Process and outcome research on the Westminster Family Recovery Pathfinder

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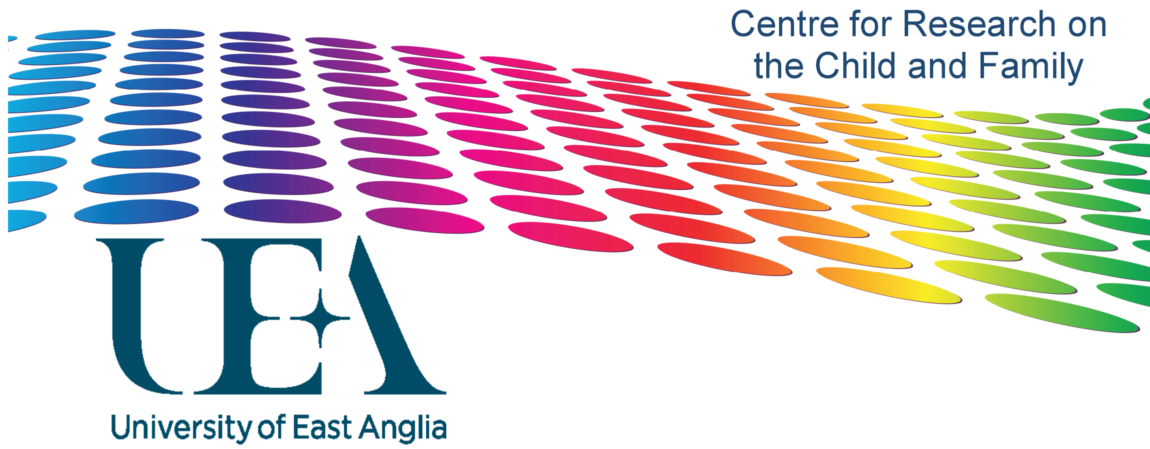
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Westminster Family Recovery Pathfinder and the Family Intervention Research Team

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Contents

1 The policy and research context ... 1
1.1 The policy context ... 1
1.2 Earlier ‘ whole family’ approaches to working families with multiple problems 2
1.3 Key characteristics of the Westminster Family Recovery Project ... 5
2 Research aims and methods ... 8
3 The FRP team ... 9
4 The Families ... 12
4.1 Demographic characteristics ... 12
4.2 Knowing the Men in FRP families. ... 18
4.3 Summary of family characteristics. ... 21
4.4 Issues and difficulties for the families ... 23
4.5 Summary of the characteristics and service needs of the families ... 29
5 The Services Provided ... 32
5.1 The referral stage ... 32
5.2 The Initial Team Around the Family (TAF) meeting ... 33
5.3 Agreeing the plan and signing the ‘care plan with consequences’ ... 43
5.4 The FRP approach to service provision and the characteristics of Phase 1 services ... 45
5.5 Case review, case closure and transitions ... 50
6 Evaluation of the services provided in small sample cases ... 53
6.1 Case aims and extent to which they were achieved ... 53
6.2 Conclusions about the impact of the FRP service on these families ... 55
6.3 Costs and benefits to FRP, Westminster Children’s services and longer term services across WCC and beyond ... 57
7 Summary and Conclusions: The place of FRP in service provision for vulnerable families in Westminster ... 64
7.1 Did FRP reach the families it intended to reach? ... 65
7.2 Did the provision of an FRP service succeed in alleviating identified difficulties? ... 65
7.3 Was the provision of an FRP service associated with improved well-being for adults and children in the families? ... 65
7.4 What are the characteristics of families with whom the FRP approach appears to be most successful? ... 66
7.5 What is it about the approach and practice of FRP professionals that is associated with more successful outcomes? ... 67
7.6 What aspects of FRP practice can be ‘mainstreamed’? ... 70
8 Reflections, hypotheses for discussion and recommendations ... 70

References

Appendix 1 Researcher rating protocols
Appendix 2 methodology and detailed report on analysis of costs and benefits

1. The policy and research context

1.1 The policy context

The emphasis on 'early intervention' and 'whole family' approaches that was central to the child and family policy of the previous government have continued to be cornerstones of the coalition government approach to services for vulnerable children and families. Such policies include early intervention to support families with young children, and also the provision of comprehensive, multi-agency and intensive services to children of all ages and their families when serious and complex difficult are recognised and pose a threat to the short and/or long term wellbeing of the children and their parents. This research focuses on the second of these. In 2008, in response to the recommendations of the inter-departmental report *Aiming High for Children: Supporting Families* (DCSF, 2007)*,* £13m was made available for a pathfinder programme 'to test ways of providing more effective support to families at risk' Fifteen 'pathfinder think family' projects were identified following a competitive tendering process (DfE, 2010a). These received a substantial grant from DCSF supplemented by contributions (financial or through staff secondments) from across local agencies providing universal or 'targeted' services to vulnerable children and adults. A national evaluation of these 15 was commissioned (Kendall et al., 2010, York Consulting, 2011) but the Westminster City Council Children's Services senior managers considered it important to commission a more detailed process and outcome study of the first 2 years of the work of their *Family Recovery Project (FRP).*

The intention was that these 'families with multiple problems' pathfinders should build on the lessons from the earlier 'family intervention projects' (FIPs) (Nixon et al., 2006; Nixon et al., 2008, DfE, 2010b, National Center for Social research, 2011). Around the same time £13m was allocated between 2009 and 2011 as part of the *Youth Task Force Action Plan* (DCSF, 2008) to 20 Intensive Intervention Projects (IIPs) that further developed the work of the FIPs with the families of young people involved in delinquency or anti-social behaviour (Dixon et al., 2010; Flint et al., 2011). A *Think Family Toolkit,* comprising 8 'Guidance Notes' was provided by DCSF (2009a) for the successful teams, which by this stage also included pathfinders focusing specifically on households where there were young carers (also included in the York Consultancies evaluation), and others where the focus was on families experiencing long-term poverty.

The FIPs and the IIPs focused in the main on families in which older children and/or their parents were involved in crime and/or anti-social behaviour or families were at risk of eviction, and were often led by housing and crime reduction agencies rather than Children's Services departments. In that respect the Westminster FIP, as a project within Children's Services, differed from some of the others, and this facilitated the integration of the FIP team with the developing Family Recovery Project which was targeted at families with multiple problems whose children were in all age groups.

This report therefore focuses on just one of the DCSF-funded *Think Family* projects aimed at families with children of all ages, referred because of the complexity of their difficulties and because there was a risk of legal intervention that might result in children being significantly harmed or needing to come into care. In most of the cases provided with a

service, the Children's Services Department was the lead agency, but central to each was inter-agency collaboration and funding.

1.2 Earlier 'whole family' approaches to working with families with multiple problems

The long tradition in the UK and USA of 'whole family' approaches to service provision for families with complex problems is documented in the policy, research and social work practice literature. The terminology has changed since Philp (1963) and Philp and Timms (1962) in *The problem of the problem family* described the philosophy and methods of *Family Service Units,* which in many respects provided an early model for this new generation of family intervention projects. The term families with multiple problems came into use as less stigmatising than 'problem family' when the 1963 Children and Young Persons Act (and later the 1989 Children Act) emphasised the importance of family support services, and the necessity of providing assistance to the family before seeking a Care Order. More recently the terminology of 'problem family' (alongside other stigmatising terms such as 'NEETs' – not in employment, education or training) has re-appeared in the media and policy discourse (Garrett, 2007).

The early discourse underpinning whole family approaches was of 'prevention' - they aimed to prevent something negative from happening: initially in 1963 to prevent children from needing to come into care; then via Intermediate Treatment teams, to prevent offending and anti-social behaviour (1969 Children and Young Persons Act) and around the same time, to prevent child abuse. The more positive term 'family support' in the 1989 Act sought to redirect social services managers away from a narrow focus on child maltreatment and encouraged 're-focusing' on family support services (Tunstill et al, 2010). The Public Law Outline protocols have a similar aim of attempting to ensure that appropriate services have been offered before a care order is sought (Judiciary for England and Wales, 2008).

Much of the early development of practice approaches and therapy methods to go along with these policy directions happened in the USA, and was more likely to be led by psychologists working in clinical settings than by community-based social workers. In the 1980s and 90s intensive family preservation service agencies set up demonstration projects, mostly based on the 'Home-makers' service approach which had many of the characteristics of the 'intensive outreach' model of practice adopted by the FIPs. The 'model' family preservation programmes were even more intensive and involved a single highly qualified social worker, with back-up from a highly experienced social work team leader, being available on a 24/7 basis to no more than 4 families, for preferably no longer than four weeks. The approach most frequently used was a combination of cognitive behavioural, problem solving and ecological approaches. Solution focused therapy often figured and found its way over to the UK at around this time. When independent evaluations started to appear they questioned the very positive early accounts of the originators, and identified key characteristic associated with better outcomes. In particular, the very short duration and lack of preparation and follow up was considered a weakness in terms of maintaining progress once the service ended. These lessons were taken on board

when family preservation models were piloted in the UK (see Brandon and Connolly's 2006 evaluation of the NCH Action for Children *Families First* project*).*

The move was then towards the development of more structured and less intensive 'model' programmes using a social learning approach. The best known of these, developed respectively by psychologists in the USA and Australia, are the *Incredible Years Parent Training Programme* (Webster Stratton and Herbert, 1999) and the *Positive Parenting* (*Triple P*) programmes (Sanders et al., 2003). Manuals were developed for these programmes, most of which which aimed to modify the approach and improve the skills of parents of older children with challenging behaviour. These 'manualised' programmes were then 'licensed' for use by family and youth service agencies in the UK and other European countries, with the requirement that practitioners should undertake approved training and agency managers should ensure programme fidelity. These have now been adapted by the programme originators to the needs of a wider range of children and young people and their families. Whilst some of these are group-work programmes delivered in service centres, others (e.g. Triple P) can be delivered more flexibly in the family home.

In the early phases of the Cabinet Office's family programme, Utting and colleagues (2007) described four evaluated programmes, pointing to their strengths but also potential problem areas when applied to a wider range of families. Barlow and Schrader-Macmillan (2009) and Barlow and Scott (2010) have reported similarly. Lindsay et al. (2008 and 2011) report on their observational evaluation of three model parenting programmes being 'rolled out' in the UK. They found positive changes for the majority of participants but no significant differences in outcome between the three evaluated programmes (*Incredible years, Triple P and Strengthening Families, Strengthening Communities*). Given substantial differences between the form and content they conclude: ''it follows that other home-grown courses might be equally effective, and priority should be given to the search for and evaluation of alternatives' (Lindsay et al. 2008 p. 159).

The evidence for effectiveness of these programmes is strongest for families in the early stages of problem development (tier 1 or 2- universal or focused on vulnerable groups or communities service levels), but the evidence of effectiveness with families with complex problems where maltreatment has already occurred is weak (MacMillan et al., 2009). In awarding contracts for the *Think Family Pathfinders* the DCFF tender documents stated that priority would be given to local authorities proposing to draw from a list of evaluated programmes. This included those already referred to, and two which have been evaluated as 'promising' with families with complex problems - Multi-Systemic Therapy (MST) and Functional Family Therapy, both of which were in the process of being trialled and evaluated in the UK. The USA and Norwegian evaluations of MST (Henggeler et al., 2002) have found this short term intensive programme to be successful with children and young people with challenging behaviour. However, a systematic review of research (Littell, 2005, 2006; Littell et al., 2005) has questioned the robustness of the evidence and recent RCT evaluations in Ontario (Leschied and Cunningham, 2002) and Sweden (Sundell et al., 2008; Olsson et al., 2009) have found no significant difference between outcomes for the 'treatment' and the 'service as usual' groups, despite higher expenditure on MST services. These mixed results when model interventions developed in one jurisdiction are transferred across national boundaries, and sometimes with children and families with different or a wider range of problems, have prompted calls from their local evaluators for more research

and evaluations to learn about aspects of the 'service as usual' provisions that are associated with more effective outcomes. Whittaker (2009) and Garland et al. (2008) discuss approaches being adopted in the USA to identify the 'common elements' of these interventions so that they can be used in a wider range of community-based services.

The Family Intervention Pilots and the subsequent 'roll-out' programmes drew on the full range of these approaches, especially the intensive outreach work that characterised Home Builders and Intensive Family Preservation projects and the home-based Triple P programmes. A particular UK aspect, since a driver for the early FIPs was concern about 'nuisance neighbours' and anti-social behaviour and criminality by adults as well as children, was the centrality of combining positive approach to helping with clarity about the sanctions that would follow if behaviour did not improve (the 'care with consequences' approach). Garrett (2007) and Gregg (2010) provide critiques of these social policy trends and approaches to practice.

At the point that this evaluation of the Westminster FRP started, in addition to the extensive research and evaluation literature cited above, there was extensive evaluative research on UK social work and child protection practice (summarised in the 12 *Messages from Research* overviews - see especially DH, 1995; DH, 2001; Quinton, 2004; DCSF 2009b; Stein, 2009) and in Morris et al, 2008; Hughes, 2010, and Thoburn, 2010). The methodology and analysis of findings for this FRP evaluation were informed by these and also by the evaluations of the Family Intervention Projects (Nixon et al., 2006; Nixon et al., 2008; National Centre for Social Research, 2009, 2011; Dixon et al., 2010; Kendall et al., 2010) and of the Intensive Intervention Projects (Pawson et al, 2009) and the interim reports of the national evaluation of the 15 *Think Family* pathfinders (Kendall et al., 2010, York Consulting, 2011). A recent literature review of evaluations of these programmes, together with a process and cost-benefit evaluation of the 20 Intensive Intervention projects working with teenagers with troublesome and challenging behaviour, is provided by Flint et al. (2011),

The early national evaluations of FiPs, which were cited in support of government plans to move beyond the 'pilot' phase, focused on a limited range of problems and outcomes. Although it is clear that some of the families had complex problems of the sort that the FRP and the other *Think Family* pathfinders aim to work with, it appears that the range of family difficulties has been wide. Findings are not specific about the sorts of families the FiPs accept into the projects and those they succeed with, but it seems likely that those who did not engage or dropped out will be families with the most complex problems. Much of the national and international research on which the initiatives are based has focused specifically on work with families in which the major problem is the challenging behaviour of young people in their middle and teenage years. There is therefore still much to learn about how the approaches, and specific interventions and programmes recommended by DCSF, can be used to best effect with families with complex problems, including those where there are child protection concerns or children are 'on the edge of care'.

1.3 Key characteristics of the Westminster Family Recovery Pathfinder[1]

As required by the tendering process (DCSF, 2008-2009), the Westminster FRP took on board some of the lessons from the evaluations of the Family Intervention projects, but also made important changes to better meet the needs of the target group of families with complex and multiple problems (Local Government Leadership and City of Westminster, 2010). Key characteristics for the *Think Family* pathfinders, mostly carried over from the pilot FIPs (one of which was a Westminster City Council service) were:

- The teams should be multidisciplinary (including members from adult health and social services, housing providers, and crime prevention teams as well as children's services education and social care professionals and neighbourhood and voluntary sectors organisations).
- Within the overarching principle of the welfare of the children being paramount, services are provided to any family members according to the identified needs and problems.
- The major roles in day-to-day work with the family are held by one and sometimes two 'intensive outreach workers' (IOW), FRP team members who usually hold the 'lead professional' role for parents. This work is modelled on the intensive outreach role developed by the FIP teams but with characteristics reported to be effective in earlier work in the USA and the UK (see 1.2 above).
- Families are offered a 'think family' service following a whole family assessment broadly based on the Common Assessment Framework (CAF) guidance.
- The service is mainly provided in the family home or within the local community rather than in a 'clinical' or 'group-work' settings, based on a phased approach to priorities jointly agreed between the lead professionals and the parents, whose consent to the sharing of information and to an outline case plan has to be obtained before work can start.
- Central to the approach followed by the pilot FIPs and the FRP pathfinder is agreement with the family about changes needed within agreed time scales. Case plans agreed at the start of the work spell out the 'rewards' (better housing; the removal of an ASBO for example) and the consequences if these aims are not achieved (eviction, prosecution for non-school attendance or an application for a care order for example) (the 'carrot and stick' or 'care with consequences' approach) (Pawson et al, 2005).
- A 'solution focussed' approach to service provision was recommended 'identifying the family's strengths and agreeing actions through a 'contract' between the key worker and the family' ('The Common Assessment Framework and Think Family Pathfinders' (DCSF, 2009c).

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[1] Where percentages are used in the text they are usually rounded to the nearest whole percentage point. Any names used in case examples are not the actual names and some details have been changed to protect confidentiality.

The tender document also listed specific model programmes that should be part of the packages of services made available to families. The FRP team took on board most of these principles (already established through their FIP pilot), adapted them to the particular needs of families with multiple and complex problems, and settled into ways of working which evolved during the first year, key characteristics of which were:

- Building up and maintaining a cohesive core multidisciplinary team. Throughout the evaluation period the head of service, service manager and the two deputy service manager have been registered social workers, each of whom had worked in a range of statutory social work and management roles with vulnerable children and families. The professional ethos of the team is a social work one, but with a strong commitment to and respect for the other professional disciplines whose contribution is recognised as essential to the provision of a whole family service. These professionals (some directly employed, others seconded) bring to the team their expertise, and agency links from, adult mental health, domestic abuse services, drugs and alcohol services, youth services, youth and adult criminal justice services, health visiting, education support, employment support, housing and welfare rights.
- Also essential to the service model developed are the seconded members of the police service and the information analysts who collect and collate detailed information on each family agreeing to accept a FRP service and the sharing of confidential information on a 'need to know basis' to the members of the team around their family and their case supervisors.
- For the majority of families a relationship-based casework service is led by one of the IOW, of whom there are around eight at any one time, who bring to the role a range of professional and practice backgrounds and relevant life experience. Depending on the circumstances of each family, the specialist team members either provide advice and specialist knowledge to the IOWs or work directly with family members on a particular aspect of the care plan. They also have a key role in helping family members to access services provided by their non FRP colleagues, or linking the IOWs to the relevant colleague in their 'home' agency.
- The core FRP team members work with changing networks or 'teams around the family' (TAFs), whose composition varies according to the needs of each family. In some cases the team comprises mainly FRP workers, in others the FRP team members are in a minority but case co-ordination is always provided by a FRP service manager.
- Once a referral has been screened for appropriateness and prioritisation, the IOW who will be the lead professional if the parents decide to accept the offer of a service meets parents in their home to answer their questions and, if they are interested in accepting the service, gain their agreement to the sharing of relevant confidential information about all family members.

- Regular (usually six-weekly) team around the family (TAF) meetings are chaired by an FRP service manager. For the early part of the evaluation, the supervision of the FRP workers for a specific family was not always provided by the manager chairing the TAF meetings for that family. Towards the end of the period this changed, and casework supervision to the IOW and other FRP staff working with a particular family is provided by the service manager chairing the TAF meetings. Initial TAF meetings differ from Initial Child Protection Conferences in that family members are only invited to meet agreed TAF members at the end of the meeting. In fact very few attend these initial meetings and the usual practice is for the IOW to visit shortly afterwards to discuss the suggested care plan. Parents and older children are encouraged to attend TAF review meetings and this happened in just over half of the cases (and most of those with the more successful outcomes).
- A characteristic of FRP work (shared with only a minority of the other *Think Family* pathfinders), is that the initial TAF identifies two lead professionals. The lead professional for the parent/s/ (or for the family as a whole) is an FRP team member. The lead professional for the child(ren) is usually a Children's Services child protection or locality team member. When the problems mainly revolve around an older child, the lead professional for the child may be a specialist education or youth justice worker. Given the nature of the problems on which FRP focuses, it is anticipated that in most cases continuing support and/or monitoring will be needed from locality services or 'targeted' support or protection services after FRP case closure. Having community-based professionals within the team around the family is a positive way of ensuring continuity, especially as in many cases these professionals have been involved at the referral stage and have helped family members to decide whether the FRP service is one with which they are willing to engage.
- Another key aspect is that the case plan is in phases, with the issues causing immediate concern to family members and referrers tackled first. These are often (for family members) practical issues around health, benefits, immigration, school or housing problems or (for the referrer) child or adult protection issues or imminent risk of a formal child protection referral, or an application for a care order. At the initial TAF, the aim is to reduce the number of professionals actually visiting the family, although others may remain as members of the TAF or arrangements are made to ensure they are kept informed of progress. These may take up a more active role during later phases of the work, when immediate problems have been alleviated.

Further information about the approach and financing from the perspective of the programme originators is contained in a joint report by Local Government Leadership and City of Westminster (2010). This report provides outcome data with respect to the first 50 closed cases.

2. Research aims and methods

This is both an ***evaluative*** study (is the work of the team effective? is it more effective with some sorts of families and in some circumstances than others? does it make good use of scarce resources?); and a ***process*** (descriptive) study (what are the components of the work that may be contributing to more or less successful outcomes?). This dual approach was necessary in order to better understand the key components of the processes and practice of the team and to assist with service planning at the end of the 'pathfinder' stage of the work.

In the initial phase, a review of DCSF and Westminster CC documentation on Family Intervention Projects (FIPs) and the 15 *Think Family* pathfinders (FRPs) was undertaken alongside earlier external and in house evaluation reports. These have been contextualised by reviewing the process and outcome research on work with families with complex problems, and on the specific interventions recommended by DCSF. There were initial discussions with Westminster senior managers and the FRP team leader about the objectives and practice models being developed. Documentation on training was available and assistance was provided on the use of the case recording system specific to FRP and getting to grips with data being routinely collected for practice purposes or for the national evaluations of FIPs and the *Think Family Pathfinders*. Ethical aspects of the research were agreed by the UEA social sciences research ethics committee.

In order to achieve the first of these objectives whilst keeping to a minimum the demands or evaluators on the time of FRP team members, the UEA researchers re-analysed the data collected for the national evaluation of the *Think Family* pathfinders commissioned by DfE (Kendall et al., 2010, York Consulting, 2011). A file data collection instrument was developed to assist the researchers in collecting additional information on the Westminster families. (For example, the national data set sought data on any mental health difficulties but did not specify whether this was with respect to the mental health of children or the adults in the family or both). This information, and well-being and change over time data available from the national evaluation was analysed with respect to the first 100 families accepted onto the projects. The research team also had access to Westminster children's services data on the families recorded on the ICS system, regular internal analyses of monitoring data prepared by the data intelligence team, a report on costs and reports on child protection cases and 'children on the edge of care' prepared by the Deputy Service Manager (Kemp. 2010, 2011). Basic data were also available on families referred but not accepted or who declined the offer of an FRP service.

These data on the full cohort of the first 100 families accepted for a service (between February 2009 and July 2010) were complemented by a detailed process analysis of the work with a purposive sample of 33 families (a one third sample), involving a detailed analysis of the records (including Children's Services records of services provided before and after FRP intervention) and (for 12 families) observation of a proportion of team around the family (TAF) meetings, and interviews with IOWs and FRP specialists. Opportunistic interviews were undertaken with one parent attending a TAF meeting and one parent after the FRP service ended. The focus for this part of the study was on exploring with team members the nature of the work and the strengths and pressures of working in this way.

An SPSS database for statistical input was constructed to allow us to expand the analytical potential from the exiting data sources. This quantitative element also forms a link into the economic analysis which built upon work undertaken within the FRP team. 'Researcher rating' protocols were developed for analysis (e.g. grouping types of families, levels of seriousness of problems; and patterns of service delivery; approaches to helping; and outcomes for parents and children. (See Appendix 1 for 'researcher rating' protocols.)

3. The FRP team

A 'snapshot' survey of the FRP team composition, skills and experience was undertaken in April 2010 via a short on-line survey. This yielded 21 responses.

The survey demonstrated that team members collectively bring to the work many years of experience, with a wide range of professional backgrounds and personal proficiencies being indicated. The respondents' mean age was 37 years (range, 24 to 56). Of the 21 survey respondents, 18 (86%) were female and 3 (14%) were male. Two thirds of the team self identified as white British or white European, with the remaining third formed of minority ethic groups. As anticipated the FRP team have a range of initial professional qualifications, with the most common professional background (N=6, 28%) being social work. Fifteen (70%) hold degrees. One person had started their first job in social care with FRP, but overall the average practice experience was 11.7 years (Standard Deviation 8.44).

Over 75% of the team indicated that they worked fulltime for the FRP, but almost 40% of respondents indicated they were agency or temporary employees. The FRP formed the primary agency for 11 (52%) respondents, with 8 (38%) indicating a joint identification with FIP and FRP: one indicated a primary agency of the Housing department and one the LA Children's Services department. Seven of the 21 respondents described themselves as 'seconded', one indicated they were 'informally loaned' and one described themselves as 'attached'.

Sixteen (76%) indicated they were line managed within FRP, with 4 (19%) indicating management through their primary agency. Professional supervision was provided fully by the FRP for 12 respondents (57%) with 3 (14%) indicating supervision through their primary agency and 6 (29%) stating that professional supervision was shared.

Within the survey, two free response questions asked about personal and professional skills with replies generating a large number of communication, relationship and supportive skills being identified, and an indication that these had developed through work or volunteering experience in many different service environments. It was not clear to us how much the team members were aware of and therefore able to benefit from the breadth of skills within the team and how this knowledge and know how was utilized in everyday work. The survey assisted the researchers in positioning the different professional members of the team which allowed us to make greater sense of the process of intervention, especially in the detailed case analysis. The survey data were complemented by individual interviews with IOWs and specialist workers.

During the process of the research, there was a move away from employing qualified social workers in the IOW role. There was considerable turnover - but also some continuity amongst IOWs and specialist staff. Team coherence appeared to be enhanced by continuity in the senior management team and the business support and intelligence analyst team members. Three of the four senior members of the team were in post for much of the time, but one of the deputy service manager posts was occupied by four different workers, There

was some evidence that progress for some families was impeded when there was both a change of service manager and of IOW, and this was especially the case if there were changes in the outside agency TAF members.

4. The Families

4.1 Demographic characteristics

Between October 2008 and the end of April 2011 306 families were referred to the project. Of these 135 (44 %) were offered and accepted a service, 167 (56%) were rejected or did not take up the service (with 4 cases still being screened) (Table 1).

Table 1 Referrals and services provided (number of families: full cohort).

Referral year	Referred	Service accepted	Completed
2009	174	67	9
2010	104	57	65
Jan- April 2011	28	11	18
Total	306	135	92

Of the 167 referred families who did not become involved with the FRP, 92 (55%) were not offered a service as they did not meet the threshold; 31 (19%) were offered a service but due to changes in circumstances did not take up or were unsuitable for intervention (e.g. moving out of borough); 23 (14%) were considered to be engaging well with existing services; 14 (8%) of families decided not to accept the service, and 3 (2%) families were referred but resided outside of council boundaries. Four families (2%) could not be offered services immediately due to team capacity despite reaching thresholds and were placed on 'waiting lists'.

As of 1 May 2011 the service to 92 families had ended, with 43 still open. Nine families had moved out of the borough. 20 families ended either because the family withdrew; the FRP team decided that it was inappropriate to continue with the service, or because an event occurred requiring statutory action incompatible with the continuation of the FRP work. For 54 families whose cases were closed by April 2011the final TAF meeting concluded that the intervention was 'successful' in that family and workers agreed that sufficient progress had been made for the family to manage without intensive FRP support (11 families) or with the support of other statutory or voluntary sector services (43 families). In three families this 'transition' intervention was specifically time limited. With respect to a small minority of the families in which a case had been closed, it was decided, with the agreement of family members, that FRP service was again appropriate, and also for a small minority of cases, a service was provided 'in their own right' to a son or daughter having problems after becoming parents and setting up their own households.

As noted above, the Family Recovery Project built on an earlier Family Intervention pilot project and for a short period the two 'projects' ran concurrently. It was decided that the model of practice developed for the FRP pilot would be used with FiP as well as FRP referrals but cases were 'tagged' as either FiP or FRP.

The first 100 cases coming through the FRP were identified as the research sample, 64 were FRP cases with 34 recorded as FIP cases. This was mainly because of different DfE reporting and evaluation requirements. Eight of the 33 intensive sample cases were 'FiP' cases; a further 2 started as FiP cases and were re-categorised as FRP cases, and 23 started

as FRP cases. Although the aims and approach to intervention were not distinguishable once the FRP team 'got into its stride', there were differences in the target group and the characteristics of the families accepted for a 'FiP' service and those accepted for an' FRP' service. The emphasis for the earlier FiP project was on providing a service in response to issues such as anti-social behaviour of parents or children, youth crime, inter-generational disadvantage and worklessness' (Dixon et al., 2010). The target group for the *Think Family* pathfinders was families with multiple and complex difficulties 'caught in a cycle of low achievement including those who are not being effectively engaged and supported by existing services' (DfE, 2010 Think Family Toolkit 5). As the project developed the FRP began to prioritise families where, complexity of difficulties was also linked with a high risk of statutory intervention by children's social care services because a child was in need of a protective service or 'on the edge of care'.

Tables 2 to 4 and figures 1-3 give details of the family composition, for the full sample where data were provided and otherwise for the intensive sample. Somewhat contrary to what was anticipated by those framing the policy, very young parents did not figure highly (table 2). The average age of mothers in the full cohort was 40 years, (SD. 8.85) with a range from 20 to 59 years. In the small sample, only 19% were aged under 25 (none under 18) and 41% were aged 40 or older (range 18 to 52). The DfE policy briefings anticipated that there would be more large families than in the general population and this proved to be the case. Looking only at the children of the 'main' parent/s 45% had had only 1 or 2 children, but 39% had had 4 or more children, although not all were still living in the household when the referral to FRP was made (table 3). Some adult 'children' had set up their own households; some were living with a separated parent or relative and a small number were in long term care, custody or adopted.

Table 2 'Main' parent/s at time of referral (full cohort) and age of main parent (mother's age if 2 parents)

Main parent	Main parent	Age group of main parent	Percentage (Small sample)
Biological mother or mother and male partner	96	18-24	19%
Biological father	2	25-39	41%
Guardian/ relative/social father	2	40+	41%

Table 3 Family composition at time of referral to FRP

Child/ren living with:	Number of families (full cohort)	Number of families (small sample)	
Both biological parents	64	13	20%
Single mother	19	8	25%
Single father	1	1	
Birth parent plus parent of one but not all resident children	6	2	
Birth parent plus partner not a parent of any resident child	7	7	22%
Relative/ guardian/ friend	3	1	

Table 4 Number of children of 'main' parent (full cohort)

Number of children	Number of families
1	11
2	34
3	16
4	20
5	11
6	3
7	5

Given that one of the reasons for acceptance of a referral was complexity, unsurprisingly family composition was varied (table 3), although 94 mothers were resident, with one usually resident but in hospital at the start of FRP intervention, four non resident but living locally, and one deceased. Therefore in over 90% of the families one or all of the children were living with their biological mother (as a single parent in 19% of the households). The complexity of family composition and the way in which the data are recorded for the national evaluation makes it difficult to be clear about the relationship to the children of a male member of the household for the full cohort. The data indicate that one or all of the children in 65% of families were living with their mother and the biological father. However, the more detailed analysis for the 33 small sample cases shows that this was the case for only 50% of these families. The biological mother lived in 30 of the households (as a single parent in 8); there was one single father household and one male guardian household and there were 9 families in which a male resident was not the biological father of all the children. In the full cohort, only one family was a single father family.

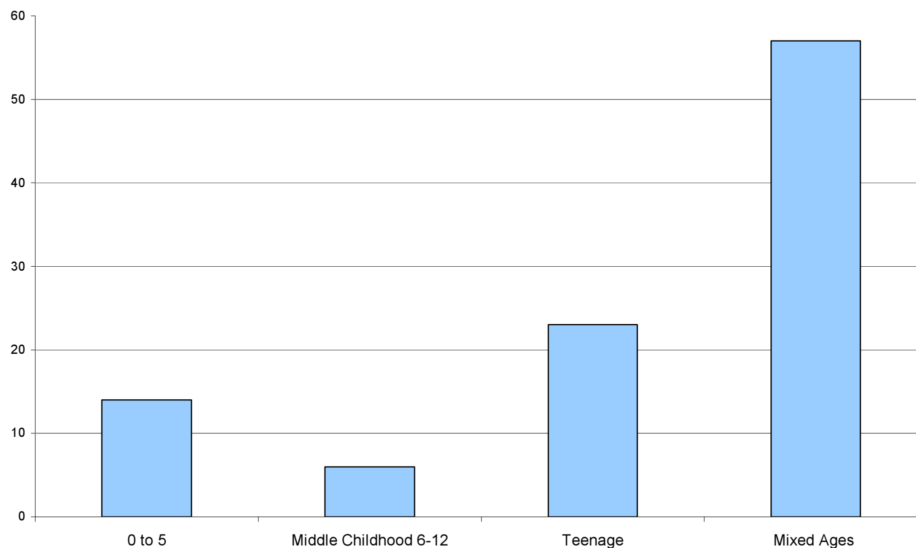


Figure 1 Number of families with age ranges of children (full cohort)

As Figure 1 shows the majority of families had children of different developmental stages, and relatively few families had young children only. Of all families 43 had 1-2 children, while 57 had three or more. Table 5 gives the ages of the children and shows that in several families there was an age gap, usually with the younger child having a different father to the older ones. In some of these families difficulties were experienced by just the older or just the younger children but in others all the children were experiencing difficulties, or severe problems with one was impacting on the parenting and wellbeing of the others. Table 6 gives the age of the youngest child and indicates that families with younger children were over-represented in the intensive sample and those with only teenagers were under-represented. This difference is explained by our wish to describe and analyse the work of FRP when the model of practice was well established, and therefore the intensive sample was weighted towards referrals in the later part of 2009 and 2010. It was hypothesised by the researchers that the characteristics of the families referred earlier and later might be different because of this change in aims. Table 7 shows that there were some differences in the ages of the earlier and later accepted cases. If divided into youngest child under or over 13, 18% of early referrals had no child under 13 compared with only 11% of later referrals: a difference which almost reaches statistical significance (chi-square: 3.239, df:1, p: .072). This difference reflects the increasing number of referrals of children with formal child protection plans, or as an alternative to a child protection plan. Table 8 shows a significant difference between earlier and later referrals in terms of the number of children, with more of the earlier referred families having 3 or more children. There was a similar (non significant) difference in terms of the age of the main parent with more of the parents in the earlier referred families being in the older age groups (clearly linked with having more children). These differences are congruent with the slight shift of emphasis of the FRP work from the earlier FiP aims.

Table 5 Age groups of children

Age grouping	Full cohort	Intensive sample	
All under 5	8	7	22%
All 5-12	6	2	
All 13+	29	7	22%
5-12 and 13+	28	11	34%
Under 5 and 5-12	11	2	
Under 5 and 13+	8	2	
All age groups	8	1	

Table 6 Age of youngest child (percentages)

Age of youngest child	Full cohort	Intensive sample
Under 5	32%	37%
5	39%	41%
13+	29%	22%

Table 7 Age groups by early and later referral date (full cohort)

Earlier or later referral	Youngest child 0- 4		Youngest 5-12		Youngest child 13+		Total	
Earlier referral	13	27%	17	35%	18	38%	48	100%
Later referral	19	36%	22	42%	11	21%	52	100%
Total	32	38%	39	33%	29	29%	100	100%

Table 8 Number of children by early and later referral date (full cohort)

Earlier or later referral	1-2 children		3+ children		Total	
Earlier referral	15	31%	33	69%	48	100%
Later referral	29	56%	23	44%	52	100%
Total	44	44%	56	56%	100	100%

Chi-square: 6.090, df: 1 p: <,05

In order to illustrate the number of families who are relatively large and with a mix of children's ages, the age of mothers at first birth was calculated. The average age of mothers at birth of their first child was 22.2 (S.D 5.58, with a range from 15 to 42 years). This is low compared with national figures, for example the average age at first birth for mothers was 24.8 in 1981, 26.7 in 2002 and 27.6 in 2009 (ONS Social Trends 34; ONS 2010). So the Mothers in the FRP are having children earlier than average, however when the ethnic diversity of these families is considered this sample may be considered to be conforming to minority ethnic group norms (Robson and Berthoud 2006) especially when it is recognised that there is also a number of intact parental relationships with large families, which may also be linked to ethnicity.

The average age of mothers at their most recent delivery was 32 (S.D. 6.35) with a range of 18-44years. The average number of children in the family network was 3.4, with an average of 2.74 children in the household at the time of referral. On average families in this sample were larger than community norms.

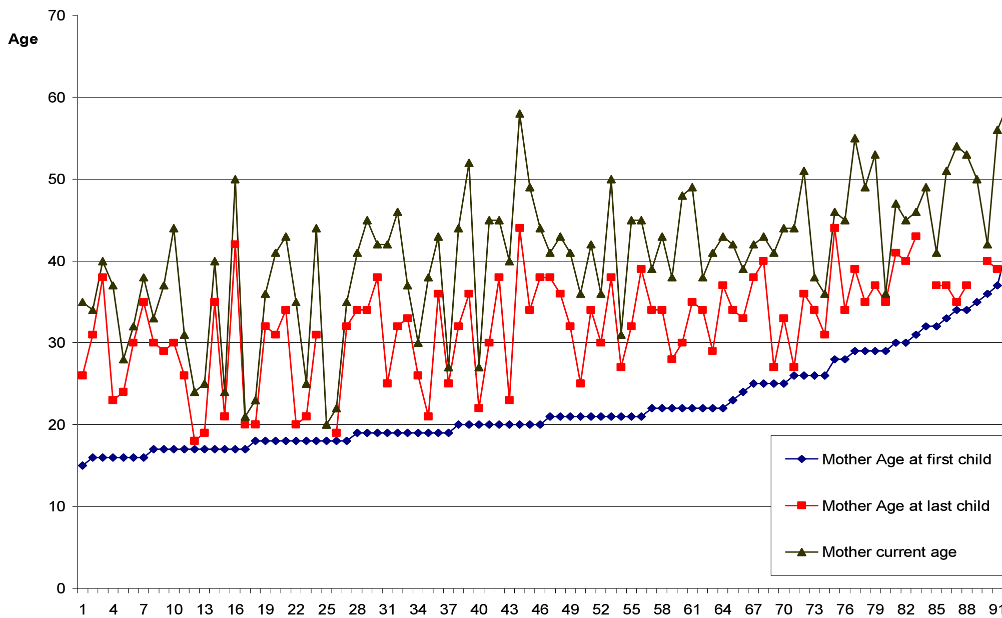


Figure 2 Age of mother at first birth, most recent birth and current age.

The average birth span for the sample (years between first and last birth) was 9.3 years (S.D. 6.1). Some young families will only have one child, and as shown in figure 3, a group of 49 women had a childbearing span of 10 years or more.

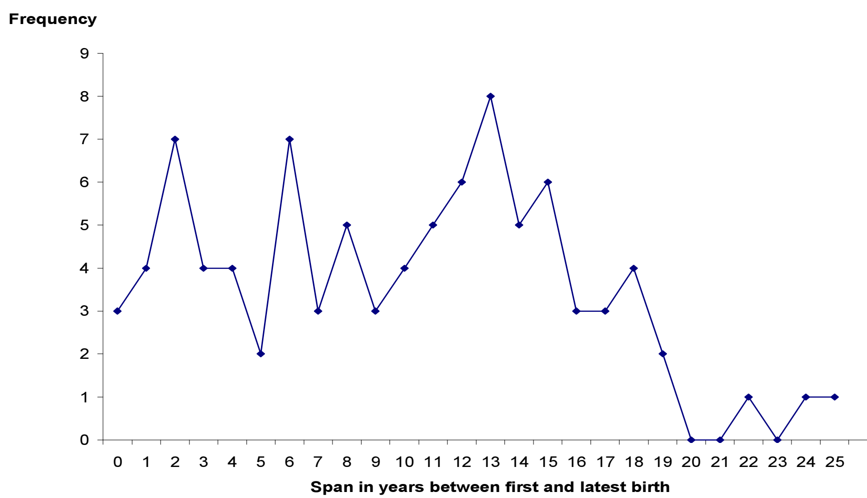


Figure 3 Birth span in years between first and latest child.

Ethnicity data were analysed only with respect to mothers as this was used as a 'proxy' for potential communication issues since she was the main focus of the work in the majority of cases. Of the 99 families with mothers, 26 mothers did not have ethnicity stated but, from

names and other records there were no indications of language issues and it has been assumed that most of these are white British, 22 were stated as white British and there were 25 self defined ethnicities in the remaining 51 families. Some descriptions indicated broad ethnic group (e.g. 'Arab'), others indicated nationality (eg Iranian, Somali) while others indicated a specific ethnic grouping (eg Iraqi Kurd). Of the mothers 20 were identified as having some difficulty in communicating in English, either by indicating the need for an interpreter or by indicting a limited range of English ability. With respect to the small sample, 15 families were of white UK heritage but there were cultural issues with respect to three of these. One mother was of European heritage and members of 15 families were of minority ethnicity, including 6 where culture differences from the local community were considered to be significant. In 6 cases an interpreter was needed for work with at least one parent.

4.2 Knowing about the men in FRP families.

For some time the position of men in families receiving 'targeted' child and family services has been recognised as problematic. In unpicking the complexities of parenting, gender and service provision Daniel and Taylor (1999) differentiated between the rhetoric in literature and the reality of working with men in practice. They considered that while the rhetoric encouraged work with fathers this enthusiasm was not shared in practice:

For decades the practice literature has espoused the importance of working with both men and women in a way as to actively encourage men to be more involved in the care of their children. The rhetoric therefore might suggest that there is a spirit of readiness for the place of fathers in society in general and in child care practice in particular. However, in both these realms there is evidence that the reality does not match such rhetoric. (Daniel and Taylor, 1999: 210)

Daniel and Taylor call for greater engagement with men in practice and attempt to delineate ways in which the aims of engagement may be specified. Along with others (e.g. Featherstone, 2001) they recognised that working with men created significant problematic issues especially in cases which included domestic violence and child protection concerns.

The first step to engaging and working with men is knowing about the position of men in families. Of the 100 families 75% were recorded as having a significant male figure within the family network. Of all the families, 24% had a resident biological father, with a further 20% of biological fathers living locally, 10 biological fathers were stated as address unknown, a further 12 fathers were known to reside at some distance, abroad, in prison or in hospital. In three cases the resident male had a 'social parent' role, and in 2 families the resident male was a biological father to at least one child in the household but not others. The level of knowledge about resident men was considerable, especially at initial TAF meetings and in intelligence reports prepared prior to these meetings. This level of knowledge was coded to establish the number of men who were relatively unknown to services. Criteria for the coding: 'good knowledge' about the men was linked to information on any man's name (and aliases) current whereabouts, address, recent

convictions/police contact, and an indication of attitudes to family/parenting. The category 'knowledge of men' included some missing material for example, known contact with police but unknown address.

Overall 11 families had no significant men identified in their network or from background intelligence. 59 families were coded as having 'good knowledge of men', 16 families were coded as having knowledge of all main men. Two families had male relatives abroad who were unknown, four families were recorded as having some peripheral unknown men, and 7 families had men who were unknown.

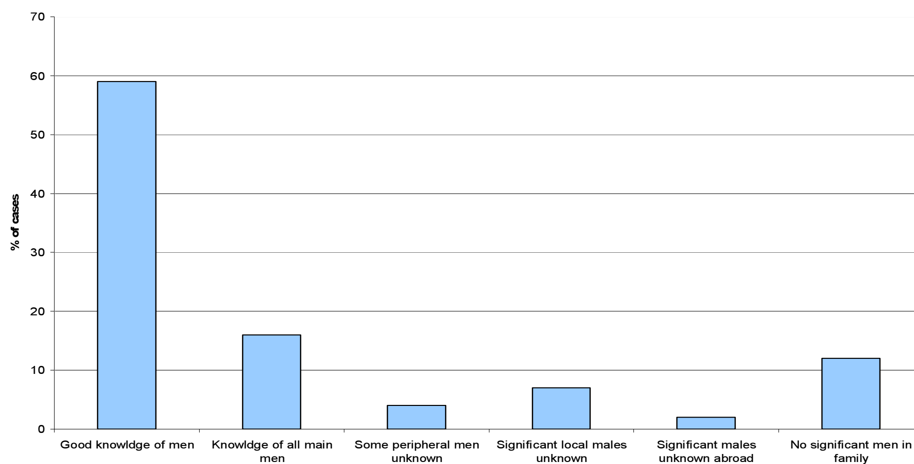


Figure 4 Knowledge of the men who may be relevant to family functioning

> ***Case Example 1.*** *Knowledge of men and engaging men in FRP work.*
> *Eleanor is a mother in her 30s with two children; one older and one younger adolescent. The biological father of both children is known to the FRP but his current address is not. The biological father was a perpetrator of domestic violence and this was a central cause of the relationship breakdown. This separation was followed by a partnership with Steve. Steve was also a domestic violence perpetrator and was involved in violent incidents outside of the home which led to imprisonment. He is now out of prison and living in the local area. There is information about Steve from the police records (such as convictions, attitudes he is said to hold, and also current address).*
> *Eleanor has a current partner, address unknown, but possibly spending some time living in the household at the time of the TAF meeting. Eleanor has mental health issues relating to anxiety and the youngest child is showing signs of anxiety within the home, where he is described as 'feeling unsafe' and also at school where his behaviour and academic performance are causes for concern. The name of the current partner is known, but there is little further detail, including his address. FRP work focused on the mother and children. Case notes occasionally mention the new partner, for example in relation to medical appointments and availability for meetings at the home. However his relationship with services, specifically FRP professionals is not noted or described. His relationship with the mother is also not explored in terms of potential support or possible risks. In the care plan the family strengths mention the mother's insight and desire to protect her children, but no mention of the current partner, or any links between family members and previous partners is made.*
> *This case example is suggestive of the risks and resource dilemma men pose.*

While there was good knowledge of the majority of the men whose behaviour and wellbeing may be relevant to family functioning and children's wellbeing, the tension remained as to how to provide and appropriate service to them. Edwards (1998) notes, absent fathers are regarded as irresponsible, but when present they may be seen as frustrating the needs of women. This is echoed by Featherstone (2001) who comments that the perception of fathers as 'resource' is balanced by the view of fathers as 'risks'. In dealing with this tension some cases had good knowledge of men but the research team could not ascertain how they were viewed, (see case example 1).

4.3 Summary of family characteristics.

Figure 5 illustrates the most usual characteristics of the FRP families

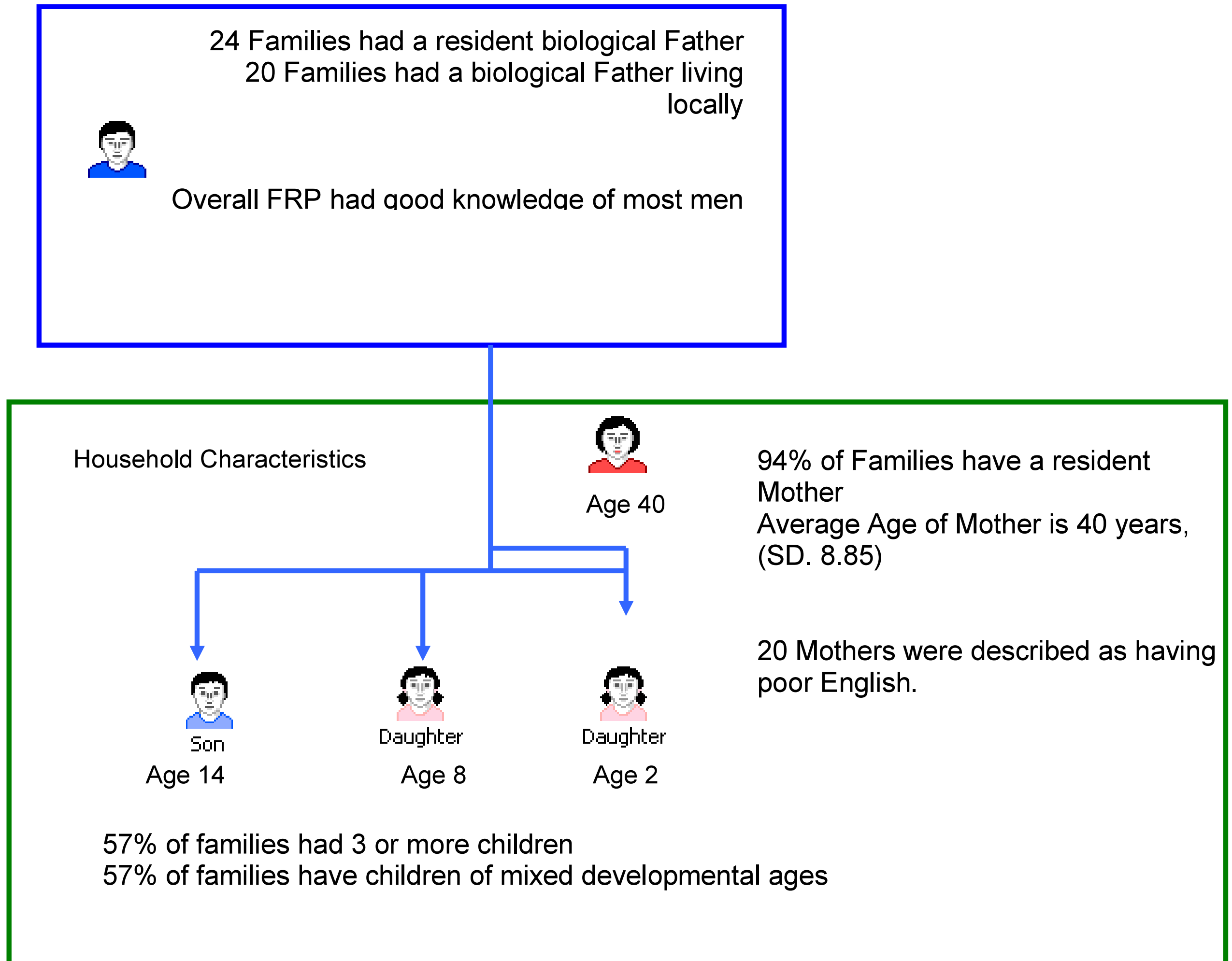


Figure 5 Representation of family demographic characteristics

Data from *Social Trends* (National Statistics, 2011) show that 25% of households with children were single parent households, a slightly higher proportion than the 23% for the full cohort of FRP families, indicating that single parent families are not over-represented amongst those receiving a service. The national report does not provide data on whether the two parent households comprised both biological parents and data do not provide information on the proportions living with two biological parents or in 'reconstituted' families. Large families are however, more likely to be amongst those receiving an FRP service than would be expected if referrals were representative of the total population (56% in the FRP cohort had three or more children compared with 28% of all families with dependent children).

Another relevant question is whether the families receiving an FRP service differ from those receiving a service from Westminster Children's Social Care as children assessed as vulnerable and having additional social care needs (Section 17, Children Act 1989), or referred because of child protection concerns. The *Children in Need* census (DfE, 2010c) does not collect this information at a national or local authority level, other than on the age, ethnicity and gender of the child receiving a service (i.e. at child level rather than household level) and aggregated data on families (as opposed to children) receiving an 'in need' or child protection service are not available from Westminster Children's Social Care. Ghate and Hazel (2003) found in their study of parenting in poor environments, that 39% of the over 14,000 households in their sample were single parent households (a higher proportion than for this study, and that a quarter of the households had three or more children (a lower proportion than in the FRP sample). This would indicate that, within disadvantaged populations, the FRP service is targeting families with more children, who are no more likely that the average to be single parent households. Turning to research studies that have reported on children referred for a family support or child protection service, Brandon et al. (1999) found that a broadly similar proportion of households in which the children were assessed as in need of a formal child protection service (26%) as in the smaller FRP sample (23%) had a 'main' parent under the age of 25, but that there was a higher proportion of single parent households in their child protection sample than in this FRP sample. A higher proportion in the child protection sample was living in reconstituted family households (16%) than was the case in the FRP sample (12%).

Turning to research samples of children referred for a family support or child protection service (the group most appropriately compared with the FRP sample which contained 'family support and child protection cases) a study of referrals to Children's services in a London borough (Thoburn et al. 2008) did not ask about household composition. However, the age of the child referred for a service (40% were aged 10+) was higher than for those receiving a child protection service in the Brandon et al. sample (only 25% were aged 12 or over), and closer to that for the 'youngest child' in the FRP sample (youngest child in 37% households was aged 10+).

In summary, in many respects the profile of families receiving a FRP service is similar to that of families living in poor environments, except that there were fewer single parent households. The service is weighted more towards families with slightly older parents and older children and larger family size than is the case for children receiving a formal child protection service, but families receiving the service appear to have broadly similar characteristics to a combined sample of those receiving a children's social care service either as families in need of support or in need of a formal child protection service.

4.4 Issues and difficulties for the families

The information available and recoded within the intelligence report and the initial TAF meeting formed the basis for coding the specific problems being experienced by individuals within the family. Coding for figures 4-8 and associated tables is based on the intelligence data and records on the full cohort of 100 cases. They do not include information obtained on the incidence of these problems as the case progressed.

While mental health, substance use and domestic violence were identified for many families, specific statements of 'no problems in this area' were rare. There were some cases where it was specifically stated that, for example a teenager had no record or evidence of drug use, but since such negative statements were rare, this report insofar as the full cohort is concerned (and the national evaluation, Kendall et al, 2010; York Consulting, 2011) may underestimate the incidence of these difficulties.

4.4.1 Mental Health

There was a high incidence of mental health problems, especially amongst the mothers. From the data provided to the national evaluators, there was a mental health issue for a child, parent or other member of the household in 47% of the 100 cohort cases. From analysis of the 100 cases in the full cohort even this high percentage may be an under-estimate. Figure 6 and table 9 show that almost 60% of mothers were reported to be experiencing some mental health difficulties, however in only 10 cases was there a confirmed medical diagnosis and associated medical intervention.

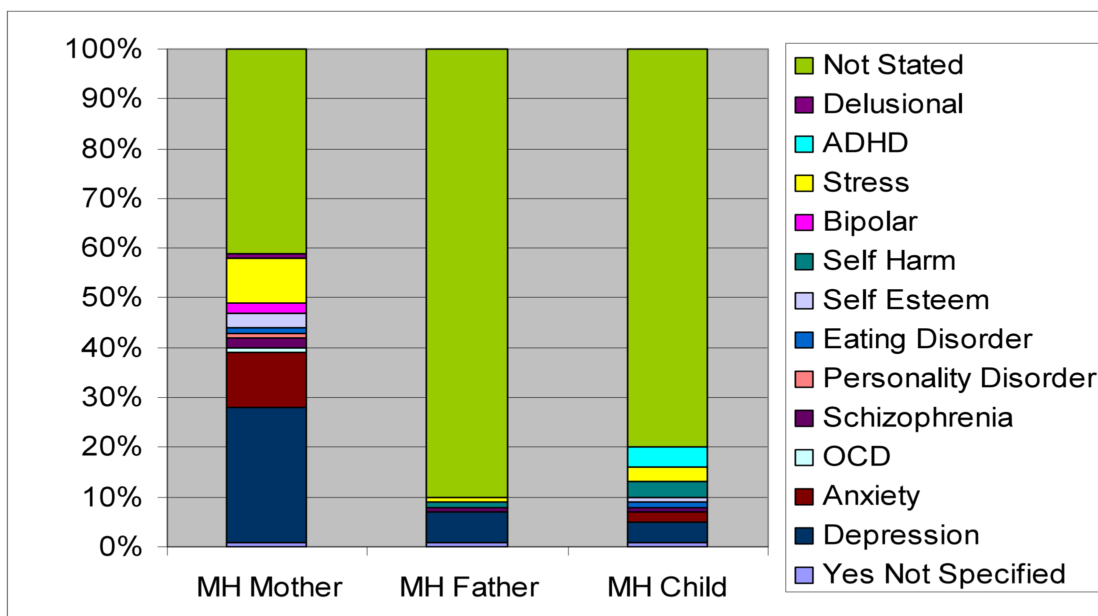


Figure 6 Mental health problems of mother, father and any child identified within the Intelligence Report or TAF minutes.

In the small sample, with respect to the mothers, table 9 and figure 6 indicate that 39% of the mothers had a mental health problem, although the more detailed analysis for these 33

small sample cases indicates that this was the case for 67%. For 5, the disturbance was of a psychotic nature, for 7 the problem was depression and for 8 it was stress-related. However, as will be seen in later sections, only in 3 of these cases was there a current psychiatric diagnosis and formal psychiatric supervision of treatment.

4.4.2 Substance Misuse

Figures 7 and 8 and tables 9 and 10 show the proportion of mothers, fathers and any children described as using alcohol or drugs. While alcohol use was recorded for more mothers than for fathers, this may be because the mothers were better known to workers and more often present in the household.

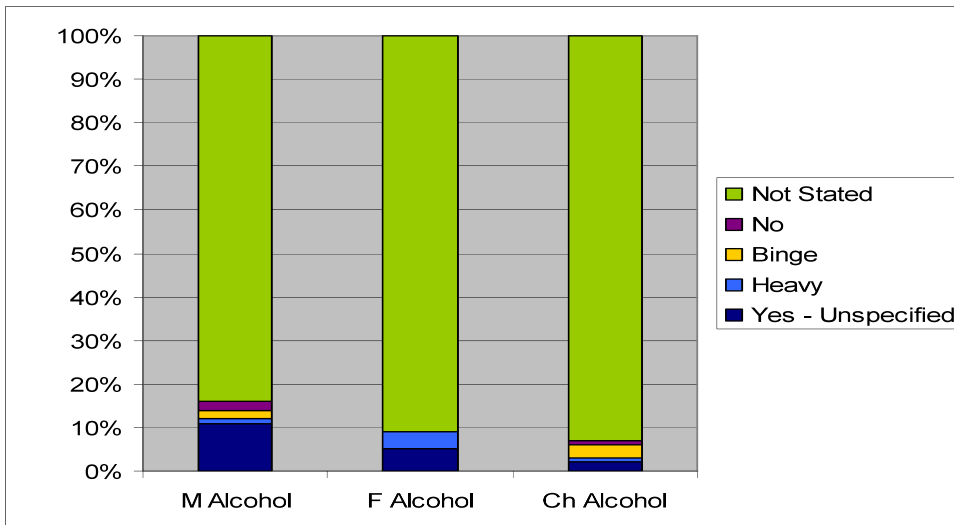


Figure 7 Alcohol use as reported in within the Intelligence Report of TAF minutes.

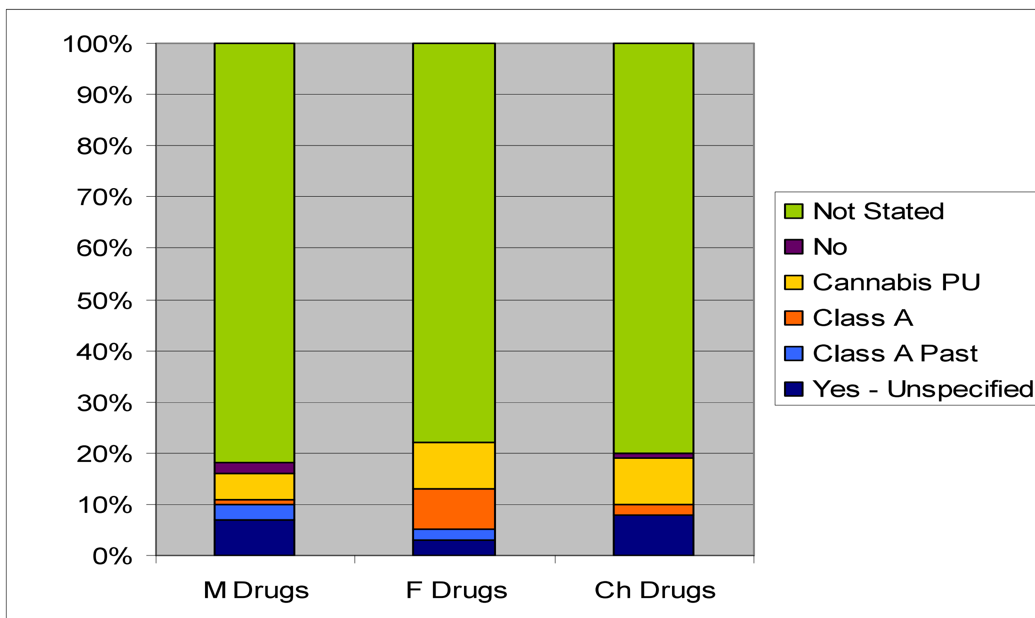


Figure 8 Drug use as reported in within the Intelligence Report or TAF minutes.

Crime and Disorder

As shown in figure 9 and tables 9 and 10, there was a high level of past or current criminal activity within the families.

Initially it was considered that only criminal convictions should be recorded, as in the national evaluation, However case notes indicated specific issues within families which had not led to criminal convictions (e.g. ‘ Father known to be violent and a risk to workers’) and also some evidence indicated criminal activity such as dealing drugs without evidence being confirmed. The proportions in figure 9 are therefore created from recorded criminal record (e.g. convictions for prostitution or assault) but also current concerns about criminal activities or behaviour.

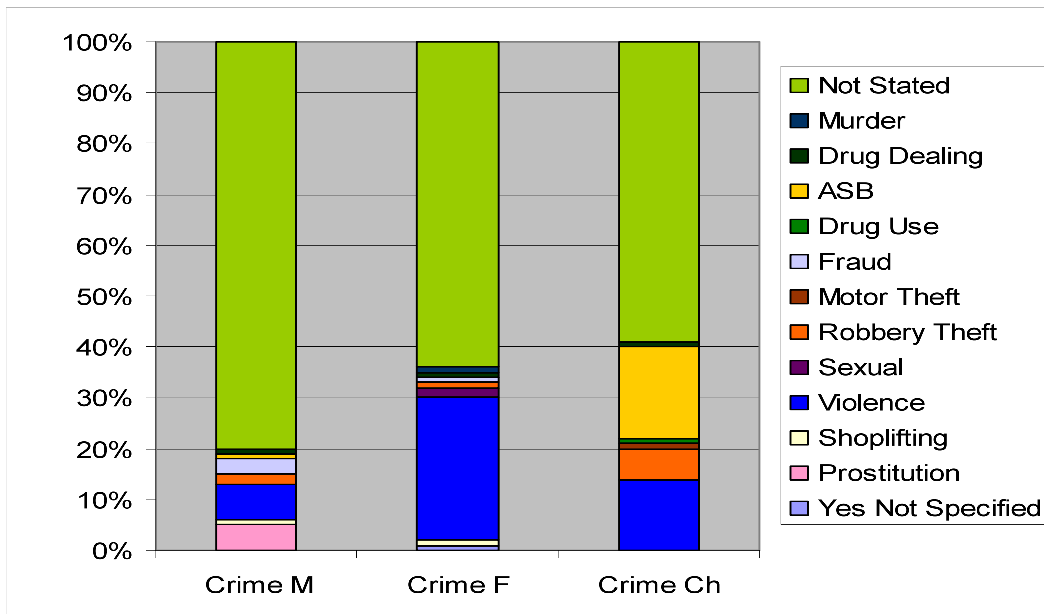


Figure 9 Criminal activity within the Intelligence Report or initial TAF minutes

As illustrated in figure 9 a large proportion of fathers (almost 30%) were known to be violent, either within or outside the family.

Table 9 Problems/ disabilities of parent/ carer in family (percentages where this problem recorded)

Problem/difficulty	Full cohort (female)	Full cohort (male)	Small sample (female)	Small sample (male)
Acute/chronic health problem			10%	9%
Problems alcohol use	14%	9%	16%	22%
Problem drugs use	18%	22%	25%	22%
Mental health problems	58%	10%	71%	21%
Criminality/ anti-social/nuisance behaviour	19%	35%	*	*

In the small sample there had at some time been police involvement in 75% of the families; action with respect to anti-social behaviour in 56% of the families and a criminal conviction with respect to a member of 53% of families. It was not always clear whether this was with respect to adults or young people. In addition, some criminal activities were of concern where evidence which would lead to a conviction was not apparent.

Table 10 Problems/ disabilities of any child/ young person in family

Problem/difficulty	Full cohort of 100 (%)	Small sample % (N=33)
Acute/chronic health problem(including obesity)		35%
Problems alcohol use	7%	3%
Problem drugs use	20%	22%
Mental health problems	20%	40%
Behaviour problems		54%
Criminality/ anti-social/nuisance behaviour	41%	28%
Problems around school attendance/conduct/attainment		63%

4.5 Issues with relationships, parenting and concerns about maltreatment

4.5.1 Domestic Violence

Of the 100 cases 31 were reported as having a current domestic violence issues, or a history of domestic violence which the family were still dealing with (17 in FRP with 14 in FIP cases). Although there was a number of mental health issues of the mother linked with DV circumstances, this association was not significant. The proportion for the small sample, where more detailed information was available was considerably higher at 66% (22 cases – 16 where there were concerns during FRP involvement and 6 where there had been earlier domestic abuse which may still be impacting on family relationships and functioning).

4.5.2 Parenting deficits and maltreatment

In the full data set on the first 100 cases, issues around parenting and parenting style were identified in 38% of cases and there were concerns about neglect in 35% of cases (usually overlapping with concerns about parenting deficits). Figure 10 shows that for the full cohort a child of one of the parents or parent figures had been on a Child Protection Register or the subject of a Child Protection Plan at some stage in a third of cases, and that in just under a third of cases at least one child in the family was subject to a CP plan at the time of referral or whilst the case was open to FRP. This can be compared to 13% of children with a child protection plan in all the Think Family pathfinders (York Consultancies, 2011), emphasising, that Westminster was amongst the small number of pathfinder authorities concentrating on the targeted group of families with complex and multiple problems where children were at risk of suffering harm or impairment to their development. However, these data were less complete than for the small sample cases so parenting and relationship issues and child protection concerns are reported more fully with respect to the 33 small sample cases. Table 11 shows that, although there were concerns that parenting deficits or intimate partner violence were having a serious impact on the wellbeing of at least one child in all except one family, the formal child protection system was used in only 11 of the small sample cases (33%) at the time of the referral or whilst the case was open to FRP. A child had been on the CP register or subject to a CP plan in the past in a further 8 cases- i.e. there had at some stage been formal child protection action with respect to a child of at least one parent in 18- 54% of the small sample cases). As will be noted in the section on services, in 22 of the 33 cases a Children's Services social worker was either the lead worker for the child (19 cases) or was a member of the team around the family (3 cases). However, in only 8 of these cases was a Westminster child protection team member involved as a key worker or member of the TAF.

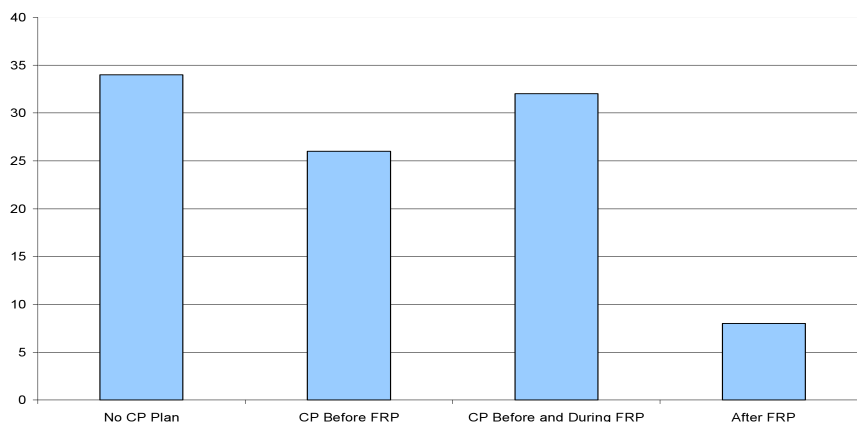
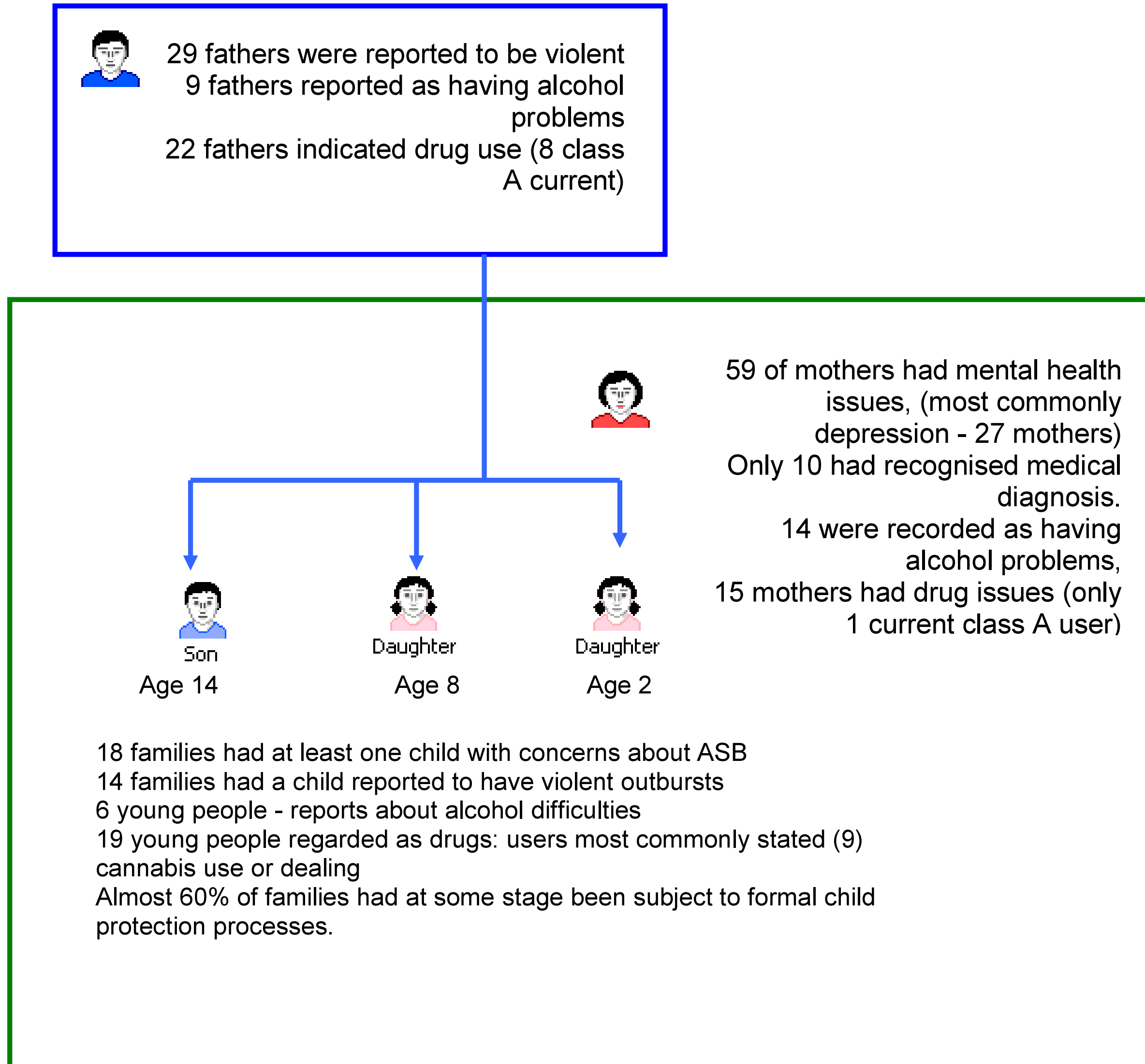


Figure 10 CP Plans within whole sample (number of families).

Table 11 Cases where there were child protection concerns (small sample: more than one answer possible)

Concern	**Number of families**	**%**
Parenting ability/ style	30	91%
Child at risk of statutory intervention	29	88%
Increase safeguarding an aim of intervention	22	67%
Concerns about neglect (current or previous)	22	67%
Reducing impact of domestic abuse is an aim of intervention	14	42%
Remain on or be placed on CP plan or application for care order made or used as a possible sanction	16	50%
Child on CP plan at referral to FRP (6) or during case	11	33%
Any child of ‘main’ parent ever on CP plan/ CP register but not at time of referral	8	24%
CP team social worker was lead professional for child or member of TAF	9	27%

4.6 Summary of the characteristics and service needs of the families



In addition to identifying the problems which led to referral and informed the FRP service aims, it is important to consider the family as a whole, in the context of their own history and the history of prior involvement with services. Answers to the question 'what sort of family is this?' should inform decisions about whether the family is likely to benefit from the service provided by FRP, and whether it should be prioritised for receipt of this sort of intensive service. It should also inform decisions about the type of service provided, the composition of the 'team around the family'. Given that the aim of the service is to meet the needs of families with complex and multiple problems who are unlikely to make progress without the provision of an intensive multi-agency service, it should also inform the planning about preparation work before referral and the nature of the service that is

likely to be necessary for the majority of families once the case closes to FRP. In the longer term, this sort of analysis should inform the discussion about the place of an intensive FRP, and the number of families at any one time to be provided with such a service, within the universal and targeted, statutory and voluntary sector services for vulnerable children and adults within the borough.

The research team devised research protocols (see appendix 1) for grouping the families according to past history, current problems, and likelihood of these problems either continuing or recurring for the different family members. Data on the full cohort provided for the national evaluation were not adequate for this process and this analysis was conducted for only the 33 intensive sample cases. The ratings were based on detailed scrutiny of FRP case notes, using a data collection instrument, minutes of meetings, summaries and, for most, the Children's Service ICS records.

Table 12 groups the broad needs and difficulties identified for the children at the start of the case. From this it can be seen that, once the pattern of acceptance of referrals was well established (given that the intensive sample was weighted towards referrals accepted after the first six months) the majority of cases accepted for a service (73%) concerned children where there were concerns about child protection or a child who may need to be in care or accommodated. There were two cases involving older teenagers at risk of custody or serious mental health problems or whose behaviour posed a risk that the family would be evicted. However, in 7 cases (21% of the small sample cases) the referral did not clearly concern either of these, and the service was provided to troubled families where immediate distress for at least one child was already apparent or a poor outcome was predicted if an intensive service could not achieve necessary change. It is possible (and indeed likely) that, given high thresholds for receipt of a targeted adult or child service, based largely on the likely need for a formal protection or care service, some of these families coping with a range of complex and serious difficulties would not have received a clearly much needed service.

Table 12 Grouping of needs/ problems identified for children

Type of problems	Number of families (%)	
Troubled child aged 13+	3	9%
Middle years child 'on edge of care'	12	36%
Child protection <5	9	27%
Child protection 5+ (where no imminent risk of care)	3	9%
Complex child and parent problems where no imminent risk of care or formal child protection	6	18%

Table 13 uses groupings first devised by researchers whose studies were reported in the *Child Protection: Messages from Research* overview (DHSS, 1995) and since used by other researchers and adapted to categorise reasons for children entering care (DfE, 2010). Although these broad 'family types' provided a useful way of thinking about family needs, and could be helpful in predicting the type of short and long term service approach needed, it was interesting to note that, when compared to earlier studies of children's services cases there were more families that did not fit into these categories. The Brandon et al. (1999) cohort of 105 evidenced 'significant harm' cases concluded that all except 8% fitted into

these categories. The proportion of families in this sample with long term and multiple difficulties (33%) was slightly less than the 40% in the 'significant harm' cohort. However there were fewer 'acute distress' families in the FRP sample and more 'specific issues' families. There were very few indeed with one 'single issue' and four that did not fit into the usual pattern of families accepted for a service by children's services teams, demonstrating the complexity of these families accepted for an FRP service, even when compared to a 'confirmed' significant harm cohort. There is no reason to conclude that the proportions in these groups are not likely to be generalisable to the full cohort of 100 families.

Table 13 Researcher rating of broad 'family type'

Type of family	Number of families	Percentage of FRP families	Percentage of 105 'significant harm' cases*
Short term problem	1		
1 single or 2 linked specific issues	14	42%	27%
3 linked specific issues	1		
Acute distress	1		25%
Families with long term and multiple problems	11	33%	40%
Complex but none of above	5	15%	8%

*Brandon et al, 1999

In summary, the above data show that Westminster FRP provided service to a group of families that fitted the aims of the originators of the Think Family Pathfinder initiative. Using the definitions of 'statutory', and 'specialist' levels of need of the national pathfinder evaluators, around 90% were in need of a 'statutory' service and fewer than 5% came into the 'universal' or 'targeted' levels of need as compared with around 37% and 30% of the 15 Think Family pathfinders (York Consultancies, 2011).

5. The Services Provided

5.1 The referral stage

All referrals for a FRP service are discussed by service managers and a decision taken as to whether, on the information provided by the referrer, the case appears to fit with the team's criteria. Table 14 shows that about a half of cases were referred from either a children's social services team or a Drug and Alcohol Team (DAT). In the small sample, almost half of the cases were referred by a children's social care team. This however conceals the fact that in the majority of cases several agencies were expressing concerns to children's services which contributed to the decision to refer for an FRP service. The number of referrals in which there had not been active involvement of more than one agency for some time was negligible.

Table 14 Source of referral

Referral Agency	100 Cases	Small sample	% of small sample
ChnS loc	26	14	44
DAT	21	6	19
Housing	6	3	9
Anti Social Behaviour Action Group (ASBAG)	5	0	0
PCT	5	0	0
Family Centre	5	0	0
Child Protection	5	2	6
Not stated	4	0	0
SSD unspec	4	0	0
Education	4	2	6
Youth Inclusion and Support Panel (YISP)	3	2	6
YOT	2	1	3
MARAC	2		0
ChSerHosp	2	2	6
ch serRemod	2	0	0
CWD	1	0	0
YPP Panel	1	0	0
Children with Disabilities Team (CWD)	1	1	3
FDA Court	1	0	0

It is interesting to note that, although, as noted earlier, there were serious child protection issues in well over 50% of cases, more referrals were made by Children's services locality or duty teams than by child protection teams.

This appears to point to a policy for Westminster Children's Services locality and duty teams of seeking to work with families outside the formal child protection system if this could be achieved. On the other hand, it would be interesting to know whether child protection team workers were less likely to refer cases to FRP, or the cases being channelled down the formal child protection route were either more serious or clearer cut

than those referred to FRP. A report by the Deputy Manager (Kemp, 2011) explores this point further, comparing FRP child protection case outcomes with matched child protection team case outcomes. It is beyond the scope of this evaluation to pursue the point further, but it did appear that some locality, duty and child protection team social workers figured frequently amongst referrers, and interviews with some of them in their role as TAF members supported the hypothesis that some have a better understanding and appreciation of where the service provided by FRP fits with the work of their own teams.

Depending on pressures of referrals and the degree of urgency, referrals were allocated immediately to a service manager and IOW or placed on a waiting list. At the end of the research period there were four families who could not be offered services due to team capacity and were placed on a 'waiting lists'.

The IOW then made an appointment to visit, sometimes alone, sometimes introduced by the referrer. Although this was seen as a practical and purposive meeting to provide more information to the parent/s or parent figures and older children if appropriate, and to gain their agreement to the sharing of information, it was clear from the research interviews with the IOWs that they planned these interviews carefully in order to encourage families to engage. In the section on costs we note that this work tends not to be included in the work-loads and costs allocated to each family. Observation of the IOWs' contributions to initial TAF meetings made it clear that they had already, in most cases, started to establish a relationship with at least one family member and consider the likely components of the first stage of the work.

Of the families referred to FRP who met service thresholds, 13 refused consent to work with the project team. When considering the costs of the service, these visits that did not lead to engagement have also to be considered as a part of the workload with a not negligible impact on the energy and stress levels of workers.

5.2 The Initial 'team around the family' (TAF) meeting

Team around the family meetings were held within varying lengths of time from this first meeting with a parent, allowing time for the intelligence analysts to prepare a chart of all family members (whether or not still living in the household), and collate details of their prior and current involvement with agencies, including any prior child protection concerns or family support services provided, rent arrears or tenancy problems, involvement with the police, education sanctions, mental or physical health concerns. The aim was to move as quickly as possible to avoid losing momentum. In some cases urgent action had to be taken to avert adverse consequences, such as a permanent exclusion from school or eviction. Invitations were usually issued to all professionals known to be working with the child (information provided by the information analysts to the team administrator) but on occasions it was decided that not all professionals would be invited (the rational for such a decision by the team manager was not entirely clear).

Attendance, missing people and missing information at the initial TAF meeting.

For 19 of the 100 cases the number of professionals attending the initial TAF meeting could not be accurately ascertained from records. Over the remaining 81 cases the modal number of people attending the initial TAF was 8, (range: minimum 4 – maximum 18, including the

intelligence analyst and the deputy service manager chairing the meeting). In most cases there were apologies from around three invitees and the range of apologies was between none and twelve. For 20 cases no apologies were mentioned, for 17 cases no apologies or non-attendance could be identified. However in a minority of cases a relatively high number of professionals (10, 11 or even 12) sent apologies. When taken at an individual case level it may be considered that the intelligence report covers a great deal of ground and that in complex cases getting all relevant professional together on one date would be very difficult. However having such a large number of professionals missing from a meeting risks the loss of vital information which individual professionals may not have considered important unless they are aware of how the overall picture of the family is emerging through a TAF meeting.

A further issue here is that a relatively small number of professional roles accounted for the majority of participants, and due to the small FRP team, participants were frequently the same individuals from the FRP. These frequent individual attendees may be thought of as a core group and there is a risk that the FRP team members become used to routine meetings dealing with detailed family matters. If FRP team members pre-dominate in meetings and attendance by 'outside professionals' is less frequent, 'cues' within the meeting may be missed and this may inhibit dissenting or alternate views from emerging.

The group processes within initial TAF meetings through which information is shared and decisions about intervention and support are made, are intimately related to authority relations and role definitions within the group. Other professionals who may be important information providers cannot be separated from the interactional styles that the professionals adopt. The chairing of meetings is therefore vital to ensure adequate consideration of information and that each professional involved with the family can contribute information and observations about the family and their circumstances.

The agenda for these meetings was for the intelligence analyst to point up the key characteristics and known issues for the family, with other professionals providing additional details from their perspective. The Chairperson then summarised the main concerns of the agencies. The IOW who had visited the family then described the response of the parents and older children if they had met them, and highlighted the areas on which the parents would like to move forward and the particular areas with which they would like help or advocacy. A draft case plan to be put to the parent/s, including any 'rewards' and 'sanctions' and time scales for the first phase of the work were provisionally agreed. A key outcome of the TAF meeting was to determine which professionals were appropriate to include in the team around the family, including a key worker for the adults in the family and a key worker for the children.

5.2.1 TAF membership

The lead professional for the parents or the family as a whole (as figure 11 and table 16 indicate) was invariably a FRP worker and usually an IOW. Figure 12 and table 15 show that the key worker for the child was usually a children's services social worker. In some more complex cases there could be more than one lead worker for different adults or children in the family. In a small number of cases one professional took on both roles, but this was an interim measure until the nature of the role and the appropriate agency could be

identified. Occasionally a specific professional was identified as having a potential role rather than being an active member of the TAF immediately post the initial meeting.

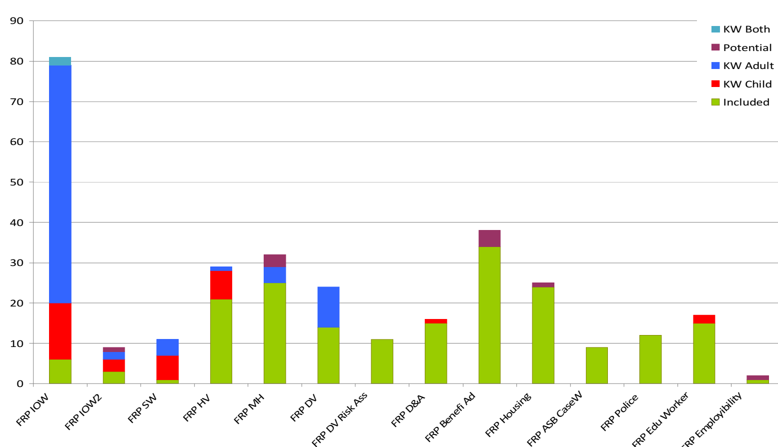


Figure 11 Distribution of roles for FRP workers who were TAF members

Table 15 Lead workers (small sample)

Professional	for adult/s	for one/all children	for adult/s and child
FRP Intensive outreach worker	23	4	5
Locality team social worker		12	
Child protection team social worker		7	
FRP health visitor	1	1	
FRP adult mental health worker	2		
FRP domestic violence worker	2		1
FRP education worker		1	
YOT /YISP worker		2	
Teacher		1	
Health visitor/ early years worker		2	
Special education Unit worker		1	
Children with disabilities social worker		1	
Role unconfirmed at TAF		1	

Table 15 shows that, for the 33 small sample cases, a FRP IOW was the lead professional for the adults in 28 families. In five of the small sample cases the adult lead professional role was held by the FRP team domestic violence worker, the adult mental health worker or the health visitor. The lead professional role for at least one child in a third of these 33 families was held by a FRP team member (the IOW in 9 cases and the education worker and health visitor in two). In 20 cases the lead professional role for one or all the children was held by a children's services social worker (including one specialist disability worker); in one case by a YOT worker and in 2 cases by a non-FRP specialist education worker. This role complexity is explained by the different needs of different adult and child members in the larger households.

Table 16 and figure 12 show the extent to which the specialist FRP team workers were members of the teams around the families, in which case they would be likely to meet family members to provide advice or undertake a specific piece of work using their specialist expertise. There was a considerable amount of joint interviewing, sometimes for a lead professional for the child or family to introduce a specialist worker, and sometimes to undertake an agreed piece of joint work. This also applied to the two lead professionals, usually from different agencies. It can be seen from tables 15 and 16 that the FRG specialist professionals most likely to work directly with family members were the adult mental health social worker and the drugs and alcohol, domestic violence and the welfare rights specialists. Other team members were more likely to support the work of TAF members by providing specialist advice, or arranging a consultation for a TAF member or an appointment for a family member with one of their colleagues working in a primary health care, education, housing or other community service. The most usual number of FRP team members in each team around the family was four (range 1 to 8). Tables 16 and 17 and figures 9-14 give the composition of the teams around the family.

Table 16 FRP membership of teams around the family (including cases with a lead professional role)

Professional	Number of cases	% of small sample cases
Intensive outreach / social worker	33	100
Benefits adviser	17	51
Addictions specialist	15	45
Adult mental health worker	15	45
Health visitor	14	42
Domestic violence worker	11	33
Domestic violence risk assessment worker	9	27
Education worker	7	21
Housing specialist	7	21
Attached police officer	5	15
ASB caseworker	3	9
Employability worker	3	9

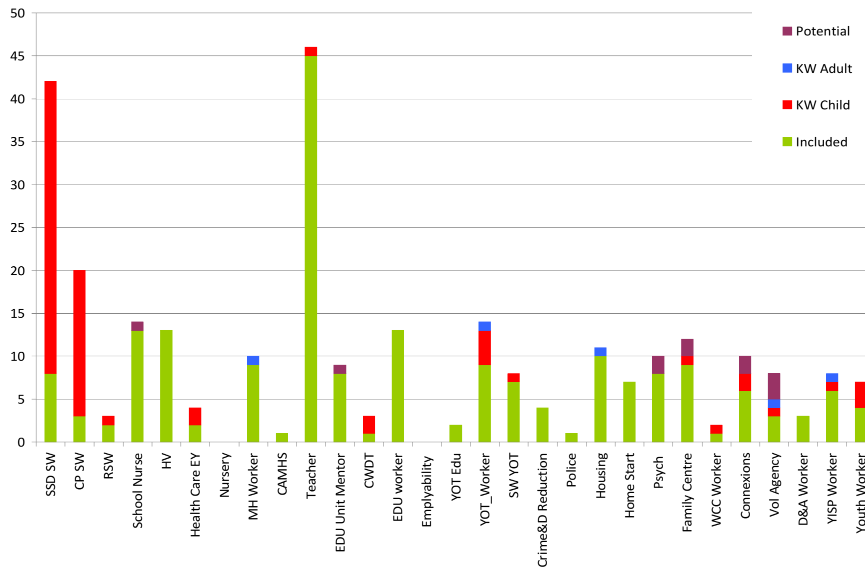


Figure 12 Distribution of roles for non-FRP professionals who were TAF members

A striking feature of figure 12 is the number of teachers included in the TAFs. This is an interesting issue given the key monitoring role of teachers but also the potential practical difficulties of them actually managing to attend TAF meetings.

Table 17 Non- FRP membership of teams around the family (including cases with a lead worker role)

Professional	Number of cases	% of small sample cases
Teacher/ special education unit worker	18	54
Special education unit professional	7	21
EWO or other education worker	5	15
School nurse	6	18
Children’s services locality team social worker	14	42
Children’s services child protection or looked after team social worker	11	33
Adult mental health social worker	10	30
YOT / YISP/ young people’s service worker	17	51
Probation officer/ crime and disorder reduction/noise reduction officer	10	30
Housing officer	15	45
Psychiatrist/ psychiatrist	10	30
Family centre worker	15	45
Health visitor	4	12
Voluntary agency worker	3	9
Children’s services disability or hospital social worker	3	9
Drugs and alcohol team worker	2	6
Employability worker	2	6
Connexions worker	1	3
IOW (WCC)	1	3

It was an explicit aim of these initial TAF meetings to keep the number of professionals with direct contact with the family to a minimum, with the others discharging any statutory roles through being kept informed, sometimes by attending TAF review meetings, or possibly a joint visit with one of the lead professionals. Where there was a formal child protection plan, the meeting had to reach agreement about how FRP TAF and professionals’ meetings would fit with child protection processes such as core group and child protection review meetings. Where care proceedings or any other court proceedings (eviction or truancy for example) had been initiated, careful co-ordination was also planned to give the FRP approach time to have an impact.

Observation of TAF meetings revealed tensions around the aim of reducing the number of professionals in some cases. This was unsurprising since characteristics which many of the families shared (alongside complexity, which meant that several agencies and professionals were involved both consecutively and concurrently) was ‘reluctance to engage’ (‘hard to reach’ families) or ‘false compliance’ (‘hard to change’ families).

Some families who had been ‘hard to reach’ in the past were at a stage when they were showing signs of accepting the need for help to make necessary changes. This was sometimes due to the effort of those around the TAF table, but more often because of a crisis (the possibility of eviction or a court attendance) or a more positive event (the birth of another child). In other cases some around the table had worked hard to engage the family as a whole or individual members, thought that they were getting somewhere, but had recently come to the conclusion that there was a problem of ‘false compliance’. This was particularly the case when addictions, domestic abuse, or teenage gang membership were features of the case. Although these professionals might accept that it was worth trying something else, they might

also be reluctant to 'hand the case over'. In some cases the phase one plan was for them to keep a watching brief by attending TAF meetings, and come back in with more specialist input at phase two or when the case closed to the FRP team.

> *There is a process of elimination to sort out what the problem is... Professionals were doing their own thing and not working with the family. The [specialist professional] was repeatedly unable to make it to meetings, so we moved the review to her office we took the meeting to the person.* (IOW interview)

> *There was an initial battle with the family centre - it was slow moving - the mother was resistant at first - she didn't want therapy. Now after we've developed the relationship we've reintroduced the idea of therapy and the mother wants things to improve.* (IOW interview)

In order to better understand the range of ways in which these networks operated, and their costs to the different agencies contributing to the teams around the families, we categorised the cases in terms of the respective contributions of FRP staff and the outside agencies. Table 18 shows that, whilst in 14 cases (42%) the bulk of the work was undertaken by FRP staff, in 13 cases FRP staff and outside agencies made approximately equal contributions to the helping network and in 6 cases, although a FRP service manager co-ordinated the work and an IOW was one of the lead professionals, other agency professionals took on most of the care plan tasks. Figures 13- 16 illustrate the main patterns of service delivery.

Table 18 FRP contribution to teams around the family

TAF composition	Number of cases	%
Mainly FRP: IOW plus co-ordinating network meetings	7	21%
Mainly FRP: IOW plus FRP specialists and co-ordinating network meetings	7	21%
Half FRP and half outside agencies	13	39%
Mainly non-FRP but with IOW and FRP case co-ordination	6	18%

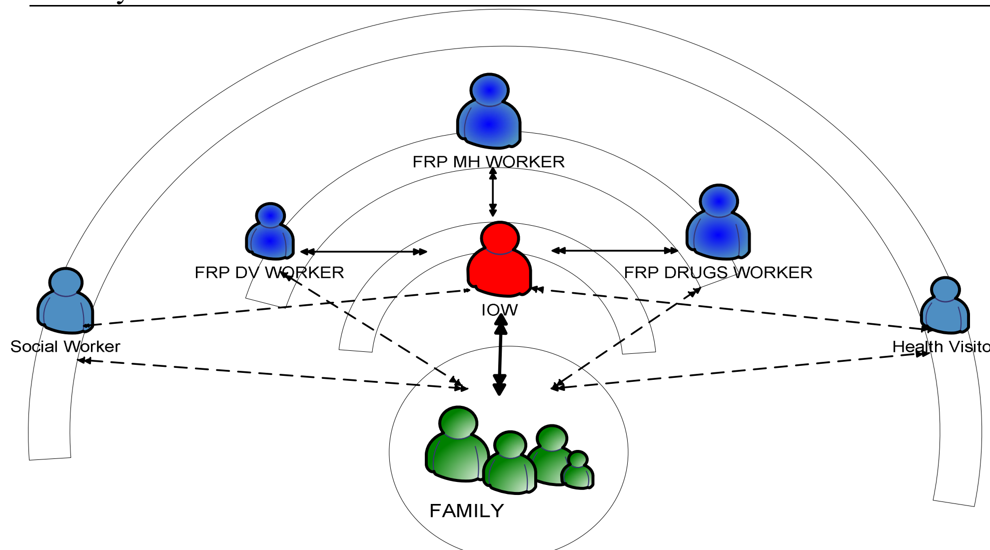


Fig. 13 Service type 1 Mainly FRP with IOW with FRP specialists as advisory

In this model the IOW provides emotional and practical support and will communicate with FRP specialists to gain specific advice, intervention or liaison with external specialist services such as substance use or mental health services. Though a number of FRP specialists

may eventually have some input into the family support this is based upon the IOW developing a trusting working relationship with the family.

Case Example 2. *Mainly FRP IOW with support from FRP specialists*
At referral the mother had left a physically abusive partner but was still living in a chaotic home with two young children. The work was oriented around enabling the mother to understand her children's developmental needs and the provision of a stable and supportive home environment.
The IOW focused her work on creating routines and a more ordered home environment.
She liaised with the FRP Domestic Violence worker about managing risk and addressing the impact of past abuse.
Supported by the social worker (lead professional for the children) she worked on the mother's parenting skills The FRP substance use worker became involved to assess and refer the mother for appropriate services once the IOW has an established a working relationship with the mother.
The FRP Health Visitor assessed and advice the mother on the children's health needs. The FRP Education worker liaised with Schools regarding the assessment of educational performance of children.

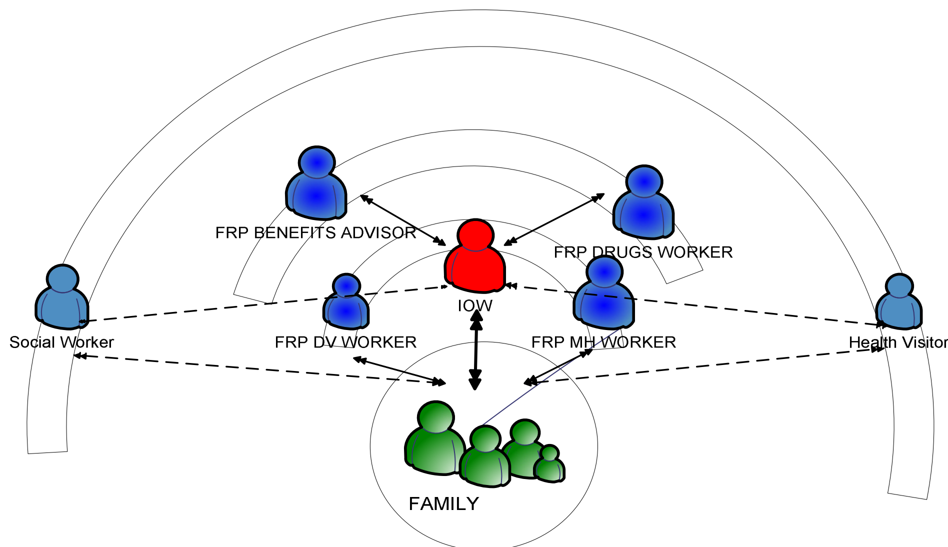


Fig. 14 Service type 2 Mainly FRP with IOW co working with specialists

Case Example 3. *Mainly FRP: FRP IOWs co- working with specialists*
The case involved domestic violence, where although the children were generally well cared for the father had assaulted the mother in front of the children. The father was also using drugs regularly which increased the likelihood of violent behaviour in the home.
The DV worker was the lead professional for the mother and the IOW worked mainly with the father. The social worker was the professional for the children.. There was also involvement from outside agency drugs team. Both parents were considered to be warm parents but their partnership was difficult.
The IOW and DV worker worked together to involve the parents. This was greatly helped by the FRP benefits advisor intervening to find ways of improving the financial position of the family. The DV worker met with the Mother to explore her needs while the IOW met with the father. The IOW built a relationship with the father then involved a drugs support agency. Later as the drugs intervention started to be productive the father started to work with domestic violence support provided by Westminster council.

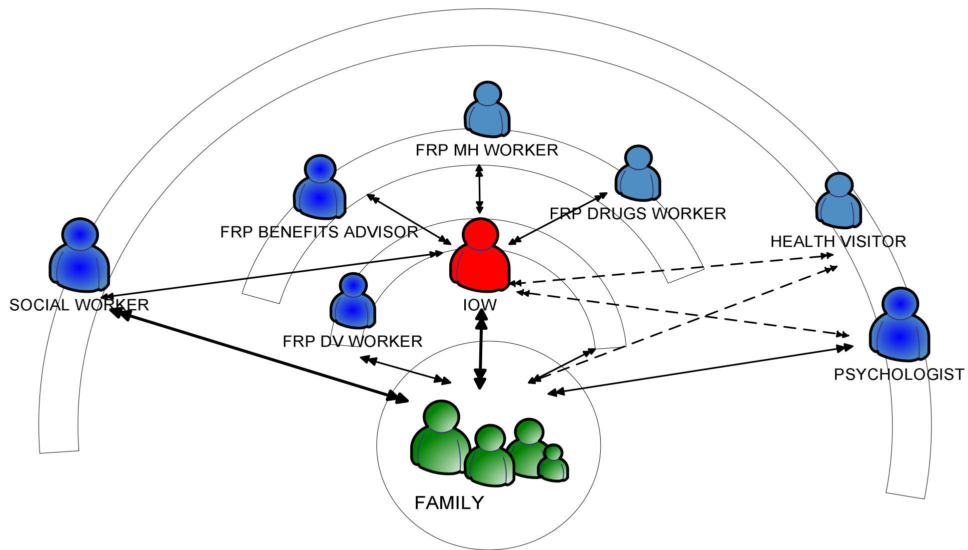


Fig. 15 Service type 3: Approximately half FRP and half outside agencies

Case Example 4.
Both the father and mother have mental health difficulties, and for the father this is exacerbated by cannabis usage. The children range in age from under 5 to teenagers. They are considered to be un-stimulated, and the household trends to be chaotic.
The IOW took the lead role for the adults with a child protection social worker being the lead professional for the children.
The team around the family included FRP drugs worker, FRP mental health worker, and FRP health visitor. But also included a psychologist from a specialist mental health service.
The IOW worked with the mother and liaised with the psychologists to encourage her to engage with a therapist to address longstanding issues relating to anxiety.
The FRP mental health worker met with the family and co-ordinated further work with the community mental health team.
The FRP drugs worker completed an initial assessment with the father, and successfully referred him to an appropriate service provided by the local drugs support agency.
The IOW and the CP social worker both liaised with the school about support and monitoring.
The FRP health visitor met with family and assessed the children before referring one child for further medical assessment.
The IOW and the FRP benefits adviser worked with the mother to reduce the family debts.
Once the drugs issues, debt and mental health aspects were beginning to be controlled the FRP DV worker met with the father and referred him on to work with a local agency about coming to terms with his violent behaviour and on the negative impact he has had on the family.
At case closure the risks of DV reoccurring were regarded as being substantially reduced with the father engaging with mental health and substance misuse support. The domestic routine was considered to be settled, school attendance was good and the children's overall wellbeing had improved. The mother was to continue with therapy, the family continued to receive support from the family centre (where a TAF member also worked part time as well as at FRP0 and the child protection team social worker remained the lead professional.

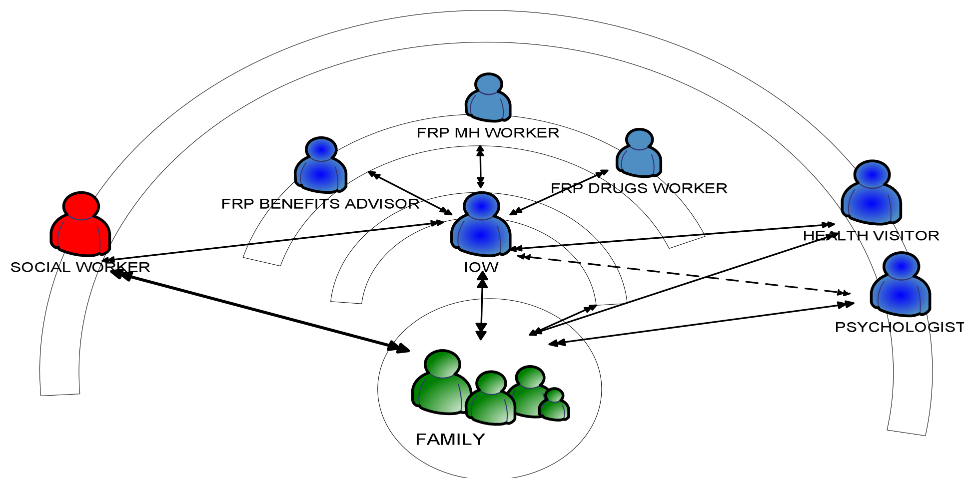


Fig. 16 Service type 4: FRP provided IOW input and case-coordination but mainly outside input.

Case Example 5. *FRP IOW and case-co-ordination with worker specialists*
This case concerned an older teenager in a reconstituted family who had been accommodated by the local authority as a younger teenager. Since returning to the family home she would go missing for days at a time. She was becoming drawn into criminal and antisocial activities and was not engaging with school. The home environment was unsettled and neglectful with the parental relationship being acrimonious, the mother drank heavily and the household routine was described as chaotic.
The CP social worker was the lead professional for the young person and the IOW for the parents. The IOW made planned visits to the mother in the family home to discuss routines and strategies for keeping her daughter safe.
The FRP Education case worker worked with the family, young persona and the school. The father was not prepared to work with the IOW but was engaged with the education worker.
The CP social work team had ongoing contact which continued after the FRP case was closed. A voluntary mentoring and support worker for teenagers was included in the TAF and continued to work with the young person. The FRP education worker also continued to be involved after the case was formally closed to FRP.

5.3 Agreeing the plan and signing the 'care plan with consequences'

In the early stages of the work, parents tended to be invited to the office to learn about the proposed plan from the team around the family members. However, uncertainty about timing and not wishing to have anxious (and usually very busy and preoccupied) parents waiting around, and not wishing to rush this important part of the work, led to a change in this practice. The usual practice was for the lead professional for the parents or family as a whole (sometimes together with the lead professional for the child) to go to the family home immediately after the meeting or within the next two days.

This negotiation between 'what was in it for the family' and what was required by the agencies had started at the initial introductory meeting and had formed the basis of the draft plan worked out at the TAF meeting. Consequently the draft plan and contract contained no surprises and was usually agreed and signed, possibly with minor changes of detail, for example, about timing of regular visits. Talking about the first meeting with the family after an initial TAF a worker commented:

> *I will say, before asking them to agree it, if you don't like our plan, let's look at what in it we need to change.*

Phase 1 plans tended to be weighted towards issues prioritised by parents, which tended to be of a practical nature. Advice and sometimes practical assistance towards clearing rent arrears, getting an excluded child back into school, moving house to get away from gang involvement or to be near a relative who could provide support with young children, help with essential household items or to clean up an un-hygienic home, all figured highly. Help to get a much needed physical or mental health specialist appointment also figured amongst these phase one plans, which concentrated on a small number of achievable goals that were important to family members as well as contributing to child wellbeing and safety.

Sanctions and rewards.

The emphasis at this stage was on the 'rewards' – the improvements in the quality of the environment and family relations that family members and professionals would work purposively to achieve. The 'flip side' of the practical help and advocacy provided directly by or co-ordinated by the IOW or other lead professionals was the sanctions that were set out in the contract as likely to follow if parents and older children did not engage with these processes and improvements in the children's safety and well-being were not achieved. In just under a quarter of cases there was a heavy emphasis on the consequences that would follow from non-engagement and in five cases neither explicit 'rewards' nor sanctions appear to have been needed in order to engage family members in working towards the aim of improved family wellbeing.

Table 19 Approaches to 'care with consequences'

Approach used	Number of cases	% s
Heavy emphasis on rewards	9	27%
Rewards, and light touch sanctions	14	42%
Heavy emphasis on sanctions	8	24%
No reference to 'sanctions' or 'rewards' in plan	2	

Tables 19 and 20 shows that entry to or remaining in care and/or formal child protection plans were the most frequently used sanctions, with the corollary being the removal of these possibilities. In 19 cases (57%) the retention or removal of a protection plan, or a move into care, was one of the consequences (or rewards) spelled out in the case plan. In 8 cases (and a further two in the course of the work) the plan was for the FRP work to be provided as part of a protection plan, and in two cases a 'letter before proceedings' had been issued (or was issued in the course of the FRP work) indicating that a Care Order would be applied for if protection concerns continued. In three small sample cases involving children in middle or teenage years a parent (or teenager) was asking for a child to be looked after so in some cases a planned placement in care was viewed (at least for one family member) as a positive rather than a sanction. At the end of the research period interim or full care orders had been obtained on at least one child in three of the small sample families (although one of these was never actually separated from her mother), two young people were accommodated under section 20 provisions, and the exit plan for another was for him to be formally accommodated. In other cases a child had moved between parents or to the care of relatives. Older children in at least two families were in custody. Thus, in around a quarter of these 33

families, out of home care or custody for a child or young person was part of the service response.

Table 20 Sanctions referred to in contract or care plan (cases do not total 33 as more than 1 sanction used in some cases)

Sanctions referred to	Number of cases	%
Child into/ remain in care	11	33%
Formal CP plan initiated/remain (but no likelihood of care)	5	15%
ASBO made/retained/ YP court	3	9%
ASBO/ court child and adult (criminal or truancy)	5	15%
Eviction/ not re-housed	5	15%
Eviction plus child into care/ CP	3	9%
No sanctions referred to	5	15%

5.4 The FRP approach to service provision and the characteristics of Phase 1 services

5.4.1 Relationship-based helping: the role of the Intensive Outreach Workers

It has been noted in the literature review that an essential component of effective services to parents with complex problems is a consistent and dependable relationship with a professional who can be relied upon to be there when he/she says she will be; who actively engages with the issues that are important to family members, provides emotional support as well as practical assistance and skilled advice, guidance and advocacy. Where therapy for physical or mental health problems is necessary the skilled helper must be able to provide it or support the parent in accessing it. Where there are concerns about child welfare or safety, this relationship has to be provided in the context of clarity about the likely consequences if children's needs are not met within agreed timescales and their wellbeing and safety not promoted.

The IOWs and specialists with a lead professional role sought to provide such a relationship-based service, usually, in the first phase, visiting two or three times a week, sometimes spending lengthy periods of time accompanying parents on visits to benefits offices, doctors' appointments, or to buy essential household goods, or to model 'having fun' on outings with the children. They were better able to prove this emotional support and be seen as worthy of trust because, although they had always to have the safety and well-being of the children in mind, the main focus of their work was the parent/s. They made it clear to parents and children that they were in regular contact with the lead worker for the child and other team around the family members, and made joint visits when appropriate. Despite the close and empathic relationships that were established in the early weeks of the work we saw no sign of this 'two worker' approach resulting in parents playing one worker off against another (an avoidance strategy that some had used in the past). Clarity about the limits of confidentiality from the start of the FRP work was essential in this respect.

The IOWs could call on specialists and in several cases worked towards supporting parents to take up more specialist services such as parent training groups or family therapy, but their particular strength in the eyes of parents was flexibility - their willingness to put their mind to solving whatever problem was uppermost at the moment, and having done so, to move on to the next.

You get to know the family really well and can decide whether a family will be confused by someone else, or it would be better to introduce the specialist worker.

In the small number of cases that the lead professional for the parents was a specialist worker rather than an IOW, there was a risk that, in focusing in on a specific problem which required their specialist knowledge and expertise, these workers lost the advantage of flexibility. If they failed to pick up on what was at the top of a parent's agenda, they risked appearing less empathic.

Given the history of 'non-engagement' or 'false compliance of most of these families, it is not surprising that a trusting relationship with the 'main' parent was established in fewer than half the cases (15). In a further 12 cases parents recognised and valued the concern of the workers, which they saw demonstrated by their reliability, persistence, and attention to practical problems. However, their trust in the worker was no more than ambivalent. These were either parents with personality or mental health difficulties, or those who were unable to give up addictions or move away from abusive relationships. Despite their best efforts the lead professional for the parents was not able to move the parents beyond very superficial or false compliance in 6 cases (just under 20%).

It was also clear that in some cases the IOWs became important people in the lives of children. Some of the younger ones became fond of them almost in the role of 'caring and friendly neighbours'. With some middle years children and adolescents they established a counselling relationship, provided advice or advocacy, or joined with them in positive leisure activities or sports (table 21).

Table 21 Was a trusting relationship established between the 'main' parent/ carer and at least one member of the FRP team*?

	Number of families	Percent
No	6	18
Ambivalent	12	36
Trusting	15	45
Total	33	100

*This was usually but not invariably the IOW and in some cases more than one family member formed a trusting relationship with more than one FRP team member.

5.4.2 The approaches, skills and methods of the IOWs

The approach of the IOWs, can be broadly described as 'psycho-social casework'. It combined practical help with social and environmental problems with the emotional support which gave some, though not all, the parents the confidence to face up to some deeper psychological or relationship problems. In that sense it attempted to be 'therapeutic' even though it was unusual for any specific therapy method to be used. The focus on improving parenting, an aim with which most though not all parents agreed, resulted in the appropriate use of educative and modelling skills. Most of the IOWs had undertaken training in one of the main parent training model programmes (mainly *Incredible Years, Mellow Parenting, and Triple P* - see section on context). Since most of the work was undertaken in the family home rather than in a day care or clinical setting, the Triple P programme could in theory be adapted best as a whole programme by the IOWs. However, the importance of flexibly responding to the complex and varied needs of parents and children, and to the differing parenting styles, strengths and deficits of the parents, meant that workers incorporated aspects of these programmes rather than using any one model as a whole. As a service manager put it:

That is one of the strengths of this project - the flexibility of response - recognising that all families are different. And all the needs are different. We have to fit around them. Rather than them fit into a pre-set service.

There were 6 cases in which a model parenting programme was followed with something approaching programme fidelity, but in 15 other cases aspects of model programmes were used. In 12 cases (just over a third) there was no indication of the use of a model programme with the family. In 5 cases parents attended a parenting group provided by a different service, either once the FRP work was underway, or at the case closure stage. Several parents had attended one or more of these parent training programmes before FRP became involved. From reports of parents' views on file, there were mixed responses, some parents valuing them but others dropping out, in at least one case because it was 'too middle class'. In two cases a TAF member provided a family therapy service in parallel with the IOW work, and in 3 other cases the phase 2 plan was for the parents to start or resume family therapy, although this was not in evidence in the time frame of the research (table 22).

Table 22 Were specific methods or programmes used?

	Frequency	Percent
None apparent	12	36
Specific parenting programme (manualised) - group or individual	6	18
Aspects of parenting programme adapted in home	9	27
Aspects of other adapted in home	6	18
Total	33	100

When interviewing the FRP lead professionals and case supervisors, scrutinising the records and in the small number of conversations we had with parents we sought to identify any specific casework methods or approaches with a theoretical underpinning. Generally a particular worker used a preferred approach with all the families they worked with, but always within the context of seeking to build up a trusting relationship. A mental health specialist referring to the composition of the team commented:

That is the joy. So many different individuals with different background into the melting pot. It is all about the ethos. Facilitating the family's journey. So all those different approaches come together very well. Sometimes a specific programme or intervention is right for the family but that is part of a bigger mix. When I'm working with families, my different- whole gamut of skills, are used as needed - whether it is CBT or reflective.

We concluded that, whilst all workers had a 'toolbox' including a range of skills and techniques they could adapt to particular families and circumstances, there was little evidence of 'pure model' specific casework, therapy or educative methods being used in the majority of cases. However, it was possible to recognise in the work one of two broad styles or approaches (table 23). In 14 cases (just under half) the approach was broadly 'psycho-social' with an emphasis on using a supportive relationship and practical help to enhance motivation so that the parent and/or older children would take up opportunities for change. In 15 cases the approach could be described as broadly 'problem-solving' or 'solution-focused', sometimes incorporating recognisable cognitive-behavioural or social learning methods.

Table 23 Was a specific casework approach used?

	Frequency	Percent
None mentioned/apparent	4	12
Broadly behavioural	2	
Broadly psycho-social	14	42
Problem-solving/solution-focused	13	39
Total	33	

Looking at the service as a whole, the most usual pattern was the provision of practical help to different family members, including guidance about parenting, advocacy and networking (12 cases). There were 7 cases in which emotional support and assistance in making and attending appointments characterised the service, and 3 cases where the IOW supported a parent or other family members in making use of the expertise and connections of one or more of the specialist FRP professionals. In 11 cases the service included all these approaches. Thus, in 18 cases (just over half) the highly intensive and flexible service provided involved the provision of emotional support alongside parenting advice, advocacy, networking and linking with specialists (table 24). Whatever the approach, a role FRP workers had in common was that of 'interpreting' the particular issues for each parent and child to the other services and thus helping to build bridges. This sometimes involves acting as advocate or going along with a family member to help them explain their position or make their case for a particular service. This is particularly important with family members who have been known to services for some period of time and are seen as 'un-cooperative', 'oppositional' or even 'a nuisance'.

> *Their dad felt as if he had been abandoned by services over the years. I went to meet him there. This is one of the key differences, working with FRP, I went to meet him 2 or 3 times a week in his home - made a relationship with him.* (specialist worker).

> *We had done something that hadn't been done before. There has been a* ***redefinition of the family'*** (IOW at team meeting, confirmed by the referring professional also present).

Table 24 FRP broad service approach

	Frequency	Percent
Mainly practical- IOW parenting advice and networking	12	36
Mainly IOW emotional support and networking	7	21
Mainly FRP specialist advice	3	9
All or above	11	33
Total	33	100

5.4.3 Some similarities and differences when compared with 'service as usual' with similar families

Many of the above also characterise 'service as usual' case-work practice in the different agencies. A key difference is the provision of services to parents 'in their own right' who are usually the 'prime clients' for one and possibly two FRP workers. Regular supervision and professionals' and TAF meetings, and the fact that there is usually a children's service social worker as lead professional for the child, ensure that the needs and safety of the children are always 'kept in mind' and prioritised if there is a conflict between the wishes and needs of the children and those of the parent/s.

> *The FRP helps the adults to sort out their needs to then help meet the needs of the children. If we cannot help the adults we cannot meet the children's needs.* (IOW)

Another difference is in the intensity of contact, and the sharing out of tasks between usually 2 lead professionals and other members of the team around the family and able to 'plug into' the services needed from their 'primary' agency/ profession. The immediate provision of practical help in areas prioritised jointly by family members and lead professionals encourages the development of purposive relationships. This was expressed by a referring professional commenting on why he had referred an already well-known family with respect to whom there had been two court appearances (for truancy):

> *'a single worker, had been tackling housing etc etc etc- trying to do everything. And kept being told - they didn't meet the threshold.'*

An interesting difference from children's services family support and child protection work is that there is more emphasis on professionals' meetings and less use of meetings attended by parents (e.g. formal child protection initial and review meetings and core group meetings). This is also a very different approach from Family Group Conferences. Attendance of parents and some older children at TAF review meetings increased as the project developed and towards the end of the evaluation period in around three quarters of the cases a parent was a regular attender at TAF review meetings. From the minutes and observations, these focused on reviewing agreed aims spelled out in the care plan, progress towards achieving them or whether a change in plan was needed. When they attended, family member participation was usually high, especially in discussions about the timing of case closure and transition plans.

However, in some cases parents considered that too much attention was paid to their continuing problems rather than achievements. If they felt 'ganged up on' by the professionals this could set back the work of the IOWs.

As the project developed, and with the inclusion of more children with respect to whom there was a formal child protection plan, agreements were reached at the first TAF meeting about how FRP processes and formal child protection processes would be arranged so as not to be unnecessarily demanding on the time of parents and professionals.

5.4.4 Intensity and duration of *service*

The generally agreed pattern of service was for the intensive outreach worker to visit the family home or undertake activities with the parent approximately three times a week in the first phase of the work with phone calls to check on details, make appointments or follow up queries with family members or TAF members. Following the first few visits the pattern was often varied to fit in with the circumstances and other commitments of parents. Also, in some cases, especially in 'child on the edge of care' or 'troublesome older child' cases the family

IOW, working collaboratively with the lead worker for the child, engaged in activities with the child alone, or jointly with a parent. These shorter visits of between half and one and a half hours were interspersed with longer contacts, sometimes to accompany a parent or child to a clinic or school appointment, sometimes to share a leisure or sports activity as a way of cementing a relationship, getting a better understanding of an underlying problem or pursuing the aim of helping parents or children to become involved in more positive activities.

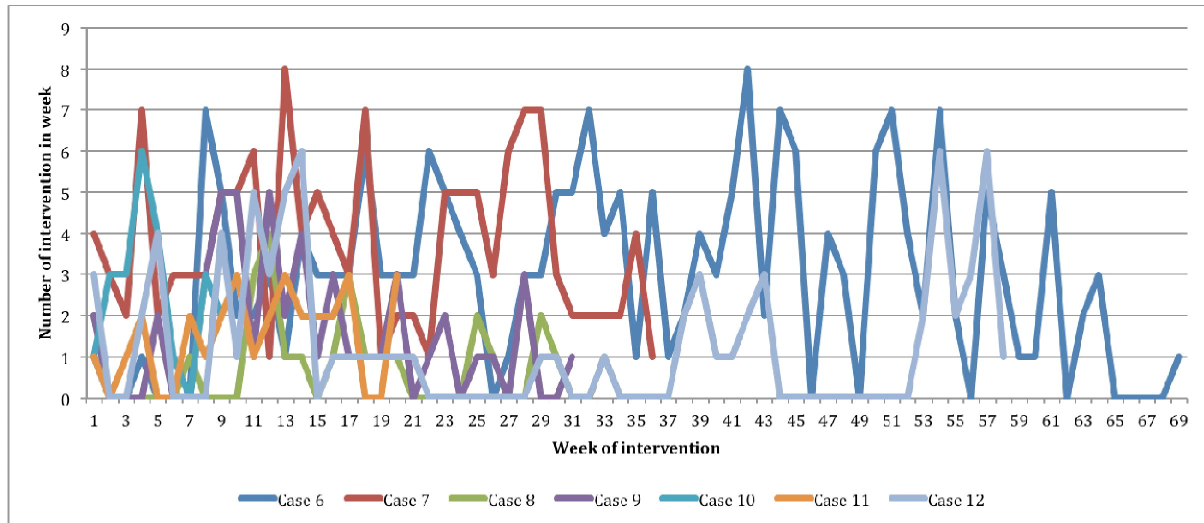


Figure 17 shows the pattern of service intensity and duration for the 7 cases used in the cost analysis (see Appendix 2).

5.5 Case review, case closure and transitions

The usual method of case review was a combination of professional supervision of the work of FRP team members, professionals' meetings held, for most cases, at monthly intervals, and more formal TAF meetings held approximately six weekly. A FRP service manager was the accountable senior professional with respect to the case and chaired the professionals', and TAF meetings, at which each part of the case plan was considered and progress reviewed.

An important contributor to effective case management and review was the highly functional recording system, starting with the case profile provided by the intelligence analysts and regularly updated. (This team also continued to provide data on reported incidences of anti-social behaviour and court appearances and criminal convictions after the case was closed to FRP and this has fed into the evaluation of outcomes for family members.) Although the intelligence analysts, service managers and FRP lead professionals had access to the Children's Services integrated children's system (ICS) records, the FRP used its own case management and recording system (a version of Share Point). As evaluators, we concur with team members in concluding that this is a functional system that met case recording, co-ordination and accountability purposes and kept time spent at the desktop to the minimum necessary for sound practice.

Table 25 gives the duration of the cases and table 26 looks at the cases in terms of a combination of intensity and duration of the work. They show that over a third of the small sample cases were open for 12 months or more (a longer period than envisaged in most 'model' intensive intervention programmes) and only 10 (less than a third, for 6 months or less). However, for around half of the families, the service provided was less intensive than in most 'model programmes' (see for example Brandon and Connolly, 2006). Just over half of the families (18) received an intensive service that continued with a high level of

engagement for over six months and 8 were receiving a high intensity service up to the point of case closure to FRP - in all these cases with active involvement of another 'targeted' or 'statutory' service continuing. The most usual length of time for the case to be open with FRP was 9 months, but the range was between 3 and 18 months. All except two of the cases had been closed by the end of the research period (mid May, 2011) following discussions at a TAF meeting, although in some cases the family had already disengaged and was not involved in the case closure or transition discussions. Families who were reluctant to engage usually withdrew in the first few weeks, although efforts usually continued to re-engage them before formal case closure. However, one case in which there was a low level of activity had been open for 8 months, and there was some (tentative) engagement in the work by a parent who then ceased her engagement before leaving the borough. Arrangements were made by the Children's Services lead professional to transfer the case because of continuing child welfare concerns. In another, the closing summary five months after the first TAF stated 'much work has been done but the family has gradually withdrawn'.

Table 25 Duration of cases (months)

Duration	Number (%)	
3-4 months	3	
5-6 months	7	21%
7-11 months	11	33%
12-17 months	11	33%
18+ months	1	

Note. 2 long-running cases had been open for several months at the time the research ended. This cut-off date is used so this table slightly underestimates the number of the longest-running cases.

Table 26 Intensity and duration of cases

Intensity and duration (short: <6 months) (lower intensity = FRP contacts average 2 per week or less)	N.	%
Short term/ high intensity	8	24
Short term: less intensive	5	15
Longer term intensive throughout case	8	24
Longer term intensive-moving to less intensive	10	30
Short term- no/little engagement	2	

In five of the cases, despite some progress, greater clarity about the risks to which the children continued to be exposed led to the case being closed to FRP and fully taken over by a Children's services team. In four of these care proceedings had been started at case closure and in another, care proceedings were being considered. In all except one of these cases the work undertaken by FRP made it possible to plan entry to care and have a care plan and appropriate placement arranged, thus reducing trauma for the child/young person. In all other cases younger children were still in the household but in some cases older children had moved out into their own homes or, in at least two cases, were in custody.

FRP information analysts reported that, for 22 families where crime and disorder was a concern, there was a 69% reduction in 'accused offences' during the 12 months following the start of the service compared with the previous 12 months (Local Government Leadership and City of Westminster, 2010). FRP internal reports (Kemp, 2010, 2011) on the first 79 closed cases found that care proceedings had been initiated in 5 cases and that of 10 cases

with respect to which there was a formal child protection plan at referral, there was no longer a need for formal child protection intervention 6-12 months after the case opened to FRP, but that in four cases there was still a formal CP plan and continuing serious concerns.

As noted earlier, a strength of the Westminster FRP approach to working with families with multiple and complex problems is that membership of the team around the family by community-based or specialist agency professionals allows for continuity or relationships when the case closes to FRP. The professionals who took over accountability for the case benefited from the (in most cases) goodwill engendered by the comprehensive nature of the service and empathic approach experienced by the family members. In some cases, if there had been a lack of continuity of TAF members, a case was 'held' by the IOW with a lower intensity of service until the community team professional (usually a local authority social worker) who was to take on case responsibility could be introduced to family members by the IOW and a 'hand-over' TAF or joint visit could be held.

> *The case wasn't with the social services when it was referred [by the duty team] then it was reallocated, then the social worker changed. There was a lack of consistency The FRP offers consistency until the family are secure with a social services team.*

Although in a few cases family members had disengaged or moved out of the borough at case closure, in most cases FRP staff took care about how they ended their relationships with family members. In the small number of cases where a new worker taking over case accountability had not been a TAF member, the IOW introduced him or her to family members, using the visit to summarise the progress made and point to areas on which parents or children still wanted to make progress. With respect to around a fifth of these 33 families, although the case was formally closed by the IOW, a specialist member of the FRP continued to have some contact, a possibility made realistic by the fact that some of these had a part time role in FRP and in a community agency. The drugs and alcohol specialist, the education worker, the welfare benefits worker and the employability worker (both of whom also had part time posts in a family centre) were particularly likely to have ongoing contact.

At the time of case closure, only one of the 33 small sample cases was closed to all professionals (other than the generally available services such as health care and schools). There were 9 cases where three or four agencies were named in the transition plan, and 8 cases where five or more professionals from different combinations of adult's and children's social care or education services, community safety or the voluntary sector made up the ongoing 'team around the family'. Looking specifically at the involvement of Children's social care before, during and after the case being open to FRP, there were only two of these 33 cases with which Children's social care 'assessment' 'in need' or 'child protection' services were not involved before the case was referred to FRP and two where there was only very brief involvement by a duty officer. In three cases there was extensive or episodic involvement before referral but the case was not open to a children's social care team when closed by FRP. There were 23 cases (70%) where there had been extensive or episodic children's social care contact before referral to FRP and the case remained open to a social work team when it closed to FRP (table 27).

Table 27 Involvement of children's services teams

Extent of involvement	Number (%)	
None	2	
Brief prior- not after	2	
Extensive prior-not after	3	
Brief prior-brief after	3	
Extensive prior and some after	23	70%

Except where a case closed because a family totally disengaged, it was normal practice for the IOW or another FRP team member to contact the parents around three months after case closure to show an interest in how the family was doing and offer any advice that might be needed. Notes of these conversations were placed on the family's file. The team was receptive to the need for a case to be re-opened, as happened with one family during the research period. In another case the domestic violence worker and the police service team member responded to an urgent request for help when a violent partner came out of prison. There were at least two cases out of the hundred when young adult family members set up their own households and FRP awareness of their vulnerability and the good relationships built up led to the 'new' family becoming a 'FRP case'. In these cases, the usual referral processes were by-passed so that appropriate help could be provided quickly by a known and respected professional.

6. Evaluation of the services provided in small sample cases

6.1 Case aims and extent to which they were achieved

The closing TAF meetings and summaries recorded and reviewed the aims set out in the contract and case plans and considered whether they had been achieved (tables 28 and 29). Because each case plan was put together around the needs and goals of the family the aims do not easily fit into the categories for which the national evaluators collected data.

Table 28 Case aims/goals and % of the 33 cases where this aim was achieved- including some where it was added as an aim in the course of work *(percentages do not total to 100% as some aims did not apply to some families)*

Case goals	number of cases in which this was a goal	% cases in which fully achieved	% cases in which partially achieved	% cases not achieved
Improve engagement with services	26	16	44	20
Improve relationships between adults*	7			
Improve parent/child or sibling relationships (**outcome for any family relationship improvement*)	18	13*	41*	22*
Enhance parenting skills	26	20	38	22
Enhance safeguarding	23	13	42	19
Improve mental health of parent/parent figure	21	10	36	16
Improve physical health of a parent/parent figure	15	7	27	13
Reduce drug/alcohol use any adult in household	14	7	22	16
Reduce domestic abuse between adults in household	15	16	20	13
Reduce level of anti-social behaviour adults/ teenagers	14	20	13	11
Encourage engagement in positive activities	22	20	32	20
Review benefits/ reduce family debt	18	35	12	7
Prevent eviction *and/or*	11			
Enhance quality of housing	20	28	15	20
Increase employment/employability	12	3	17	22

These tables do however give an idea about the particular aims which were most likely to be fully achieved. These tended to be those prioritised by the parents themselves, with reduction of debt, engagement in positive activities, and anti-social behaviour of children being more likely to be achieved than, for example, the full achievement of the aim to reduce drug or alcohol intake or domestic abuse.

Table 29 Case aims/goals for children and whether achieved (number of cases and percentage of 33 cases in which this aim achieved/ not achieved)

Aim/goal	Number of cases this aim in initial plan	% in which achieved	% in which aim partially achieved	% in which aim not achieved
Improve mental health of child/ren	12	*		
Improve physical health of a child/reduce impact of a child's disability	9	*		
Improve behaviour of child/ren	19	10	33	16
Reduce impact of parental health problems on child/ren	3	6	7	3
Reduce impact of parental mental health problems on child/ren	12	*		
Reduce impact of domestic abuse on child/ren	13	*		
Reduce/prevent offending by a child/ young person	15	*		
Increase school attendance	18	11	45	0
Improve educational attainment	18	10	32	14
Improve further education/employment of young person	4	2	5	0
Arrange/improve nursery attendance	6	6	3	0

**Outcome not differentiated between adults and children in household in recording system or not routinely specified in records or at case closure*

High priority aims for IOWs, shared by most parents but conceptualised differently, was the improvement of parenting skills and engagement by themselves and their children in positive activities and these goals were likely to be at least partially achieved. It is encouraging to note that there was only one family in which the goal of improved school attendance was not achieved at all. Where little or no progress was made in improving school attainment, this was largely attributable to the short time scale for the work and the evaluation. When goals were not achieved at all, the records indicate that this was not for want of effort by workers, and that in most cases the family members themselves made some attempt to achieve agreed goals. Where an aim was not even partially achieved, this was usually attributed to lack of engagement (with respect to 24 of the agreed aims) compared to the 18 agreed aims where parents and workers were unsuccessful despite making some attempt to achieve them. Lack of engagement was most likely with respect to the aims of reducing domestic abuse, substance abuse and improved parenting. Only with respect to the aim of improvements in housing conditions was there no success in some cases despite the engagement of parents.

6.2 Conclusions about the impact of the FRP service on these families

In the light of all the available evidence on these 33 cases (a one third sample which was broadly representative of the first 100 cases) we were able to reach conclusions about the interim outcomes for the children; about changes over the period of FRP service in the overall wellbeing of the children and parents; and about changes in parenting capacity.

In 57% of the small sample cases (table 30) there was discernable improvement in the wellbeing of all the children in the family, and in only one case could no improvement be identified in the wellbeing of any child in the family, or there was a deterioration. In the four cases where there was deterioration in wellbeing for one child and improvement for one or more, the deterioration was usually with respect to teenagers and improvement with respect to younger children, which could be attributed to improved parenting. In the 9 cases where there was no change, or the position of the children had been clarified to facilitate better long term planning, we would argue that, given the extent of difficulties at referral, and the extent of non-engagement or 'false compliance' at the time of referral, even halting a deteriorating situation, and the families continued engagement with services, is a positive outcome.

Table 30 Changes in children's overall wellbeing (researcher rating)

Interim outcome	Number of families	
Deteriorated for one/no change for other/s	1	
Deteriorated for 1 / improved other/s	4	12%
No change only child or all	7	21%
Some improvement all	12	36%
Marked improvement all	7	21%
No change but greater clarity has enabled coherent child welfare plans to be made	2	

There was an improvement in the wellbeing of the 'main' parent/s in just over half of the small sample families (although not necessarily in the same families as for the children) but there was no discernable improvement with respect to 42% and deterioration in 2 cases (table 31). However, in 63% of cases there was evidence of improvements in parenting competence with deterioration in only one case (table 32).

Table 31 Interim outcome for 'main' parent: change in wellbeing (researcher rating)

Change in parent wellbeing		
Deteriorated	2	
No change	14	42%
Some improvement in some areas	8	24%
Much improvement	9	27%

Table 32 Interim outcome change in parenting comptence (researcher rating)

Change in parenting capacity		
Deteriorated	1	
No change	11	33%
Some improvement in some areas	14	42%
Much improvement	7	21%

Positive results were most likely to be found with respect to improvements in material circumstances, where there was improvement for three quarters of the small sample families (table 33). As well as contributing to the quality of life of parents and children, it can be hypothesised that these changes will have resulted in a reduction of anxiety and stress in the

families, which is likely, in future months, to have an impact on wellbeing. Practical assistance was also seen by parents as evidence of a commitment to address issues that mattered to them, and therefore contributed to families' willingness to engage, not only with the FRP team but also with community TAF members. There was evidence that this willingness to engage with services continued for many of the families after case closure.

Table 33 Interim outcome: changes in material circumstances of family (researcher rating)

Material circumstances		
No change	8	24%
Some improvement	15	45%
Substantial improvement	10	30%

Given the serious problems of a large proportion of the children at the start of the service, even substantial improvement may still not bring the level of wellbeing of some adults and children up to the average. Table 34 shows that in less than a third of the families was the wellbeing of all the children rated as at least average (when compared to a child with a similar disability living in similar neighbourhoods and economic circumstances). This makes it even more important for satisfactory transition arrangements to be in place at case closure. For families to be engaging positively with universal and targeted service at case closure should be included as a positive outcome measure in the ongoing monitoring and evaluation of the FRP service.

Table 34 Interim outcome: overall wellbeing of child/ren (researcher rating)

Overall wellbeing		
All below average	13	39%
One/some below average- one/some average	10	30%
All average	10	30%

Table 35 Overall interim outcome for family following FRP service (researcher rating)

Interim outcome for family		
Unsuccessful: No change in wellbeing of adults or children	4	12%
Some aims achieved, still serious problems, family not accessing help	4	12%
Some aims achieved still serious problems, family accessing help	4	12%
Some aims achieved, still some problems, family accessing help	7	21%
Successful: most aims achieved- still some problems, family managing/accessing help/ likely to seek timely help in future	8	24%
Successful. Aims mainly achieved, family managing well. Children's wellbeing satisfactory	2	6%
Still serious problems but FRP service helped to achieve a coherent case plan to improve wellbeing	4	12%

Table 35 gives a composite researcher rating of the overall success of the FRP work with these 33 families. Eight cases (just under a quarter) were rated as 'unsuccessful' in that either

no family member engaged with the service, no discernable change was achieved, or, despite the achievement of some aims there were still serious problems and family members were not engaging with services at case closure. Ten cases were rated as successful and in 15 cases some aims had been achieved or the position was clarified to allow for a clear way forward in improving the children's (and in some cases also a parent's) wellbeing (i.e. at least a partially successful outcome in just over three quarters of the small sample cases (76%)).

6.3 Costs and benefits to FRP, Westminster Children's services and longer term services across WCC and beyond

6.3.1 Costing the Family Pathfinder Interventions

It has been estimated by the FRP team and the national evaluators that the average cost per family is in the region of £19,000 (York Consulting, 2011). These figures are obtained using a 'top down' approach taking the aggregate direct (staff employed within the Pathfinder team) and indirect (professionals brought in that were external to the team) costs and averaging this over the number of 'completed' families.

These costs are inevitably an over-estimate of the costs of on-going work once the team is established and funding secured. They include significant set-up costs: the Pathfinder teams had to be established, publicise the service aims and methods within WCC so as to ensure appropriate referrals and information for families who might benefit from the service: key workers and specialist team members had to be recruited and trained and a pattern of individual and teamwork established. Also, the project funding was time-limited and FRP managers had to invest a significant proportion of expensive professional time to ensure the continuity of the programme beyond the pilot period. A further reason to believe that these are over-estimates is that the costs were averaged over 'completed' cases and so do not capture the time spent on discussing cases or visiting families which were not suitable or eligible for pathfinder support (as Table 1 shows, only 44% of the 306 referrals were offered and accepted a service).

As mentioned in the York Consulting (2011) report, an alternative approach to costing the intervention would be to take a 'bottom up' approach and to estimate costs according to the time allocated to each family by the professionals involved. This methodology would perhaps provide a more accurate indication of the ongoing costs of working intensively with families with complex and multiple problems: it would also allow an insight into the diversity across the 15 Think Family Pathfinders and associated costs.

Seven case studies are taken to illustrate the 'bottom up' costing methodology (including only FRP costs and not the time of the TAF members from community or 'outside' specialist agencies – see Table 36. (See Appendix 2 for details of methodology and sources.) The FRP work-logs indicate which FRP professionals were involved in interventions with the family on a weekly basis and the length of time allocated to each intervention. In addition the method of intervention - face to face in the family home, face to face in a professional setting, telephone or email – was recorded, these data are used to estimate the costs of travel associated with meetings in the family home. The administrative support given to the team is excellent and, alongside a social work manager, an intelligence analyst or administrative worker would usually be involved with general case management. Although this is not reported in the work-logs, the cost of this is estimated by including the salary costs of an administrative officer for each General Case Management intervention recorded in the work

log. There is a well-established method for estimating the overall costs associated with providing social care set out in the annual - Unit Costs in Health and Social Care. These unit costs incorporate estimates for infrastructure – office space, administrative and HR support – plus the costs of initial and ongoing training. We match the professionals involved with the FRP interventions with an equivalent worker – based on salary and role.

Table 36 Bottom-up cost of seven cases illustrating the range

				Costs		
	Hours	***Salary only***	***Plus estimated travel***	***Plus administrative support***	***Unit costs***	***Unit costs plus training***
Case 6	68.75	£1,043	£1,986	£2,299	£4,487	£5,066
Case 7	45	£684	£1,409	£1,651	£3,693	£4,677
Case 8	11.5	£157	£311	£358	£849	£938
Case 9	14.75	£214	£291	£406	£922	£1,235
Case 10	14.75	£223	£348	£437	£940	£1,164
Case 11	12.5	£179	£251	£354	£653	£744
Case 12	42	£582	£904	£1,054	£2,339	£2,649

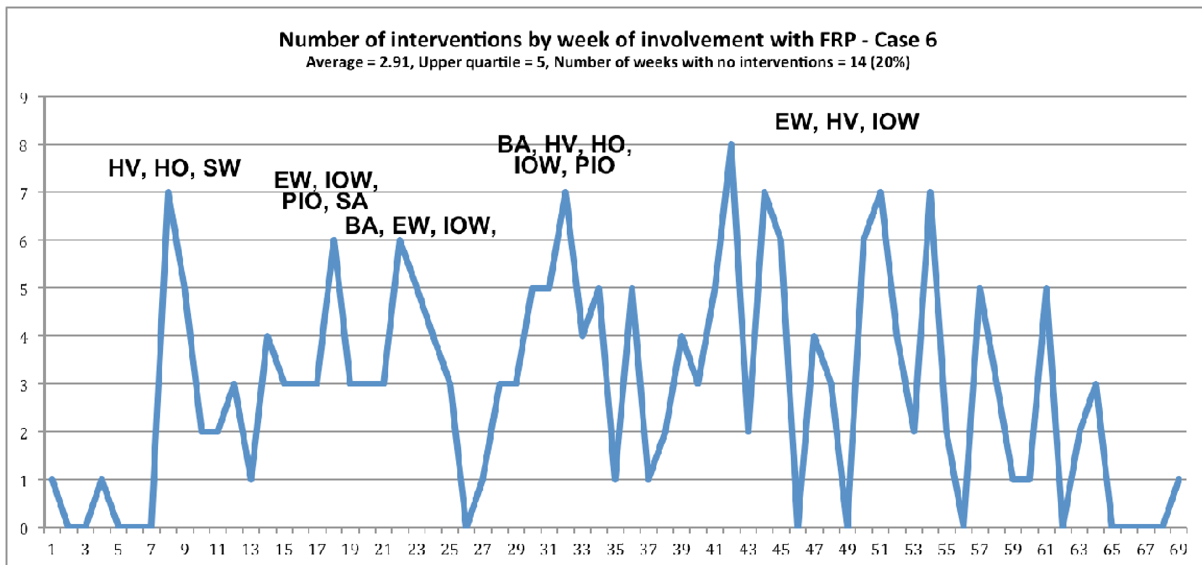
Four of the seven case studies record between 10 and 15 hours of staff time directly involved with the family, two between 40 and 45 hours and one involves just under 70 hours. The estimated costs calculated on salary alone are low, ranging between £157 and £1,043. The estimates rise as travel, administrative support, infrastructure and training costs are included. The upper range is £744 to £5,066, which is considerably lower than the 'top down' estimates. Even interventions with identical inputs in terms of hours can result in different estimates of costs given the different composition of staff or location of intervention.

Just as the 'top-down' costings were over-estimates, these 'bottom-up' costings are likely to significantly under-estimate the per-family costs. The accuracy of the work-logs is clearly key to the reliability of these estimates. One test of the robustness of these data is to cross refer them with other measurements of the same intervention where they are available. For example, in case 6, where full case notes as well as the work-logs are available, the total hours of intervention recorded in the work-log is 68.75, whereas 99 hours are recorded in the case notes. A second issue is that where the work-logs record the direct involvement of a less experienced professional, say an intensive outreach worker, whose work is monitored or supervised by someone more senior within the office the time associated with supervision may not be recorded as it does not relate directly to the case. Finally, the Family Pathfinders hold six weekly Team Around the Family (TAF) and other Case Management meetings but the details (duration and composition of attendees at these meetings) are not always fully recorded.

Three cases are selected to illustrate 'high' 'medium' and 'low' cost FRP cases.

Case 6. A high cost, high intensity and long duration case: several aims achieved but statutory service needed at FRP case closure
This lone parent family was referred by an Education worker due to persistent and long standing concerns about the educational attendance and attainment of the two children. One child was also considered to be disruptive when attending school and education welfare were in the process of taking proceedings (for the second time) against the mother because of high levels of truancy.
The FRP IOW's initial work involved establishing a relationship with the mother who was very reluctant to engage and felt that professionals 'were against her'. The IOW also went through

children's services and other agencies' records and constructed a family history and case chronology to help her understand why previous attempts to help the family had been unsuccessful. The benefits worker provided advice and support in relation to the legal process which initially created some tensions with other agencies. The mother persisted with the claim that health difficulties underpinned her children's non- attendance. One child was diagnosed with a chronic health condition. FRP IOW spend much time working with routines and reinforcing health routines. Housing difficulties were identified and FRP benefits and housing specialists were involved in getting the family re-housed and ensuring benefits were being claimed. The family appeared to be more stable after 12 months of engagement with FRP workers. However, relationships with the mother started to breakdown. One child remained at risk of permanent exclusion and with poor attendance increasing again, legal proceedings were being considered just after the case was closed to FRP. This family is likely to need a lower intensity, longer duration service, with periods of more intensive intervention, until all the children reach adulthood.



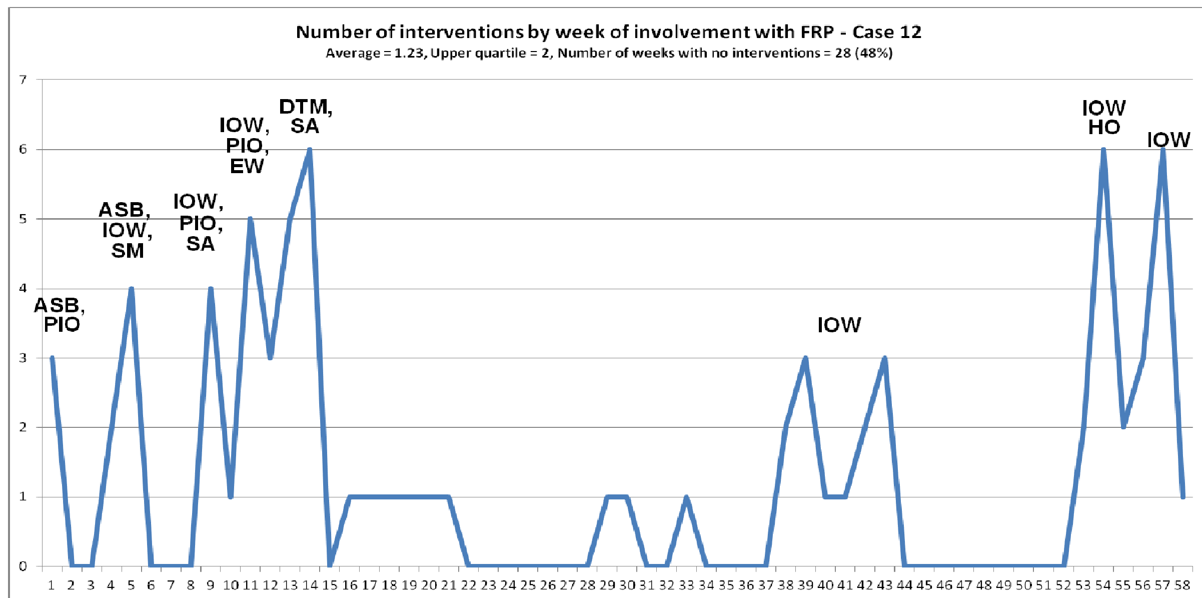
Estimated Unit Cost plus training £5,066

Staff roles – Benefits adviser (1.5 hours), Education worker (18 hours), Health Visitor (11.75 hours), Housing Officer (2.25 hours), Intensive Outreach Worker (25.75 hours), Police Intelligence Officer (0.5 hours), Senior Analyst (0.25 hours) Social Worker (8.75 hours).

Case 12. A medium cost case- long duration with varying intensity of service provision: some aims achieved but statutory services still needed post-FRP

This family was referred to the FRP as the teenage children were involved in anti-social behaviour, especially related to binge drinking. The mother also had mental health and alcohol difficulties. The mother was supported with building family routines and clearing up the house so the family could manage everyday activities more easily. FRP also worked with the family on financial issues, including an application for ESA. NOSP was also involved during the FRP intervention as was a YISP worker. At the end of the intervention the young people were considered to be doing well in education.

A referral to mental health services was made and the mothers drinking was less problematic as the intervention concluded. The mother was also referred to a family centre were she had been receiving counselling. Professional opinion was that the parental partnership was harmful to the children's wellbeing and detrimental to the mother's mental health, however the mother refused to acknowledge this and no work was undertaken on this aspect.



Estimated Unit Cost plus training £2,649

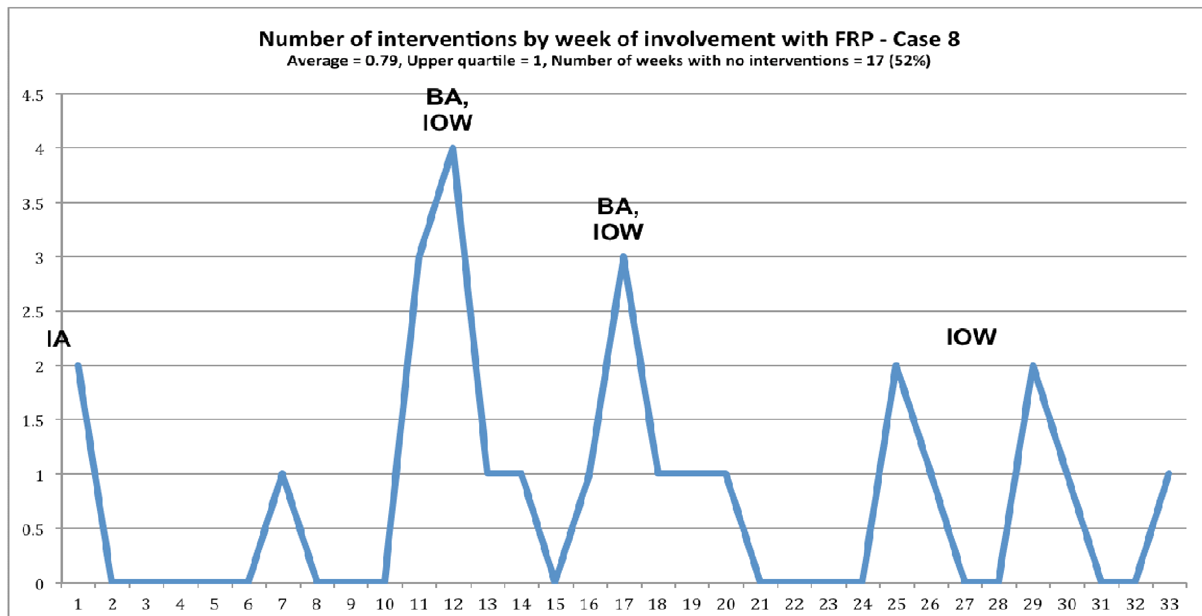
Staff roles – ASB Case worker (0.75 hours), Benefits Advisor (6 hours), Deputy Team Manager (4 hours), Education Worker (0.25 hours), Housing Officer (0.25 hours), Intensive Outreach Worker (28.75 hours), Police Intelligence Officer (1.25 hours), Senior Analyst (0.5 hours), Sevice Manager (0.25 hours).

Case 8   A low cost, medium duration case with a successful outcome

Refereed by a local social work team this family were living in overcrowded accommodation in poor repair. The family had significant financial difficulties. The mother and father were separated, although they were on good terms and the father still saw the children. The core problem was that the children were at risk of entering care as they exhibited challenging behaviour and the mother was unable to control this, with little family routine, behavioural boundaries or appropriate parenting. The behaviour of the children was better when staying with other family members.

The family was receiving support from a family centre and the FRP work centred around developing parenting skills. A financial plan was put in place by the benefit adviser to manage the debt. The father was in work but unwilling to assist the mother with money.

One child was referred to a speech therapist to assist with language development. Older children were linked into reading recovery programmes and learning support. The family was re-housed during the FRP intervention and this helped them to settle into a routine which was supported by the IOW. The mother aims to return to work and the employability worker was involved towards the end of the FRP intervention.



Estimated Unit Cost plus training £938

Staff roles – Benefits Adviser (3.25 hours), Intelligence Analyst (3.5 hours), Intensive Outreach Officer (4.75 hours).

Table 37 gives a broad estimate of the proportion of the 33 small sample cases that were high, medium and low cost to FRP and to the other agencies over this period of FRP service provision.

Table 37 Variations in cost to FRP and to other agencies
Costs to other agencies

Cost to FRP	Low	Medium	High	Total
Low	1	3	4	8
Medium	3	5	4	12
High	1	2	10	13
Total	5	10	18	33

Table 38 predicts the likely need for specialist and statutory services over the short and longer term.

Table 38 Prediction (researcher rating) of future service needs (all family members) at case closure to FRP

Likely service needs	Number of families	%
Short-term/ not intensive then remain closed	3	
Short term intensive/ then remain closed	1	
Long-term episodic	16	48%
Long term intensive	8	24%
One or more children in long-term care	3	
Young person in prolonged custody	2	

Given the complexity of the difficulties experienced by the majority of these families at the time of referral, the reluctance of many of the parents and older children to engage with services, and the chronic nature particularly of some of the physical and mental health problems and addictions of some of the parents and children, it would be surprising if a relatively short intervention, however intensive, were to completely mitigate the likely future cost. We estimated that just under half would need longer term episodic but less intensive children's and/or adult social care services, and that over a third (39%) would need longer term intensive adult, criminal justice and/or children's social care services. When putting together the long term needs and problems of parents and children, we estimated that in 14 of these families (over a third) parents and/or children would require high cost services from one or more agencies as the children grew up: that 10 would require moderate expenditure and only 9 would not consume more resources than the average family living in a similar area, coping reasonably well with a similar health problem or disability (table 39).

Table 39 Likely future costs to adults, children health, social care and justice services

	Frequency	Percent
Low	9	27
Medium	10	33
High	14	42
Total	33	100

However, on the evidence available, a case can be made that intensive multi-agency intervention at this stage will have had a positive impact on likely future costs. There was evidence that, as a result of the FRP intervention:

- some children on the edge of care will remain safely in the care of their families;
- some families had not been evicted who would have been without intervention
- at least half of the parents had stabilised their lives and were thinking positively about future employment ;
- some young people on the verge of criminal careers had pulled back from gang membership and criminality;
- some mothers had decided to end their relationship with violent men;
- some addicts had reduced their alcohol or drug intake, with consequent benefit to their own mental and physical health and their children's wellbeing;
- the majority of the parents had given serious thought to how they could reduce the impact that their own problems were having on their children's life chances and taken some steps to make necessary changes.

On the basis of our scrutiny of the work with these parents and children, a strong case can be made that the intervention of FRP will have reduced long term costs in almost half of these cases, that a case could be made for this in another 11, but that the work will have had little impact on long term costs in 6 cases (Table 40). Data on outcomes with respect to these

variables for the first 52 closed cases are available in the Local Government Leadership and City of Westminster Report (2010).

Table 40 Is there evidence that FRP involvement is likely to have reduced future costs?

	Frequency	Percent
No	6	18
Some indications	11	33
Strong evidence	16	48
Total	33	100

7. Summary and Conclusions: The place of FRP in service provision for vulnerable families in Westminster

Overall, we conclude that FRP has provided an effective service for the majority of these vulnerable 'hard to engage' or 'hard to change' families. With careful monitoring of referrals, and especially with care taken to avoid a prolonged waiting period before the first visit to the family and initial TAF meeting, and care about the timing of case closure and transition arrangements, the service should continue broadly as now. Decisions about the characteristics of families to be accepted by FRP in the future may lead to the conclusion that additional specialists either as team members, or with a formal link to the FRP, would be appropriate. However the central characteristics of the service should remain:

- a flexibly delivered intensive outreach service, with objectives phased and intensity and duration set according to parents' and professionals' agreed priorities
- a lead professional for the child (usually from Children's services if there are child protection or 'edge of care' concerns) and a FRP lead professional for the parent/s or family as a whole
- provided from a multi-disciplinary team base
- with a strong social work professional ethos, consultation and case management,
- together with robust links with the community based professionals who are members of the teams around the families.

The fact that most families continue to need a specialist or statutory service at case closure is to be expected. Effectiveness will be enhanced by continuing attention to securing a co-ordinated approach with the longer term services provided by locality teams, including the Locality Young People's Service (LYPS), neighbourhood family centres and specialist services for parents and young people with mental health, addictions and chronic relationship difficulties and criminality. Whilst close liaison with the specialist child protection and looked after children's teams is necessary for only a minority of cases, good links at service manager level are essential and there may, in a small number of cases, be scope for co-working with a support/therapeutic foster care service during FRP intervention.

FRP is one amongst the small number of pioneering specialist teams that are contributing to the growing knowledge-base on how to engage and then make a difference to families with complex problems. We concur with the evaluators of the IIP projects who conclude:

> *'Rather than attempting to identify one project or model of delivery that is most effective there is a need to recognise that a range of initiatives and approaches are required to achieve positive outcomes with a diverse range of young people and families. However, holistic whole family approaches, multi-agency partnerships, a key worker, intensity and longevity of engagement and access to specialist and statutory support services will be common elements of successful approaches* (Flint et al., 2011, p 131).

7.1 Did FRP reach the families it intended to reach?

The quantitative and qualitative data support our conclusion that all except a small minority of the families (somewhere between 5 and 10 of the first hundred) who were offered, and at least initially took up the offer of a FRP service, were families with multiple and complex needs in which at least one child was suffering or likely to suffer significant harm or significant impairment to their development if difficulties were not appreciably alleviated. When comparing these families to those reported on in the national evaluation of the 15 *Think Family* pathfinders, our analysis indicates that a larger proportion of the FRP families was at the more vulnerable end of the continuum served by these projects. (69% of those accepted for a service by the 15 Think Family pathfinders were at the 'specialist' or 'statutory' level of the continuum (York Consultancies, 2011) compared with our estimate (on the not unreasonable assumption that the one third sample on which we had additional information is broadly representative) that at least 90% fitted into these service needs levels.

7.2 Did the provision of an FRP service succeed in alleviating identified difficulties?

We concluded that in around 63% of the small sample families sustainable improvements in wellbeing had been achieved for at least some family members, and that in a further four cases, the work of the FRP resulted in clarification of a complex situation allowing a clear plan to be made for safeguarding and promoting the welfare of some very vulnerable children. Only four of the small sample cases (an estimate of around 12% of the total accepted for a service) were rated as unsuccessful in that no positive change was achieved or there was deterioration in the general functioning of the family, with a further four at risk of slipping back because they were not accessing appropriate services at case closure.

7.3 Was the provision of an FRP service associated with improved well-being for adults and children in the families?

Achievement of aims does not in itself lead to improved well-being. For example, two frequently cited aims were for a risk assessment to be made of a parent or for a parent to attend a parenting or therapy group. These are 'output' measures and may or may not be linked with (or 'proxies' for) better 'outcomes' in terms of parents or children's improved wellbeing.

From the rich data available and interviews with FRP workers it was possible to follow an agreed rating protocol and rate the well-being of adults and children in the families at the start and end of the service. From this we were able to reach conclusions about changes in wellbeing. Additionally, irrespective of any change achieved, we considered, whether there was evidence that the children were of at least average wellbeing at FRP case closure. Since there was no control or even comparison group, it is not possible to say that the service 'caused' any improvement; only that any improvement or deterioration that occurred did so over the period when the service was being provided. Baseline data were available that showed that most cases were referred because prior to referral the wellbeing of children in the family was causing concern and that earlier services provided appeared not to be having an impact on child or parental functioning or wellbeing.

Given the high level of vulnerability and the comparatively short duration of the FRP service, it is no surprise that, even though in most cases some aims were achieved, only around a third could be rated as 'successful' overall. Even in the 'successful' cases the wellbeing of an adult or a child in a large majority of the families was rated as 'below average'. Despite improvements in the wellbeing of at least one child in around 57% of families, in only 39% of the families could the wellbeing of all the children be described as at least 'average' (when compared with a child of a similar ability level or with a similar disability in a similar economic group). This was recognised in the arrangements for case closure in that only around a quarter of the families were no longer receiving a 'specialist' or 'statutory' service either from Children's services teams or the Youth Justice services when the case closed to FRP. Our prediction (table 38) was that around half of the families would need a long term lower intensity or episodic service from a specialist service catering for the needs of vulnerable families (a Children's service locality or adolescents team or a neighbourhood family centre); that around a quarter would need a more intensive service for at least a period and that in around 15% of cases children would need an out of home care service or a child or young adult would spend considerable periods in custody.

We concluded, that, in just under half of these cases the long term costs of the provision of services to these families would be high; and it would only be low in around a quarter of the cases. This is, of course, the predictable result of FRP being successful in its aim of providing a service to the most troubled families with complex needs. There was strong evidence to support our conclusion that the work undertaken by FRP will have made a contribution to reducing long term costs in around half of the cases, and to some extent in a further third, with no discernable impact in around a fifth of cases. The FRP contribution could be identified by evidence of reduced difficulties of parents or children; improved capacity of parents or children to cope with chronic difficulties or disabilities; or clarifying the situation so that these subsequently needed services would be more effective because based on a clearer understanding of child/s or adult's needs and the sorts of services they were most likely to benefit from. A manager said:

> *Sorting out the mess - we can do well for some - some of them can easily be closed. Eg complex immigration or welfare benefits/debt/housing cases. But very few will be off the books [of Children's Services] when we close them.*

7.4 What are the characteristics of families with whom the FRP approach appears to be most successful?

From a detailed consideration of the families and interviews with workers we conclude that FRP is most successful, and a most appropriate and cost-effective resource, for families with multiple and complex problems, most of whom have histories of involvement with family support or child protection services but where there is evidence that they are either 'hard to engage' or 'hard to change' (see Thoburn, 2009) for definition). 'False compliance', or parental and older child inability to maintain momentum once a crisis is over, has been compounded in the past, for many of these families, by specialist adult and child mental health services, support workers within schools or children's social care teams 'giving up on them' or by duty and assessment or child protection teams concentrating on 'assessment' at the expense of 'helping'. There is a history for several of a revolving door of repeated assessments and short term crisis-based interventions, when for at least half, a planned lower intensity/ longer duration or episodic service provided by the same team or setting would be more likely to be effective, and, given the cost of repeated assessments, probably cost no more. One of the positive results of FRP involvement is clarity about the shape of the longer

term service that is most likely to be needed (and cost effective) for the families the team has worked with.

Another group of families for whom the FRP services appear to be associated with positive outcomes is those where there is evidence of parental warmth and competence but where a period of 'acute distress' or linked problems of the parents spill over onto their care of the children. These include parents with mental health difficulties or addictions who are receiving an inconsistent service from adult mental health teams or whose diagnosis does not result in them crossing the threshold for a planned service. Past or current domestic abuse (including abusive behaviour from teenagers to parents) is sometimes part of the profile of these families.

Both groups have in common that complexity is increased by material problems including debt, unclaimed welfare benefits, inadequate housing or the threat of eviction, or by legal or immigration issues.

In most cases one or more of the children has an emotional, behavioural or physical difficulty, or is reacting negatively to parental stress, which in turn impacts on school attendance or attainment. In some cases challenging behaviour at home or in school, conflict between siblings, or with peers or neighbours, or criminality in teenagers are the result of long term and often unrecognised emotional neglect (Stein et al, 2009).

Perhaps most important in signalling that a referral is appropriate, is that a professional has recognised a 'turning point' which may indicate that an intensive service at this point in time may result in engaging the family in working towards change. This can be linked with the 'care with consequences' / 'rewards as a consequence of engagement' approach of FRP.

In summary, the FRP approach appears to work best with families where there is complexity and 'muddle' which has to be sorted and cut through before more deep-seated issues can be worked on. This complexity may be long term or may have resulted from a fairly recent set of 'shocks' to the family system. In addition there has to be an indication that a turning point has been reached or a crisis recognized, and some evidence that parent-child relationships are 'good enough' to make their preservation worth working for.

In contrast it was possible to tentatively identify the characteristics of families for whom the high intensity (and comparatively high short term cost) of the FRP service and the commitment of other TAF members was either less successful or not a good use of resources. These tended to be families where there was already a degree of clarity about the surface and underlying problems, who were already being provided with a service by specialist and/or statutory agencies, but where the existing 'team around the child' had become 'stuck'. These might be described as 'last chance' referrals – try another specialist service just in case. In these cases, it might be a better strategy to incorporate some of the positive aspects of the FRP service into the services already being provided instead of referral to another, essentially short term service (see paragraph 7.6)

7.5 What is it about the approach and practice of FRP professionals that is associated with more successful outcomes?

As with most innovative 'pushing out the boundaries' projects, it is difficult to capture in an evaluation report the 'chemistry' that was forged between team members, and to quantify the contribution to success of the high morale, team work and energy of this small group of workers from disparate professional backgrounds bringing in different prior experience. At a time when there are reports of staff vacancies and low morale in many social care

departments (as for example reported in the Munro Report, DfE, 2011) it is important to note that all those interviewed reported high satisfaction with the way they were enabled to work with families, and this was also clear in our observations of the team at work. These comments from an experienced health professional and a voluntary sector worker reflected those from others who joined the team, or were seconded on a part-time basis, having previously held a less than wholly positive view of children's social care practice.

> *I loved it. It was an extraordinary experience. It was a real blessing to come and work here - away from silos- having the resource within FRP to work in a multi-disciplinary way. It set me up for the direction services are going in: working in a multi-disciplinary team.*
>
> *We've always had that link which has got stronger since I've been here. I've got to value working with social workers.*
>
> *It overwhelmed me when I came here. All in one big room - just being able to walk over there and say 'I've just seen Bill- how are things with the family?'. As a practitioner, it is much easier to know where things are going. And for the family too.- how to guide the client through their journey.*

The two essential ingredient of the FRP approach that can be discerned when families become engaged and some improvement in wellbeing is achieved are flexibility and the provision of a dependable relationship with at least one energetic, committed and caring professional who refuses to be put off if a parent or child goes through a spell of being confrontational or less than fully engaged. Family members want to be convinced that they 'matter' to the members of the FRP team who provide them with a service. During the work, and at case closure, this can result in what one FRP worker described as a 'redefinition of the family' so that progress made during this short term intensive intervention can be maintained, and the goodwill engendered 'rubs off onto' other members of the team around the family previously seen as unhelpful or hostile. A mother caring for two children whose earlier born children were in care or adopted said:

> *Since I've been with you people - its not like social services – they pounce and take your children away. All that going to court - it all costs money.*

An IOW commented that she thought that because FRP modelled the approach of 'hanging on in there' with families, other members of the team around the family (in this case she was referring to teachers, but it could equally apply to social landlords) were more likely to revise their approach and reassess how they could provide more positive help.

Going back to flexibility, the approach is the 'classic' psycho-social casework approach of 'start where the client is', which in most cases means an initial emphasis on practical assistance to deal with a crisis, an immediate threat to family cohesion, or a deteriorating financial or housing situation. Because a 'potential for change' moment has been recognised at the referral stage, the phase 1 care plan combines the priorities of family members with the agenda of the professionals: it takes on board the necessity of improving the situation for the children, usually by also improving the wellbeing of the parents, and intra and extra-family relationships.

> *With some families suspicion is so deeply entrenched. They need to be at a point in their lives when they realise they need intensive support.*

Flexibility was also noted in terms of the duration and intensity of the service, both being negotiated with family members and TAF members. This flexibility is illustrated by the involvement charts in paragraph 6.3.1. These charts illustrate how the FRP approach differs from some of the 'model' intensive intervention programmes.

In order to maintain momentum, and convince parents and children that change for the better can be achieved, energetic, caring and professionally supported IOWs turn their attention and skills to whatever they and the family members agree needs doing. The strong emphasis on improving parenting is appropriate given the identified problems with parenting in the majority of cases, and IOWs used their parent training skills and aspects of model programmes to good effect. However a too narrow focus on parenting skills at the expense of tackling other problems parents wish to be helped with, could be counter-productive and result in disengagement. The readily available back-up of the specialist team members, who provide a specific service to a family member or use their expertise to provide the IOW with specialist consultation and links to community resources, convinces family members that they do matter and their own aims will be worked on. We saw evidence of this in the way that the draft care plan agreed at the initial TAF meeting was sometimes changed if it did not sufficiently address the issues identified as priorities by family members. The IOW and the FRP team 'keep the child in mind' but, because they work jointly with a lead professional for the child, they can focus fully on improving the situation for the parents or older siblings.

A centrally important aspect of the FRP service is that this is a small 'compact' team – in terms of office base and team identity. There is clarity that the over-arching professional identity is that of child and family social work, and this is essential if the team is to confidently and safely accept cases where children are at risk of significant harm. However, respect for the roles of the business support and intelligence analyst teams as well as the management and specialist practitioner team members was much in evidence and was regularly re-enforced by training events and team meetings.

It is unlikely to be affordable for services to all vulnerably children and families to be delivered in this way, nor do most families, even those with complex needs, want or need this intensity of service other than for a comparatively brief period. However, for those that do, this model of team organization appears to be an important aspect of its more successful work. The morale of team members appears high, and from our limited conversations with family members and client feedback on the records, families appear to relate to the FRP team as a whole. (As an example, we noted that any member of the team will pick up the phone and respond to a family member in a considerate and concerned manner if 'their' worker is not at their desk.)

Provided that the essential characteristics of the service (as described above) were present, the range of skills and approaches brought to their work by the IOWs appeared to matter less than the values that informed their work. We noted that it was the exception rather than the rule for 'phase 1' care plans to be quickly achieved and for a move to 'phase 2 objectives and service provision. For a range of reasons, but most often because the family members were ready to move on, or a valued IOW left and the family felt they had moved on sufficiently not to need or wish to make a new 'intensive' relationship, in very few cases were phase 2 plans even started on. However, they were often part of the lower intensity or more focused 'transition' plans. Some families for example who had had 'tasters' of parenting programmes provided by their IOW engaged with a parent education group, or with family therapy at a family centre.

In the small number of cases where either the IOW or a specialist worker taking on the lead professional role pursued a more focused agenda- on specific parenting problems, domestic abuse or anti-social behaviour for example, and did not address the wider range of issues that family members raised, there were indications that the family members were more likely to not engage, or disengage.

Other cases that worked out less well were those that had changes of key worker (especially of IOW and service manager but also of key worker for the child). Some families refused to engage with a new worker and either the family withdrew or a decision was taken, especially if some progress had been made, that it would be better to close the case to FRP and seek a careful transition, with continuity provided by a continuing service by other members of the team around the family.

7.6 What aspects of FRP practice can be 'mainstreamed'?

Whilst the team structure and composition is specific to the intensive service provided, some aspects could well be incorporated into the locality and other teams.

Most obviously, even in less intensive cases, if a family can benefit from two lead professionals, this is likely to be more cost effective than one worker providing a less effective service to all family members.

The Intensive Outreach Worker role is a specialist role in its own right, that can be successfully filled by a social worker or other professional or para-professional, selected for personal qualities (including evidence of analytic ability and lateral thinking), motivation and provided with appropriate training. It is different from a 'family support worker' role as usually available in social work teams providing a more narrowly-defined or less intensive service. However, it may be appropriate for locality teams to employ intensive outreach workers to work with families who do not need all the aspects of the FRP service. Such workers are already employed by some family centres and Sure Start children's centres and some family support workers have the necessary qualities.

The 'team around the family' approach is increasingly replacing 'team around the child' thinking. The care taken over transitions by the FRP team should equally characterise transitions between children's services teams and voluntary and statutory adult services, voluntary and local authority sector children's services such as family centres and CAMH services and child health services.

Some aspects of the combination of flexible family casework and the availability of specialists could be achieved possibly through 'out-posting' or attachments of specialists based elsewhere into children's services or LYPS teams, together with reciprocal 'linked worker' arrangements of child and family social workers to other teams and community resources such as family centres or child development centres.

The intelligence analyst role has already been rolled out across Children's services teams, and there are aspects of the business support model that could be adopted more widely.

8. Reflections, hypotheses for discussion and recommendations

- The Westminster FRP model differs from some (possibly most) of the other 15 Intensive Family Pathfinder Pilot Projects. It is more firmly embedded within children's social care services for families with complex problems, including those

with formal protection plans. It is our impression that the combining of the FiP work with the FRP team is also fairly unusual, and that it has been successfully achieved. However, over time, fewer cases have been taken on that fit the more usual FiP profile (mainly families with teenage children engaging, sometimes along with parents, in anti-social, neighbourhood nuisance or criminal behaviour). Such young people are still being referred, but mainly in families where there is more complexity; where there are also younger children, and there is a higher likelihood of children coming into care, or of the need for formal child protection plans.

- Some evaluations of intensive 'whole family' projects conclude that successful outcomes are more likely if they are provided from a non-statutory agency base, since families with a history of statutory intervention are considered to be more likely to engage. There was no evidence of this being the case with FRP, even though the service was based in the same building as statutory children's services teams. There were clear advantages to the children's service base, in that it facilitated a good understanding of the nature of the service by potential referrers.
- We had the impression that some social work members or children's services teams were more likely to make appropriate, timely, and well-prepared referrals than others. We would recommend that the role and working methods of FRP be introduced to new social workers during their induction into the department.
- The roles of the intelligence analysts and the business support staff within the team are of central importance and should continue. There are questions around how to make sure that the detailed learning about family functioning, and especially about the characteristics of the service provided that have worked well, or not worked well whist the case was open to FRP, are transferred to the Children's services case records and those of other mainstream agencies. If, following the Munro review, the ICS can be sufficiently improved, it would be desirable to use a single case management and recording system. This will ensure that essential information on children's records informs FRP practice and vice versa. But until the ICS case recording system is simplified, the more 'fit for purpose' Share Point system will be needed. At the very least (as is the case now) the TAF minutes, the care plan and the closing summary should be transferred onto the main children's services record at FRP case closure.
- We would recommend that, at case closure, information is recorded, and discussed by the members of the TAF, not only on which aims were achieved, but also on changes over the period of the service for adults and children, and on well-being at case closure. We found the 'McMaster data' (provided to the national evaluators) was unreliable - possibly because it was not consistently obtained. We would recommend completion with respect to each child of the Goodman strengths and difficulties schedule at the start and end of service, and also an appropriate similar schedule relevant to parent wellbeing and family functioning.
- We were interested to note that, although some parents were sad to lose their IOW and their links with the team as a whole, there did not appear to be a problem in closing cases. Some cases were open for longer than others, but that seemed appropriate. For example, the TAF members, and especially the IOW and Service manager for the case, wanted to ensure that appropriate transition arrangements were in place so that progress was not lost.
- With respect to cases where there are child protection and core group meetings or LAC reviews, it is important to ensure that the different processes fit together. There

was in a small number of cases confusion between a 'phase one' TAF plan (involving cutting down the number or workers and interventions) and a formal child protection plan allocating specific roles to a larger number of agencies/ workers. Different models of involving family members in the two systems (attendance at conferences and core group meetings in the CP system and heavier reliance on the IOW to engage the family in the FRP system) need to be carefully managed if family members are not to be overwhelmed by the need to attend meetings or be briefed before and after meetings.

- FRP workers did not use the more usual language of 'contracts with consequences' but rather 'care plans' and 'family agreements' in which consequences (positive and negative) were clearly spelled out. The balance appeared to be appropriately chosen in each case between rewarding positive activities (the preferred way forward) and the appropriate and timely reference to or use of sanctions.
- We tentatively suggest that FRP managers should consider carefully whether to take on cases where specialist agencies are already involved and impediments to progress are already clear. Yet one more attempt by referral to another specialist agency may just delay the making of decisive decisions in a timely fashion, e.g. for a child to be accommodated or a court application made. In such cases it would be preferable for other specialist agencies to employ intensive outreach workers, or the 'two lead professionals' model of case allocation. On the other hand, there were cases where good results were achieved by taking on a case for allocation of an IOW but in which most of the TAF members were from outside agencies.
- From our review of cases, we would suggest that an IOW, focusing flexibly on a range of issues, should always be allocated to a case, even though it appears that there is a single issue such as domestic abuse or addictions. In such cases it is preferable to have the specialist worker working with the IOW rather than taking on the key worker role.
- Given the well-evidenced fact that some of the worst outcomes are for those children who have suffered abuse or neglect and return to a birth family member after spending some time in care, it was surprising that more referrals to FRP were not in this category. The 'turning point' factor would apply and in some cases there is a high degree of complexity. Families with these characteristics benefit from two key workers and an intensive service provided by a small and well-coordinated team rather than 'surveillance' and 'monitoring' by uncoordinated workers.
- Similarly, the 'turning point' and 'clearly spelled out consequences' aspects of FRP practice would also suggest that there could be more referrals to FRP at the 'pre-proceedings' stage when care proceedings are being considered.

Last word:

Some aspects of the FRP approach should be, and are being, incorporated into the 'service as usual' work of children's social care locality and child protection teams. However, we conclude that there will continue to be a role for a well managed and well-co-ordinated multi-disciplinary team, closely linked with Children's social care services and with a social work/social care approach to helping, to work intensively but flexibly with families with complex and multiple difficulties whose children are otherwise likely to suffer significant harm.

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Appendix 1

RESEARCHER RATING PROTOCOLS

Researcher rating of broad 'family type' (adapted from groupings first identified by Cleaver and Freeman, used in other research, e.g. the Brandon et al 'Significant Harm' study, and adapted by DH/DfE as categories for referral in the CiN and Children Looked after data sets

1. ***Short term problem***

Families where there is a clearly identifiable problem or linked problems which are likely to be remediable within a short period and once their impact is removed or substantially diminished, the family is likely to function adequately. Examples might be a single parent using unsafe child care arrangements in order to maintain himself in work, or an asylum seeking family with debts due to lack of understanding of benefits entitlements leading to stress around inadequate housing and mounting debts. There will be evidence of 'good enough' standards of parenting in these families which have slipped due to this short term problem. These would not be appropriate referrals to FRP.

2. ***1 single or 2 linked specific issues***

Families are included in this group if there is evidence of commitment to children's wellbeing and parenting skills in the past of at least one parent, but a serious problem, which may be recent or intermittent over a longer period, results in family stress and parenting deficits or risk of significant impairment to the wellbeing of parents/s and children. An example might be a teenage boy becoming involved in criminal behaviour or with gangs which is resulting in family conflict and the threat of eviction because of neighbour complaints about anti-social behaviour. Other examples might be a single parent who has good parenting skills but who starts a relationship with an abusive partner; or a two parent families with several children in which the father's redundancy has accentuated long term mental health problems. A parent or child with a chronic or acute illness or disabling condition which destabilises a family that has managed 'well enough' may come into this group.

3. ***3 or more linked specific issues***

Similar to 3 but where, for example, domestic abuse may be combined with mental health or addiction problems, and teenagers becoming involved in anti-social behaviour in part due to stress and conflict between the parents. Parents in this group tend to be older, have three or more children across the age groups, sometimes with different fathers. The situation may be complicated by unresolved issues (possibly earlier domestic abuse or continuing conflict and difficult contact arrangement with the father of one of the children. Since the aim of FRP is to work with families with complex problems, it is unsurprising that there are several families in this group. Although the issues are complex, and some may be long-standing, there are likely to have been periods when the family has been on an even keel, and there will be parenting strengths as well as weaknesses. One or more children in the family may be doing well.

4. Acute distress

In this group are families who, at the point of referral, are in a very precarious state, often close to complete disintegration. On the surface they present at the time of referral very similarly to families with complex, multiple problems of long duration. However, as with groups 1 to 3, there is evidence, once the picture clears, of family strengths. Intensive work consecutively across the range of problems, in the context of a supportive 'team around the family' can 'get the family back on their feet. Asylum seeking families, whose situation becomes precarious because of eviction, a death in the family or other shock to the family system come into this group, as do families coping with one or more deaths of key supportive family members.

5. Families with long term and multiple problems

Included in this grouping are families who have caused concern to agencies over a substantial period of time, (possibly across generations) and who present with a range of problems, usually including deficits in parenting. There may be previous children in care, and a pattern of repeat referrals for services. Families in this group can benefit from the provision of intensive services at a time when there are signs of motivation for change linked with the availability of sanctions that have meaning for the parents. They may be 'hard to engage', some may appear to engage but have exhibited 'false compliance' in the past; and others may seek and benefit from assistance but find it hard to maintain progress. They are likely to need a long term or episodic 'targeted' service after the intensive service withdraws. Continuity with at least one member of the 'team around the family' for the FRP service can be particularly helpful and they can be supported appropriately by services with 'permeable boundaries' such as Family Centres that encourage self-referral

6. Complex but none of above

In most studies of children's services caseloads, almost all families fit into groups 1, 2 4 or 5. It is interesting that there were more families in the FRP cohort that did not fit into these categories.

Table 21 Was a trusting relationship established between the 'main' parent/ carer and at least one member of the FRP team*?
Rating based on evidence from records, including in some cases comments made by family members and recorded in TAF meeting minutes, and in some cases interviews with IOWs and specialist workers. The rating is usually with respect to the IOW but may refer to one or more other FRP professionals.

Table 30 Changes in children's overall wellbeing (researcher rating)
Rating based on evidence from interviews with professionals and records including any statements of parents or children recorded in minutes of meetings: comparing minutes of initial TAF with the closing summary: also evidence about changes in school attendance and attainment, any re-referrals because of offending or anti-social behaviour, and any reports of continuing problems in physical or mental health or challenging behaviour. With respect to health issues, was there evidence that these were being appropriately responded to by parents and child.

Table 31 Interim outcome for 'main' parent: change in wellbeing (researcher rating)
Rating based on evidence from interviews with professionals and records including any statements of parents recorded in minutes of meetings: comparing minutes of initial TAF with the closing summary: also evidence about any reports during and post-intervention of offending or anti-social behaviour, and any reports of continuing problems in physical or mental health or challenging behaviour. With respect to health issues, was there evidence that these were being appropriately responded to and treatment advice followed?

Table 32 Interim outcome change in parenting capacity (researcher rating)
Rating based on evidence from interviews with professionals and records including any statements of parents recorded in minutes of meetings: comparing minutes of initial TAF with the closing summary.

Table 33 Interim outcome: changes in material circumstances of family (researcher rating)
Rating based on evidence from interviews with professionals and records including any statements of parents recorded in minutes of meetings: comparing minutes of initial TAF with the closing summary. Evidence in the records of improved income through employment, reduced debts, improved housing, threat of eviction removed. Higher material standards reported.

Table 34 Interim outcome: overall wellbeing of child/ren (researcher rating)
In considering the wellbeing of the child at service closure the researchers had in mind a child living in a similar area who would be considered to have a 'reasonable standard of health or development'. For children with a chronic illness or disability the notional comparator is a child with a similar disability or condition wit averagely competent parents.

Table 35 Overall interim outcome for family following FRP service. Researcher rating
Composite based on all data available from records and interviews

Appendix 2 Costs and benefits to FRP, Westminster Children's services and longer term services across WCC and beyond

Hourly wages

Across the 7 case studies, 14 groups of professionals were involved and the following average hourly wages were applied in costing their time.

Role	Average hourly wage - London
ASB case worker	£16.70
Benefits advisor	£10.22
Deputy team manager	£19.54
Domestic Violence Worker	£13.13
Drug and alcohol worker	£13.13
Education worker	£14.74
Health visitor	£18.70
Housing officer	£14.53
Intelligence analyst	£17.43
Intensive Outreach Worker	£13.13
Police intelligence	£20.69
Senior analyst	£27.47
Service manager	£22.66
Social worker	£17.69

The hourly wages were derived from three sources: Local Government Employee Survey; Unit Costs in Health and Social Care; and the Annual Survey of Hours and Earnings.

1 - Local Government Employee Survey

This data set provided detail on salary and hours for virtually all of the FRP team with the exception of those employed by the local health or police authority and the senior analysts.

FRP	*Local Government Employee Survey*	*Average annual salary – London*
ASB case worker	Youth Offending Support Worker	£33,008
Benefits advisor	Welfare Rights Officer	£20,186
Deputy team manager	Social work team leader/senior practitioner	£38,608
Domestic Violence Worker	Community, Support and Outreach Worker	£25,949
Drug and alcohol worker		
Intensive Outreach Worker		
Education worker	Education Welfare Officer	£29,211
Housing officer	Housing officer	£28,719
Social worker	Social worker	£34,964

Source: Local Government Employee Survey, 2010

Annual hours = 38 per week = 1976 per year

2 – Unit Costs in Health and Social Care

This data source includes detailed information on salary and hours for those employed in the health sector.

FRP	*Unit Costs in Health and Social Care*	*Average salary*
Health visitor	Health visitor – London weighting 1.2	£30,800
Deputy team manager	Social work team leader/senior practitioner – London weighting 1.16	£38,608
Service manager		

Source: Unit Costs in Health and Social Care, 2009/10
Annual hours = 38 per week = 1976 per year

3 – Annual Survey of Hours and Earnings
This data source provides hourly wages for police officers and intelligence analysts.

FRP	*Standard Occupational Classification*	*Hourly pay*
Police intelligence	Police Officer (sergeant and below)	£18.10
Senior analyst	Public Service Administrative Professionals	£23.86
Intelligence analyst	Health and social welfare associate professionals	£15.42

Source: Annual Survey of Hours and Earnings, 2010
London weighting of 1.16 applied

Time associated with travel
1) Method of Intervention - given

Face to face – home = 1 hour

Face to face – professional setting = 0 hours

Telephone = 0 hours

2) Method of Intervention – missing

Where the method of intervention is not recorded we estimate the likely method based on the observed location of of each type of intervention. For example, amongst the nine Benefits/Debts/Finance interventions where the method is recorded, 4 were in a professional setting and 5 in the family home, there a weight of 0.5 is applied.

	Home:Office observed	*Weight (hours)*
Benefits/Debts/Finance	4:5	0.5
Domestic Violence Victim Support	16:25	0.4
Education support	10:8	0.5
Health Support	26:3	0.87
Housing advice	4:6	0.5
Parenting	51:22	0.66
General Case Management	Only in office	0

Administrative support
The administrative support given to the team is excellent and an intelligence analyst or administrative worker would usually be involved with general case management. Although this is not reported, we estimate the value of this by including the salary costs of an

administrative office for each General Case Management intervention recorded in the work log. According to the Local Government Employee Survey, the average salary of an administrative officer/assistant in London is £23,315, giving an hourly rate of £11.80.

Unit costs – with and without training
There is a well-established method for estimating the overall costs associated with providing social care set out in the annual - Unit Costs in Health and Social Care. We match the professionals involved with the FRP interventions with an equivalent worker – based on salary and role. The unit costs incorporate estimate for infrastructure – office space, administrative and HR support – plus the costs of initial and ongoing training.

Role	***Salary (£)***	***Unit costs 2009/10 category***	***Salary (£)***	***Unit costs (£000s)***	***Including training costs (£000s)***
ASB case worker	33,008	Social Worker	30,633	38	52
Benefits advisor	20,186	Social work assistant	22,220	28	
Deputy team manager	38,608	Social work team leader	38,608	49	63
Domestic Violence Worker	25,949	Social worker	30,633	38	52
Drug and alcohol worker	25,949	Social worker	30,633	38	52
Education worker	29,211	Family support worker	22,950	27	29
Health visitor	30,800	Health visitor	30,800	31	35
Housing officer	28,719	Family support worker	22,950	27	29
Intelligence analyst	30,469	Social work team leader	38,608	49	63
Intensive Outreach Worker	25,949	Family support worker	22,950	27	29
Police intelligence	35,765	Social work team leader	38,608	49	63
Senior analyst	47,147	Social work team leader	38,608	49	63
Service manager	38,608	Social work team leader	38,608	49	63
Social worker	34,964	Social worker	30,633	38	52

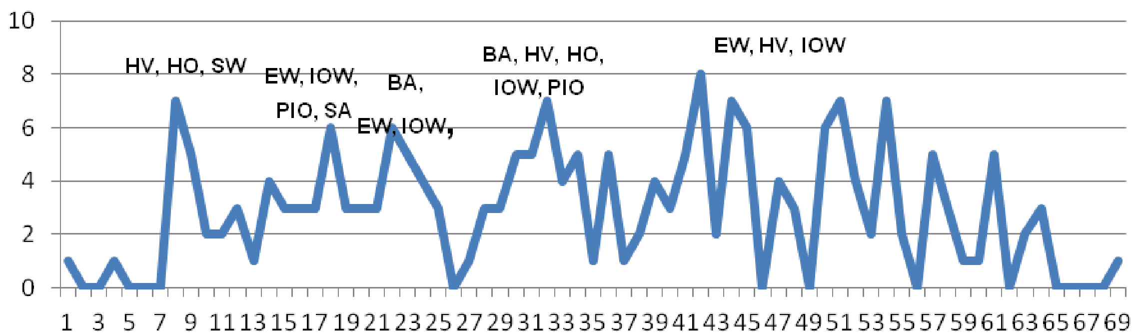
Source: Unit Costs in Health and Social Care, 2009/10
London weighting 1.16 for all categories except Health Visitor where a London weighting of 1.20 is applied.

Case 6

This lone parent family was referred by an Education worker due to persistent and long standing concerns about the educational attendance and attainment of the two children. One child was also considered to be disruptive when attending school and education welfare were in the process of taking proceedings (for the second time) against the mother.

The FRP IOW's initial work involved creating a relationship with the mother who was very reluctant to engage and felt that professionals were against her. She also went through children's services and other agencies' records for several years and constructed a family history and case chronology to help her understand why previous attempts to help the family had been unsuccessful.

The benefits worker provided advice and support in relation to the legal process which initially created some tensions with other agencies. The mother persisted with the claim that health difficulties underpinned her children's non- attendance. Late on in the case one child was diagnosed with a chronic health condition. FRP IOW spend much time working with routines and reinforcing health routines. Housing difficulties were identified and FRP benefits and housing specialists were involved in getting the family rehoused and ensuring benefits were being claimed. The family appeared to be more stable after 12 months of engagement with FRP workers. However, relationships with the mother started to breakdown. One child remained at risk of permanent exclusion and with poor attendance increasing again, legal proceedings were considered just after the case was closed to FRP.



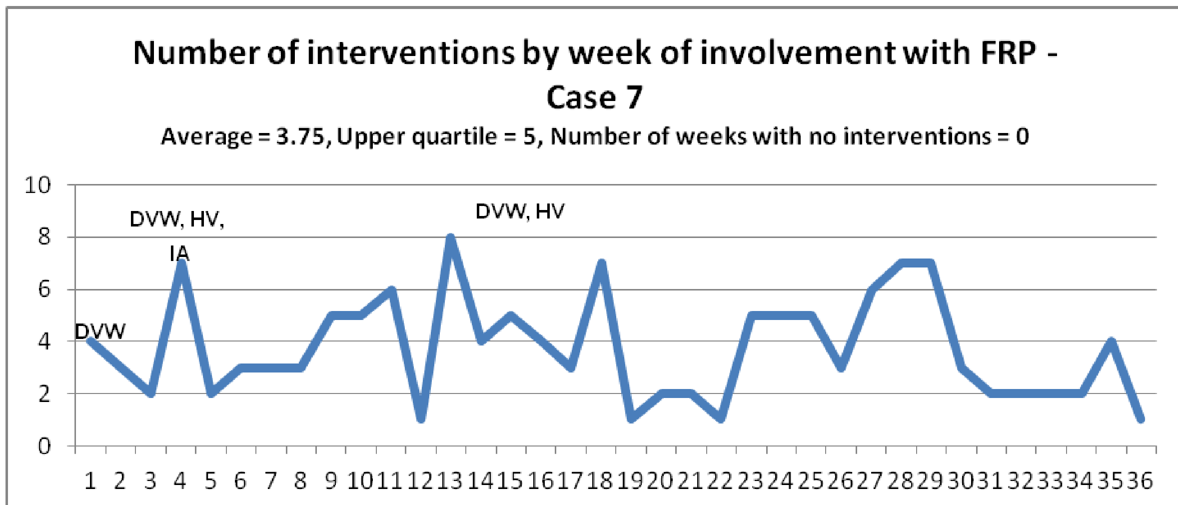
Hours of staff time = 68.75 Unit Cost plus training £5,066

Staff roles – Benefits adviser (1.5 hours), Education worker (18 hours), Health Visitor (11.75 hours), Housing Officer (2.25 hours), Intensive Outreach Worker (25.75 hours), Police Intelligence Officer (0.5 hours), Senior Analyst (0.25 hours) Social Worker (8.75 hours).

Case 7.

This case was referred jointly by a domestic violence worker and housing. This family had one child who was subject to a Child Protection Plan following physical and emotional abuse and this was also related to episodes of domestic violence between the parents, with the father assaulting the mother. This was one of the small number of cases in which there was no IOW with the DV worker and the health visitor (ensuring the child's health needs were met as she has a mild medical condition) jointly provided intensive support and advice. In the early stages of the case the father was not living in the home. Much FRP work consisted of supporting the mother around the domestic violence issue. The father did not attend a DV programme.

The mother was rehoused. However she became s angry that the professionals viewed her partner as a risk to herself and her child and resumed her relationship with the child's father. The lead worker for the child, a children's services social worker, remained involved throughout the period. The case was closed to FRP when a professionals' meeting agreed that care proceedings should be initiated. A care order was made but the child remained with the mother, who subsequently ended her relationship with the father. Six months after the case was closed to FRP, the mother, with support from her own mother, was considered to be providing good care for the child and consideration was being given to seeking repeal of the care order.



Hours of staff time = 45 Unit Cost plus training £4,677

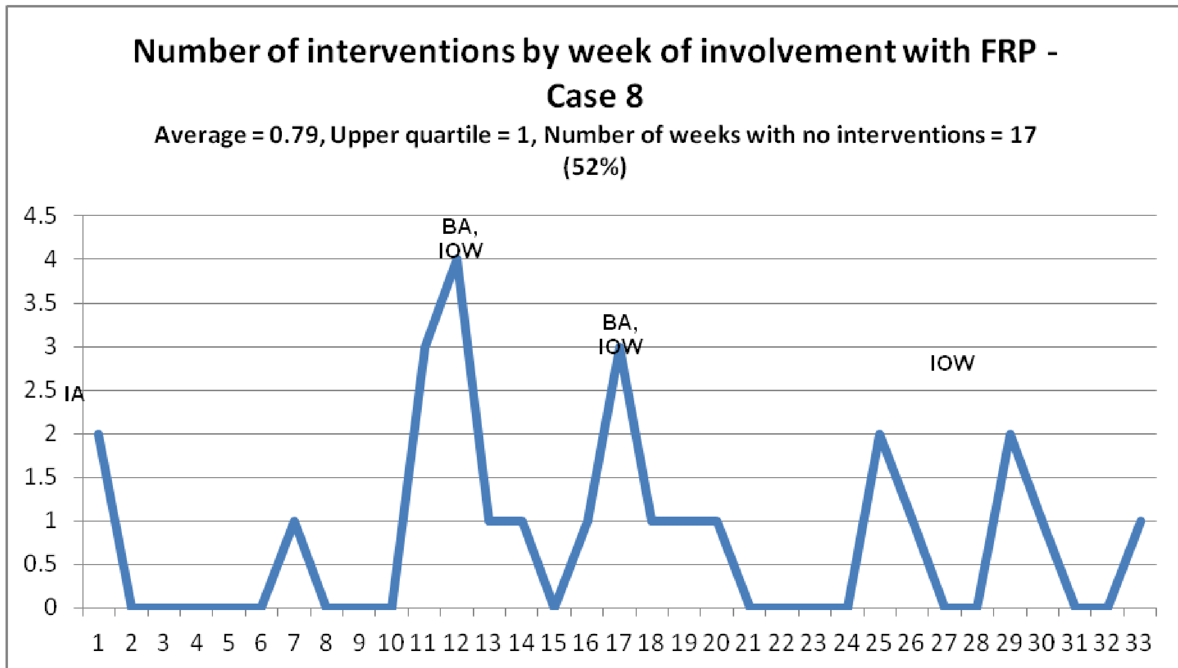
Staff roles – Domestic Violence Worker (28 hours), Health Visitor (11.25 hours), Housing Officer (0.25 hours), Intelligence Analyst (3.5 hours), Police Intelligence Officer (2 hours).

Case 8

Refereed by a local social work team this family were living in overcrowded accommodation in poor repair. The family had significant financial difficulties. The mother and father were separated, although they were on good terms and the father still saw the children. The core problem was that the children were at risk of entering care as they exhibited challenging behaviour and the mother was unable to control this, with little family routine, behavioural boundaries or appropriate parenting. The children's behaviour improved when staying with other family members.

The family were receiving support from a family centre and the FRP work centred around developing parenting skills. A financial plan was put in place by the benefit adviser to manage the debt. The father was in work but unwilling to assist the mother with money.

One child was referred to a speech therapist to assist with language development. Older children were linked into reading recovery programmes and learning support. The family were re-housed during the FRP intervention and this helped them to settle into a routine which was supported by the IOW. The mother aims to return to work and the employability worker was involved towards the end of the FRP intervention.

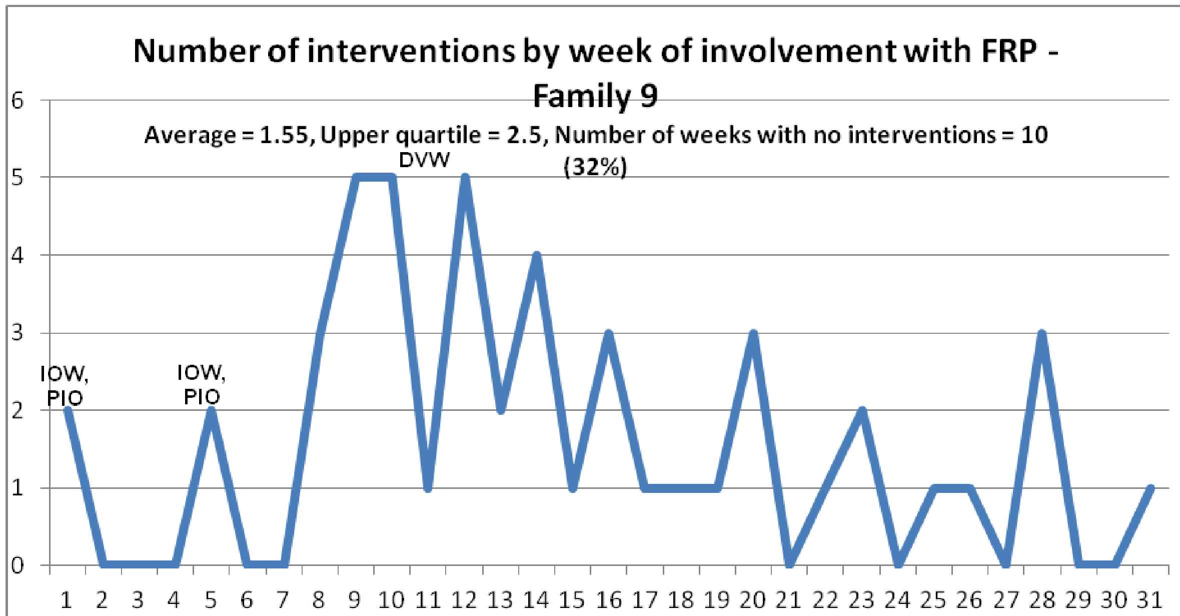


Hours of staff time = 11.5 Unit Costs plus training £938

Staff roles – Benefits Adviser (3.25 hours), Intelligence Analyst (3.5 hours), Intensive Outreach Officer (4.75 hours).

Case 9

This family were referred to FRP by children's services following longstanding concerns about domestic violence, the mother's mental health and poor housing conditions. Despite attempting to engage the mother in DV work no relationship was established. The mother did not acknowledge that she was at risk of DV, despite a history of violence within the relationship. The family were referred back to children's services and a mental health worker.



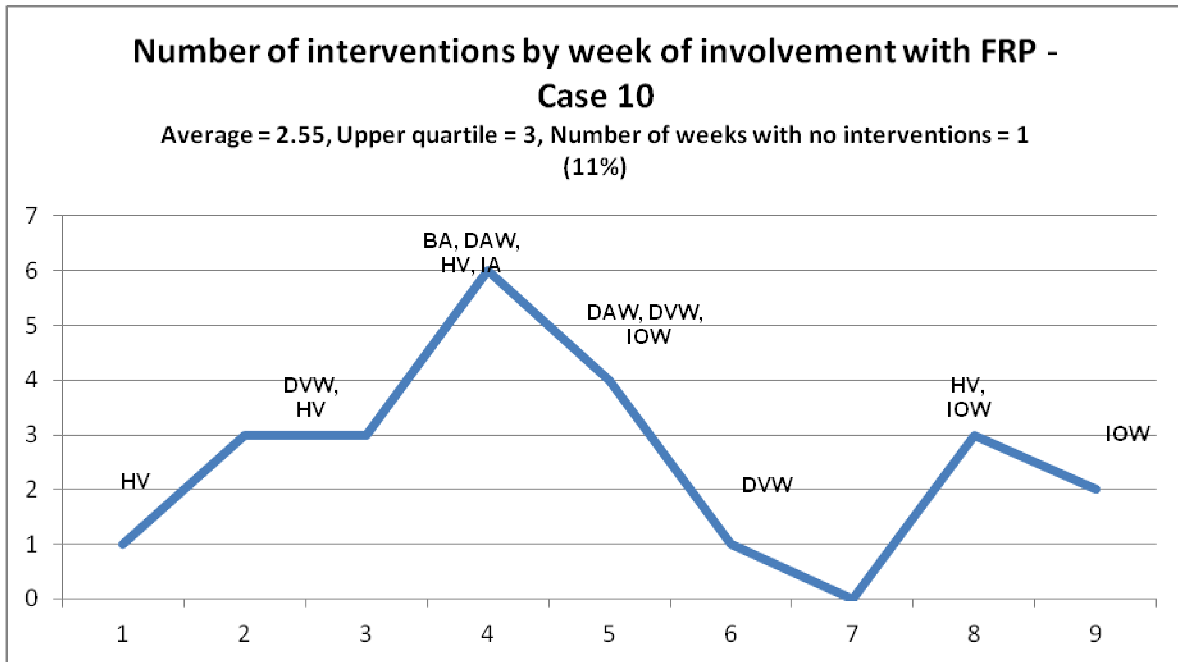
Hours of staff time = 14.75 Unit Cost plus training £1,235

Staff roles – Domestic Violence Worker (11.5 hours), Intensive Outreach Officer (0.5 hours), Police Intelligence Officer (2.75 hours).

Case 10

This family is part of a large extended family well known to local social services. The referral from social services to FRP concerned the father's long-term use of drugs and alcohol, domestic violence, financial and housing difficulties. The father was currently separated from the mother but was at risk of being evicted due to rent arrears.

Much FRP work revolved around working with the mother about her relationship with the father. Due to a DV incident during the FRP work, the mother was rehoused. Initial work with the father on his drug and alcohol use petered out and he become uncontactable. The mother was supported with financial issues and referred onto DV support groups, which she appeared keen to follow up.



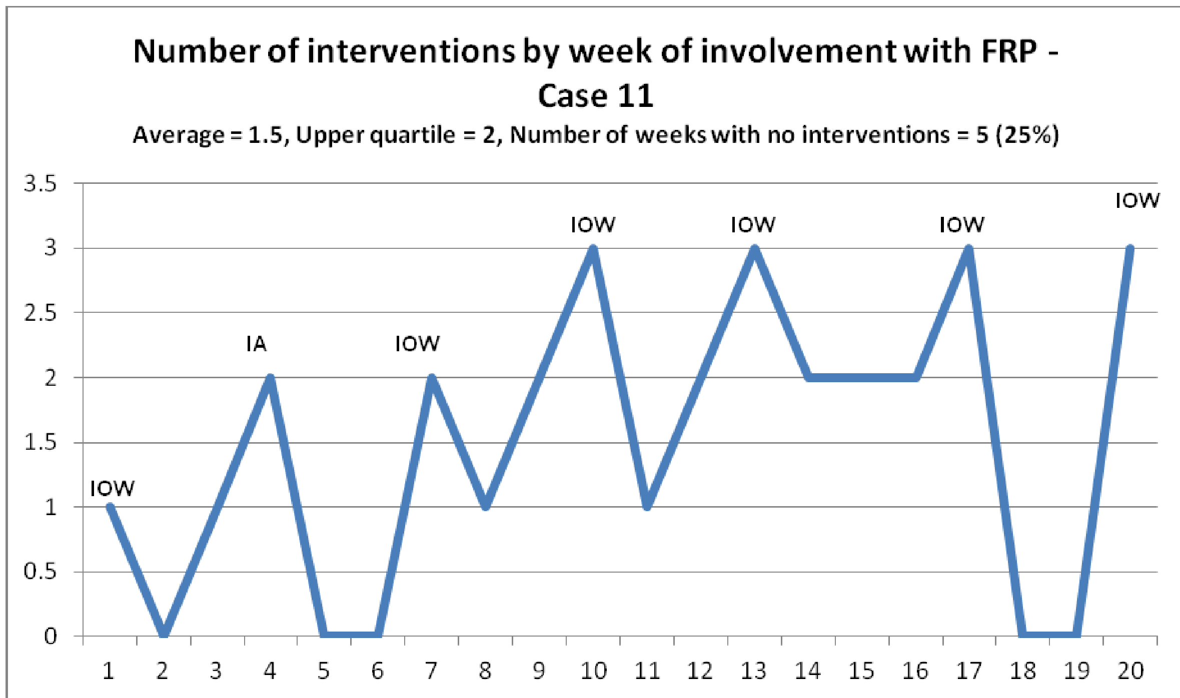
Hours of staff time = 14.75 Unit Costs plus training £1,164

Staff roles – Benefits Advisor (0.25 hours), Domestic Violence Worker (2 hours), Drug and Alcohol Worker (4.75 hours), Health Visitor (2 hours), Intelligence Analyst (4.5 hours), Intensive Outreach Worker (1.25 hours).

Case 11

This family were referred to FRP due to longstanding concerns about their impact upon the neighbourhood. The household is very noisy, with frequent parties and people coming to the house at unsociable hours, often aggressive behaviour occurs. The teenage children are also involved in antisocial behaviour. FRP work focused upon the mother and managing the family routines.

There were some housing issues to manage including ensuring repairs were undertaken. DV issues were recognised but the mother did not agree to explore this aspect. The mother was referred on to an employability worker to assist in applying for jobs.



Hours of staff time = 12.5 Unit Costs plus training £744

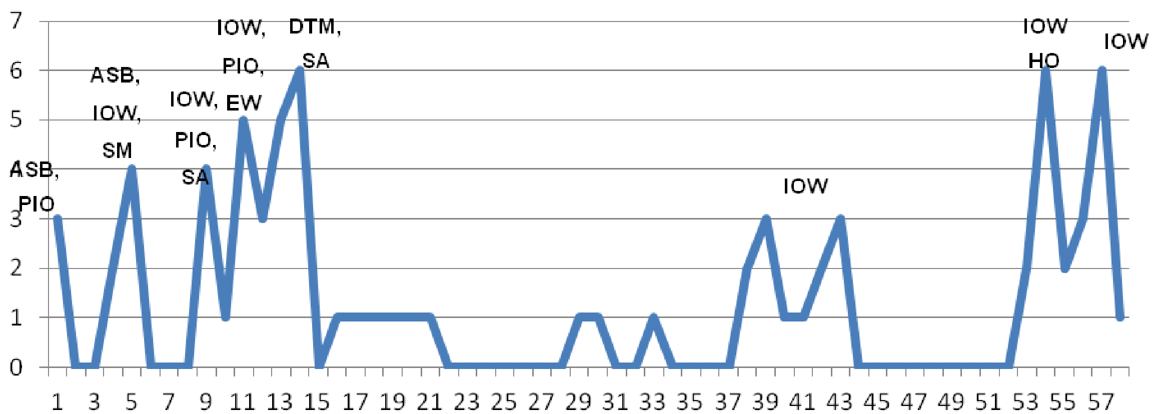
Staff roles – Intelligence Analyst (3.5 hours), Intensive Outreach Worker (9 hours).

Case 12

This family was referred to the FRP as the teenage children were involved in anti-social behaviour, especially related to binge drinking. The mother also had mental health and alcohol difficulties.

The mother was supported with building family routines and clearing up the house so the family could manage everyday activities more easily. FRP also worked with the family on financial issues, including an application for ESA. NOSP was also involved during the FRP intervention as was a YISP worker. At the end of the intervention the young people were considered to be doing well in education.

A referral to mental health services was made and the mother's drinking was less problematic as the intervention concluded. The mother was also referred to a family centre were she had been receiving counselling. Professional opinion was that the parental partnership was harmful to the children's wellbeing and detrimental to the mother's mental health, however the mother refused to acknowledge this and no work was undertaken on this aspect.



Hours of staff time = 42 Unit Costs plus training £2,649

Staff roles – ASB Case worker (0.75 hours), Benefits Advisor (6 hours), Deputy Team Manager (4 hours), Education Worker (0.25 hours), Housing Officer (0.25 hours), Intensive Outreach Worker (28.75 hours), Police Intelligence Officer (1.25 hours), Senior Analyst (0.5 hours), Sevice Manager (0.25 hours).