the roll out of IFSS across the whole of Wales, which has created some disruption locally, not least with some IFST members leaving to take posts in the new teams and uncertainties about future local arrangements and funding beyond March 2014.
- 7.4 **The IFSTs at sites 1 and 3 have reduced in size significantly during the final year of this phase.** Over the same time period, the size of the IFST at Site 2 has remained unchanged. Although some skills and capacity has been lost from the sites as a result of the staff churn, **the remaining IFST workers have continued to develop and become increasingly experienced and expert in delivering IFSS.**
- 7.5 **IFSS Boards and Operational Groups have continued to meet and were seen as effective,** even though attendance has been mixed. In one case the Operational Group was put on hold as it was felt there were insufficient issues or interest to require it to meet now that the set up phase had passed. IFSS Board agendas have focused heavily on post Phase one funding and regional

¹⁴ Separate reports covering years 1 and 2 of the evaluation process have been published and can be accessed via the Welsh Government website: <http://wales.gov.uk/statistics-and-research/evaluation-integrated-family-support-service/?lang=en>

roll out strategic planning issues, with a reduced emphasis on day-to-day operational issues.

- 7.6 **Section 58 agreements have been developed in all three sites, but to date there has been no cause to use these as partners have generally bought into the IFSS model.** Indeed, the evidence suggests that operationally at least, partner awareness levels and commitment to IFSS has grown, mainly due to the relationship building work of the IFST members.
- 7.7 In year 3, the number of referrals to IFSS fell slightly compared to the volume recorded in year 2. However, **the monitoring data indicates that the quality of the referrals in year 3 has improved, as a larger proportion of these cases (92%) progressed to Phase 1.** This reflects improved awareness of and buy-in to the programme by referring Social Worker teams.
- 7.8 In two of the sites, **IFSTs had to operate a waiting list due to demand exceeding capacity**, although in one case this reflected a significant decline in the scale of the IFST. Waiting lists caused some frustrations given the importance of making a timely intervention. Cases were accepted on the basis of the most appropriate, predominantly in terms of the families' willingness or motivation to change, when capacity became available.
- 7.9 **There is a high degree of consistency in terms of the volume of cases recorded as being accepted onto Phase 1 of the IFSS programme (47-49 across the three Phase one sites) in year 3.** This consistency contrasts with the contextual data which shows a variation (645 – 2,435) in the number of registered Children in Need across the areas.
- 7.10 **The volume of cases accepted onto Phase 1 represents an increase in throughput of around 50% relative to performance in year 2.** This has been delivered with significantly smaller teams in two areas. It suggests that there may have been excess capacity at these two sites in previous years.
- 7.11 IFSTs in all sites have had to review when they accept cases and how many they can process at any one point in time. Some sites have moved towards practitioners having two cases at a time, with one finishing and one starting, to deal with demand. This approach seems to be working.

- 7.12 There is **continued variation and flexibility in how IFSS has been delivered across the Phase one sites**, although the general approach and ways of working are very similar. At Site 1 and Site 3, the intensive period usually lasted for six weeks, whereas at Site 2, it tended to be shorter at four weeks, although some work could be carried over to the first week of Phase 2.
- 7.13 In addition, **there have also been some structural changes to how the model is implemented**. For example, at Site 1, a new resource panel approach to referrals was introduced part-way through the year, and at Site 2 IFST workers were assigned to build networks in particular geographical areas. The sites have also sought to provide greater structure and clarity to wider services during Phase 2. At one of the sites, a phased reduction in IFST worker inputs has been introduced as part of wider efforts to help manage the transition from Phase 1 to 2.

Key successes and achievements

- 7.14 A considerable amount of evidence has been generated and analysed as part of this evaluation process. Taken in the round, it shows that **the IFSS approach appears to improve short-term outcomes for a good number of families**, as has been observed with similar intensive family support interventions implemented elsewhere.
- 7.15 The general trend with the Goal Attainment Scores across the sites was consistent, with an initial spike in progress after the initial intensive period, followed by slower progress between one month and six months, and a second spike observed at the 12 month review stage. The extent to which these positive outcomes will persist into the future is unknown currently, but it will be interesting to explore this over the coming years.
- 7.16 **The programme is perceived to have worked well for certain types of families, although for others the story has been a less positive one**. There was a broad consensus among the IFSTs about who should receive IFSS and for which types of family the approach worked best. Although only one site has sought to document this, all three IFSTs used broadly similar

phrases around: **crisis point; the importance of timing; and the motivation to engage or change their behaviours.**

- 7.17 Across the three Phase one sites (amongst IFST staff, IFSS Board and Operational Group members, as well as referring social worker teams) there was almost **universal support and praise for the programme. In particular, the tools and techniques, and multi-agency style of delivery used were seen as being highly effective.**
- 7.18 **Most of the families interviewed felt the IFSS programme had been largely successful.** In the majority of cases, families explained that a number of the issues they had faced such as substance misuse, acute mental health problems, problems with parenting, housing, gaining employment, children's truancy and problematic/abusive relationships had been either fully or partly resolved following their engagement with IFSS.
- 7.19 Similarly, most families **described IFSS as a considerable improvement on the support that they had previously received.** IFST practitioners were felt to be more willing to get to know families and were described as less judgemental than traditional social workers; something which has helped families to feel more comfortable about opening up and sharing their problems.
- 7.20 In addition to the reports of effective access to services, many parents talked about **feeling significantly more confident in their ability to manage their own problems and challenges in the future, and also now felt motivated to do so.**
- 7.21 They were also better able to understand some of the causes of the issues that they had experienced (including long-standing mental health problems, addictions and/or trauma as a result of difficult childhoods, bereavement or other past events). Most of the families taking part in the research believed that they were making progress (to differing extents) to overcome these problems through the support of their IFST practitioner and suitable referrals to additional support and counselling services. In the longer term, further

support may be needed to ensure that families with long standing difficulties are able to continue to manage well in the future.

Key areas for development going forwards

- 7.22 IFSS was perceived to have been **less successful where families had very chaotic lives and serious multiple issues to address at once**. The timing of the intervention and the level of motivation within the family also appears to be very important.

Issue 1 for consideration: as highlighted in the interim evaluation reports, the evidence suggests that IFSS appears to be an effective policy intervention for supporting families to move away from a potential 'crisis' or 'tipping point'. However, the programme may not really tackle the existing stock of families who have gone through a crisis in the past or whose lives are extremely chaotic and they are not motivated to turn things round. A different intervention, perhaps over a longer period and focussed on building motivation to change, may be required in order to engage families from this cohort and to make them receptive to IFSS-style support.

- 7.23 When families did not think they had benefited, they most often related this to: **lack of continuity of service; phase 1 being too short; the IFST lacking specialist skills; gaps in wider service provision; and to some extent, family members not fully engaging**. However, each issue was reported by fairly small numbers of families.

Issue 2 for consideration: the evidence suggests that for some cases the length of the programme is too short or the transition from Phase 1 to 2 is overly severe. An additional stage of support may be required after Phase 1, during which IFST work with the family continues but is gently tapered over time as part of a managed process. It is clear from the evaluation that it is difficult to generalise in terms of the needs of different families. However, it may be sensible to pilot this additional phase of the model and it would make sense to do this at the Phase one sites given that they have the most experience.

- 7.24 It is evident that **IFSS is only as good as the IFST workers who are delivering the intensive support to families**. The importance of having staff with the right experience, expertise and skills cannot and should not be underestimated. Professional judgements are required during all stages of the process.

Issue 3 for consideration: considerable learning and development has taken place over the last three years at the Phase one sites. The current IFSTs have built up their experience over time. However, at the start they relied heavily on the experience they brought from other fields. The need for newly recruited members to be similarly experienced is important alongside any IFSS training that they may be offered.

- 7.25 Some **uncertainty remains about how best to get most value out of the CSW role**. Concerns have been raised that the role is becoming increasingly focused on management and training activities, at the expense of research and case handling elements.

Issue 4 for consideration: whilst it is not problematic for CSWs to take on more IFST team management responsibility, it is essential that the balance of their activities is reviewed on a regular basis. It is imperative that the CSWs retain their professional credibility which comes from having a recognised caseload.

- 7.26 **IFSS is heavily reliant upon the volume and quality of the referrals that come through from the social worker teams**. Progress has been made in this area during year 3 but ongoing challenges remain.

Issue 5 for consideration: the evidence from the Phase one sites demonstrates how much resource must be invested in raising awareness of IFSS, building effective relationships with the social worker teams and wider partners (in order to embed IFSS tools and practices). Furthermore, given the significant level of staff churn seen across the referring social worker teams, there is likely to be an ongoing need for this work to continue into the future.

- 7.27 In terms of throughput, performance during last year with reduced capacity suggests that **IFST workers might be able to handle two cases at one time (where one is entering and one exiting the intensive phase)**.

Issue 6 for consideration: reflecting on the increased throughput with reduced capacity, there was support from across the sites to explore the option of IFST workers taking on two cases at any one point in time. The situation would need to be monitored carefully as some of the more complex cases or the work with larger families will require additional IFST worker time. It could be appropriate to pilot this approach at one of the Phase one sites.

- 7.28 Monitoring activity across the sites remains inconsistent.

Issue 7 for consideration: A more structured and systematic approach across all sites, in terms of monitoring, target setting and evaluation, would be beneficial and would aid strategic planning decisions. More specifically, the scale of the demand for IFSS intervention locally should be considered when funding and other decisions such as the size and shape of the IFSTs are taken. Additionally, beneficiaries should be tracked over time so that the sustainability of IFSS impacts can be assessed robustly.

Annex A: Background information on similar interventions

The Option 2 service

The Option 2 Intensive Family Preservation Service is a crisis intervention programme aimed at supporting those families where serious child protection concerns are related to parents' use of alcohol or drugs. It is an adapted version of an American model, called 'Homebuilders'. The Option 2 service was focused geographically on Cardiff and the Vale of Glamorgan, although different versions have emerged in other parts of the UK.

An adaptation of the Option 2 model, named 'Families First'¹⁵ was set-up in Middlesbrough in 2006 (see Woolfall et al. (2008)). Although the scheme was based on the Option 2 model, there were some important differences e.g. Families First was jointly funded from child and adult services, the service held case responsibility for families and included six social workers who had statutory responsibilities that enabled them to remove children from the family home if necessary. It did not operate a 24 hour service but offered out of hours support if that was needed. The initial intensive intervention lasted up to eight weeks with additional services available for up to four months, after which the case was transferred to mainstream provision.

As with IFSS, the Option 2 model uses a combination of Motivational Interviewing and Solution Focused counselling styles and techniques. These are delivered alongside a range of other therapeutic and innovative practical tools to help create positive changes for families and thereby reduce the need for children to enter care. Option 2 families appear to share many of the characteristics of IFSS beneficiaries, in that the family environments are often rather chaotic, with multiple problems evident, including, though not always, issues such as inter-generational abuse, low maternal self-esteem, as well as high levels of violence and poverty.

Referrals into Option 2 are triggered by a moment of family crisis when the children are at risk of removal or registration. The service often involves an

¹⁵ It should be noted that this is different to the Welsh Government Families First programme.

intensive but short phase - usually 4-6 weeks – of support. During this period the Option 2 worker is available 24 hours a day, seven days a week, and on average will spend c30 hours with a family.

After the referral stage, the Option 2 team makes contact with the family within a 24 hour period. The initial assessment phase is used to determine whether the family is actually in a crisis and is ready to change. At the same time, the risks within the family are explored and decisions are taken in relation to what immediate steps can be taken to address these. A safety plan is also produced to ensure the children are not placed at unacceptable levels of risk.

During the next stage of the work, the therapist identifies the main positive aspects of the family unit and specific problems or barriers to change are tackled. As the therapeutic work continues, goals for the future are established. This stage draws on techniques used in Brief Solution Focused Therapy, and sets a limited number of achievable goals for the family members to work towards. This stage could involve support with regards to anger management, relaxation and time management skills etc.

In the final stage of the Option 2 service, families are encouraged to practice their new skills, and linkages are established with wider service provision in order to help them to maintain their progress. At this point in the process, the therapist withdraws from the family, although monitoring continues over the next 12 months. As with IFSS, during this stage, families are able to access a 'booster session' if things are not going well e.g. there is a relapse or another crisis.

An evaluation of the Option 2 model was conducted by Forrester et al in 2012¹⁶. The main conclusions from the evaluation were positive in terms of the impact of the service on improving family outcomes. Specifically, it was reported that the Option 2 model significantly reduces the need for children to

¹⁶ Forrester, D.; Holland, S.; Williams, A, and Copello, A. (2012) 'An Evaluation of the Option 2 Intensive Family Preservation Service' March 2013. Available at: http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0095.pdf

enter into care, is likely to generate substantial cost savings for local authorities and other social care, health and criminal justice agencies, and overall, helps to improve family well-being and parental welfare.

Reclaiming Social Work

The Reclaiming Social Work (RSW) approach was designed by Steve Goodman and Isabelle Trowler. It was originally implemented in the London Borough of Hackney and was initiated in 2007. The so-called 'Hackney' model is based on the establishment of social work 'units' comprising multiple social workers and clinical workers. Importantly, the social workers operate within a small multi-skilled team, thereby creating an environment in which more than one professional to work with the child and his/her family. These teams comprise a consultant social worker (CSW), a social worker, a child practitioner, clinical therapist and an administrator.

Through a combination of different skill-sets and areas of expertise blended together within the units, it was envisaged that a shared understanding of and responsibility for cases would be established. Linked to this, the expectation was that these teams would be able to provide a better and more balanced service through mitigating the risk of over-dependence on single workers. However, within the model, the CSW retains overall responsibility for all cases, though the social worker or child practitioner can take the lead on cases where appropriate. Importantly, each family member is known to each member of the unit and direct work is undertaken by everyone as appropriate.

In many ways, some of the central themes of RSW (enable child-centred practice, use of a reflective approach to help in understanding, assessing and planning, achieving a balance between identifying the risks to the child and the strengths of the family, systemic practice in direct work with families, provision of early clinical intervention where appropriate) can be observed clearly within IFSS e.g. through the recruitment of IFST workers from different backgrounds, the adoption of the CSW role and routine use of reflective meetings.

The Reclaiming Social Work approach was evaluated by Cross et al in 2010¹⁷ and the overarching conclusion from the research was that the model had been very successful. For example, it was claimed that the number of looked after children fell dramatically over the course of Reclaiming Social Work. Additionally, the overall cost of children's social care in Hackney was reduced by c5% over the same period, which in part can be accounted for by the reduction in the number of looked after children, but also by a marked (55%) reduction in the number of staff days lost to sickness, by placement stability and by low numbers of children in residential care. The evaluation also found that social work units consistently worked better together in comparison to traditional social work teams.

Troubled Families

Over recent years there have been significant shifts across the UK policy landscape in relation to interventions designed to support families with complex needs. One of the most high profile policy developments was the launch of the 'Troubled Families' agenda in England.

The programme committed to work with local authorities and wider partners to help 120,000 troubled families in England turn their lives around by 2015. The primary focus was on supporting the children in these families to have the chance of a better life, as well as reducing the costs to the taxpayer. It was estimated that the cost to the public sector associated with the 120,000 Troubled Families across England would be in the order of £9 billion over the period 2010-2015 (£8 billion reactive spend, £1 billion targeted intervention).

Troubled families places the onus on local authorities to both identify troubled families within their area, and to create effective intervention strategies. While the families identified by local authorities as being 'troubled' will have been known to services before the initiative, the payment by results nature of

¹⁷ Reclaiming Social Work, London Borough of Hackney Children and Young People's Services, Part 1: Independent Evaluation, Part 2: Unpacking the complexity of frontline practice – an ethnographic approach, Steve Cross, Alison Hubbard and Eileen Munro (2010) available at: <http://www.safeguardingchildren.co.uk/files/sgc/Eileen%20Munro%20Review%20of%20the%20Hackney%20Model.pdf>

troubled families provides an opportunity for local authorities to rethink their approach to effective family intervention, including which partners they engage in delivering support to families.

Whilst local authorities have been encouraged to formulate their own approaches to working with troubled families, the Department for Communities and Local Government (2012) has established 'five key features of effective family intervention'¹⁸:

- *A dedicated worker, dedicated to the family.* Much of the success of family interventions are derived from the skills of individual workers, both in building an effective relationship with the family, and in encouraging other services to assist the family. Critically, the individual worker has the capacity to shape the opinion of the family on the whole family intervention service, and the extent to which they engage with the intervention.
- *Practical, 'hands on' support.* The provision of quick, practical support is a useful first step in building the relationship with a family. For instance, in providing beds or a washing machine to help make the children's lives more comfortable. This may also help to affirm the individual worker as being 'different' to other professionals that have worked with the family in the past.
- *A persistent, assertive, challenging approach.* Family intervention workers are seen as being very persistent and crucially, different in their approach to other forms of support. On some occasions, they are seen as a 'wake-up call' for the beneficiary family.
- *Considering the family as a whole.* Gathering the necessary intelligence and gaining a robust understanding of the family through observation and relationship building, as part of determining the best way forward for the *whole* family.
- *Common purpose and agreed action.* Ensuring professionals and agencies work collaboratively towards a common goal for the family. This helps to avoid circumstances whereby the family receives mixed messages from different service providers.

¹⁸ Department for Communities and Local Government (2012) 'Working with troubled families: A guide to the evidence and good practice'

An evaluation report¹⁹ by the National Centre for Social Research shows that intensive intervention to support and challenge troubled families can be effective in turning round their lives. It was claimed that a family receiving intensive support and challenge is twice as likely to stop anti-social behaviour as one not getting the intervention.

Summary

Table A-1 below provides an overview of the key features of the RSW, Troubled Families and Option 2 interventions.

Table A-0: Key RSW, Troubled Families and Option 2 features

	Reclaiming Social Work approach (Hackney model)	Troubled Families	Option 2
Objectives	Improving social service for children and families. Establishment of social work 'units' comprising multiple social workers and clinical workers who have a shared understanding of and responsibility for cases. Units will have the potential to provide a better and more balanced service through mitigating the risk of overdependence on single workers. ²⁰	The primary focus was on supporting the children in these families to have the chance of a better life, as well as reducing the costs to the taxpayer. <ul style="list-style-type: none"> • get children back into school • reduce youth crime and anti-social behaviour • put adults on a path back to work • reduce the high costs these families place on the public sector each year 	A crisis intervention programme aimed at supporting those families where serious child protection concerns are related to parents' use of alcohol or drugs. It focuses on immediate intervention. Families are seen within 24 hours of referral.
Target	Vulnerable children and families in Hackney. London.	120,000 troubled families in England turn their lives around by 2015.	Focused geographically on Cardiff and the Vale of Glamorgan, although different versions have emerged in other parts of the UK.
Deliverables	<ul style="list-style-type: none"> • child-centred practice • reflective approaches in 	<ul style="list-style-type: none"> • joining up local services • dealing with each family as a whole 	The Option 2 model uses a combination of Motivational Interviewing and Solution Focused

¹⁹ Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011, Department for Education, December 2011, available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184031/DFE-RR174.pdf

²⁰ <http://www.hackney.gov.uk/sw-community-social-work.htm>

	Reclaiming Social Work approach (Hackney model)	Troubled Families	Option 2
	<p>understanding, assessing and planning</p> <ul style="list-style-type: none"> balancing the risks to the child and the strengths of the family use of systemic practice in direct work with families early clinical intervention where appropriate 	<ul style="list-style-type: none"> a single key worker for each family for intensive working mix methods approach to support 	<p>counselling styles and techniques. These are delivered alongside a range of other therapeutic and innovative practical tools to help create positive changes for families and thereby reduce the need for children to enter care.</p>
Cost Savings	<p>The overall cost of children's social care in Hackney was reduced by c.5%. <i>Cross et al. (2010)</i>²¹</p>	<p>It was estimated that the following average savings per troubled family could be achieved:</p> <ul style="list-style-type: none"> Leicestershire: £25,740 per family. West Cheshire: £20,000 per family. Manchester: £32,600 per family. Wandsworth: £29,000 per family. <p><i>Department for Communities and Local Government (2013)</i>²²</p>	<p>Approximately £1500 per family, just in relation to public care. <i>Forrester et al. (2012)</i>²³</p>
Lessons	<ul style="list-style-type: none"> Multiagency working led to better communications between partnership agencies. Families described a sense of being listened to. More open and supportive structure helped staff with the emotional demands of the job and reduced staff costs 	<ul style="list-style-type: none"> Much of the success of family interventions are derived from the skills of individual workers, both in building an effective relationship with the family, and in encouraging other services to assist the family. The provision of quick, practical 	<ul style="list-style-type: none"> Providing support at the right time when it is needed. Achievable plans for families to work towards. Recognising strengths of the family. Workers building relationships with families to help them understand

²¹ Cross, S.; Hubbard, A. and Munro, E. (2010) 'Reclaiming social work: Independent Evaluation and Unpacking the complexity of frontline practice an ethnographic approach' Human Reliability Associates, London School of Economics. April 2010.

²² Department for Communities and Local Government (2013) 'The cost of troubled families'.

²³ Forrester, D.; Holland, S.; Williams, A, and Copello, A. (2012) 'An Evaluation of the Option 2 Intensive Family Preservation Service' March 2013

	Reclaiming Social Work approach (Hackney model)	Troubled Families	Option 2
	in retention and sickness.	<p>support is a useful first step in building the relationship with a family.</p> <ul style="list-style-type: none"> • A family should be considered as a whole. • Ensuring professionals and agencies work collaboratively towards a common goal for the family. 	their problems.

Source: Various, identified within the table

Further recommendations for family intervention

Aside from the work arising from troubled families, there have also been a number of recommendations arising from the LARC 4²⁴, the fourth round of the Local Authority Research Consortium, on effective multi agency working for families with complex needs. More specifically, five key lessons arising from the most recent and previous rounds of LARC research have been identified:

- Engaging children, young people and families as equal partners in the process. This is substantiated by the work of Maras²⁵ who in detailing an evaluation of multiagency approach working in Greenwich, noted the need for a family-led approach developed in collaboration with the parents
- Ensuring consistency of the lead professional support, which helped families and professionals to work better together
- Integrating all elements of the Common Assessment Framework process from holistic assessment Team Around the Child model and meetings, lead professional role, action planning and reviews
- Ensuring multi-agency working and information sharing which improved understanding of need and service provision

²⁴ Easton, C.; Featherstone, G.; Poet, H.; Aston, H.; Gee, G. and Durbin, B. (2012) 'Report for the Local Authority Research Consortium (LARC) Supporting families with complex needs: Findings from LARC4.' NFER.

²⁵ Maras, P.; Bradshaw, V.; Croft, C.; Gale, L. and Webb, J. (2008) 'Working with families with complex needs: A multi-agency approach'

- Developing a better understanding of children and young people's needs at the earliest possible stage.

Annex B: Approach to the beneficiary interviews

The insight into the needs, experiences and opinions of beneficiary families was developed through the use of in-depth family interviews. The interviews were designed to bring the families' IFSS experiences to life, thereby ensuring their views and experiences are at the heart of the evaluation and the report.

Rationale for using a qualitative approach to engaging families

Qualitative interviews allowed the research team to explore families' complex circumstances and experiences in-depth. Family members were encouraged to discuss the IFSS programme in detail and consider the impact it had on their lives.

The research team used discussion guides to structure the interviews to ensure the key relevant issues were covered and that interviews were broadly conducted in a consistent fashion. It is worth noting however that in reality, interviews were not always carried out consistently, largely due to the varied make-up and abilities of the family groups involved. The interviews were participant-led with family members being able to focus on the issues and concerns that most mattered to them.

The approach was flexible to work around the lives of families and allow most family members to take part, with younger children (aged over six) being encouraged to have their say.

Interpreting the qualitative research

Unlike quantitative surveys, qualitative exploration is not, by its nature, designed to yield findings which are statistically representative of all families participating in the IFSS programme. As such, we do not attempt to quantify or count findings. Qualitative research is instead, intended to be illustrative and to provide in-depth understanding around a subject. Therefore, claims cannot be made about the extent to which the conclusions may be generalised to all the beneficiary families or seen as representative of all families. Instead, findings should be viewed as representative of the broad

range of views given by families, with a focus on issues that were important to families and relevant to the evaluation.

The focus on families' own priorities meant that some family members may not have discussed particular issues in detail if they were not a priority for them. For example, mothers experiencing domestic abuse were sometimes less concerned about issues such as finding employment whilst they had more pressing problems in their lives. Hence whilst certain topics or needs may not have been a key focus of interviews, they may well still have been issues that affect families, though at that moment were not deemed important, relative to other concerns.

It is worth noting that many families were not involved in each of the three waves of the research. Attrition, or the loss of research participants is a challenge as longitudinal research progresses. In this instance, researchers found that some families were either not contactable for further participation, or simply unwilling to take part. As such, we cannot always comment on the totality of an individual families' experience. For example, families who were only interviewed in the first wave of the research were not able to discuss phase two and beyond, and those interviewed in waves 2 and 3 found it harder to recall the initial stages of the programme in detail, having not engaged in the research until these latter stages.

Reporting includes verbatim comments and case studies to illustrate certain key themes of case 'types'. These should not be interpreted as defining the views of all the families. Instead they give insight into how a particular issue or topic was addressed by that particular family or family member.

Approach

Beneficiary families were interviewed to increase understanding around the processes and outcomes of the programme, the family members' perceptions of the services provided for them, and their suggestions for improvements. The interviews took place over three waves from July 2012 – September 2013.

As with any project of this kind, there was some drop-off with families who had taken part in the initial interviews being unwilling or unable to take part in subsequent interviews. Where this occurred, attempts were made to replace each family with a new beneficiary family from the same cohort (who had joined the IFSS programme at a similar time).

The first set of interviews (wave 1) took place between July and October 2012. Most of the families had just completed Phase one of the programme, or were at the early stages of phase two. The interviews focussed on families' experiences and situation prior to the intervention, their experiences of the IFSS programme, and the impact that the programme was starting to have. In total 26 families were interviewed in wave one (nine in Site 1, nine in Site 2 and eight in Site 3).

The second set of interviews (wave 2) took place between April and July 2013. Most of the families had completed phase 2 of the IFSS programme at this point. These interviews focussed on the latter stages of the programme and how well the families were managing in their lives. The interviews also included some specific questions on the families' economic situation so we could explore the impact of the April 2013 benefit changes. In total, 22 families were interviewed in wave two (eight in Site 1, seven in Site 2 and seven in Site 3).

The third set of interviews (wave 3) took place during the summer 2013. These final interviews focused on a range of issues affecting families that had been identified in the previous two waves (such as substance misuse, mental health problems, domestic violence and parenting issues). Families were asked to consider how they were coping with regards to these issues, 'before, during and after' completing the IFSS programme. Families were also asked about other life experiences that could have had an impact on their wider well-being. In total, 13 families were interviewed in wave 3 (five in Site 1, four in Site 2, and four in Site 3).

All the first wave interviews took place in participants' homes. The interviews in the second and third waves took place in participants' homes or by

telephone. In general, the face-to-face interviews lasted between an hour and a half and three hours, and the telephone interviews lasted around an hour.

Efforts were made to involve as many members of the family as possible in these discussions. Where possible, the whole family was involved in an initial interview, and family members were brought back together towards the end of the interview. The middle stages were used to interview family members separately or in groups (such as a group of siblings or both parents together) to ensure that each family member had an opportunity to give his/her views without being unduly influenced by other members of the family. Children aged six and under were not interviewed.

The researchers also sought to interview members of the immediate family who did not live in the family home. In some cases, additional telephone interviews were used, while in others, additional family members came to the family home on the day of the interview. Those family members who were not interested in taking part were not interviewed. In many cases, their lack of interest and engagement related to the fact that they had limited involvement in the IFSS programme.

This report includes families who have had positive, mixed and negative experiences of IFSS. However, generalisations about the proportion of families experiencing different outcomes should be made with caution. While there was no evidence to suggest that a disproportionately high number of families with positive experiences were targeted through this process, the evaluation team did discover that families with more positive experiences were often particularly keen to talk about the IFSS programme and the progress that the family had made. This suggests that those with less positive experiences may have been less keen on taking part in the research process.