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Evaluation of Greenwich's Family and Adolescent Support Service (FaASS) practice approach

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About What Works for Early Intervention and Children's Social Care

The evaluation was conducted by the Early Intervention Foundation in 2021–2022. What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF) are merging. The new merged organisation is operating initially under the working name of What Works for Early Intervention and Children's Social Care (WWEICSC).

To find out more, visit our websites at: https://www.eif.org.uk and https://whatworks-csc.org.uk.

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WHAT WORKS FOR EARLY INTERVENTION AND CHILDREN'S SOCIAL CARE IS PROUD TO BE A MEMBER OFTHE WHAT WORKS NETWORK

What Works Network

This report was first published in April 2023.

The aim of this report is to support policymakers, practitioners and commissioners to make informed choices. We have reviewed data from authoritative sources but this analysis must be seen as a supplement to, rather than a substitute for, professional judgment. The What Works Network is not responsible for, and cannot guarantee the accuracy of, any analysis produced or cited herein.

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Contents

Executive summary

This report presents findings from a feasibility and pilot study evaluation conducted by the Early Intervention Foundation (EIF), now merging with What Works for Children's Social Care (WWCSC) and operating under the working name of What Works for Early Intervention and Children's Social Care (WWEICSC). The evaluation explores the systemic practice approach embedded within Greenwich's Family and Adolescent Support Service (FaASS) units.

Approach being evaluated

FaASS is Greenwich's Early Help service, which supports families with children aged 0–19, or 25 years if the young person has SEND (Special Educational Needs and Disability), with whole family support including parenting, employment, family relationships, home finances, housing and education. The service introduced the systemic approach in 2017 when there was a large restructure in the service. The new approach was based on the Reclaiming Social Work Model, which includes in-depth training, small units, group systemic case discussions, clinician support and enhanced administrative support.

Research questions

The evaluation aimed to explore the following sets of questions:

1. Evidence of feasibility: Is the approach being delivered as intended; and what are the enablers and barriers to delivering the approach?
2. Evidence of promise: What are the potential benefits of the approach for families, practitioners and the wider service; and are there any unintended consequences?
3. Evaluation feasibility: What is the most feasible way to evaluate the approach; and which outcomes are critical to measuring impact?

Methods

Adopting a mixed-methods approach, this evaluation involved:

- analysis of administrative data (family data and management data)
- analysis of training needs analysis survey data collected by FaASS
- pilot of family outcome measures administered at the beginning and end of the pilot (approximately six weeks apart)
- survey with FaASS practitioners to gather their reflections on the use of outcome measures
- interviews with one clinician, three unit leaders, two senior youth and family practitioners and five youth and family practitioners
- observations of three training workshops, one in-house training workshop, two practice meetings and a virtual service day.

Findings from the different data collection methods were triangulated to draw conclusions. The evaluation ran from February 2022 to August 2022.

Key findings

Evidence of feasibility

The evaluation provided evidence of how the approach is operating as intended (as specified in the theory of change) across eight units of FaASS:

- **Fidelity:** The evaluation data suggested there is a clear, shared vision for what the approach involves and how it is expected to lead to positive outcomes for children and families. There is broad agreement that key components of the approach include having practitioners assigned to units, weekly practice meetings, service-wide high-quality training on systemic practice, restorative approaches and trauma-informed practice, ongoing in-house workshops, clinical input from a clinician and the use of systemic tools during support with families. Aside from reduced clinical input in practice meetings due to capacity issues, the other elements appear to be delivered as planned.
- **Adaptation:** There was little variation in delivery across units and practitioners.
- **Dosage:** The elements of the approach were delivered at the anticipated frequency.
- **Reach:** Data provided by Greenwich suggests that FaASS is working with the families they intended to work with: that is, families with a range of issues including emotional abuse, neglect, parenting issues, child and parental mental health, domestic violence and housing issues.
- **Quality:** There was a strong sense that components of the approach are delivered with high quality. Interviewed staff members held the view that training, practice meetings and clinical input were meeting their needs and supporting them to develop their skills as a practitioner.
- **Participant responsiveness:** From interviews and observations it was clear that FaASS staff members were very engaged and positive about the approach being taken. Evaluation evidence suggests a majority of families engage well with the support from FaASS.
- **Intervention differentiation:** The new approach was introduced in 2017. Key differences from the previous way of working included introducing whole family working, access to a clinical input and the provision of high-quality training for all staff members in the service.

Enablers and barriers

- **A number of core enablers and barriers to the delivery of the approach fell into the following four categories and included:**
- **Service vision and values:** All staff had a clear understanding of the service vision and values which they were committed to.
- **Provision of training and support:** The provision of high-quality training and ongoing support was viewed to be fundamental to the successful delivery of the approach.
- **Team structure and staffing:** The structure of the service and the characteristics of staff were felt to be important for the effective delivery. Key features were the unitary model, the role of the clinician, administrative support, diversity of workforce, experience and expertise of staff members.

- **Capacity and workload:** Interviewed staff members pointed to the importance of having a small and protected caseload to ensure they had sufficient time and capacity to plan and reflect on the support they were providing for families.

Evidence of promise

The evaluation was not designed to assess the causal impact of the approach. However, the benefits of the approach for families, practitioners and the wider service included the following.

- **Practitioner outcomes** identified by interviewed FaASS staff members centred on increased feeling of being supported, better understanding of families' relationships, strengths and wider network, increased knowledge and use of the systemic practice model, improved confidence working with families, high-quality practice, increased resilience to work with families, more efficient and effective work with families and lower staff turnover.
- **Family outcomes** identified by interviewed FaASS staff members and supported by administrative data included improved understanding of other family members' perspectives, increased awareness of support network, improved confidence and awareness of personal strengths and skills, stronger therapeutic alliance, increased resilience, improved outcomes and reduced intensive or statutory support. Data collected by FaASS provided further support for some of these outcomes.
- **Outcome measures** that were used as part of the pilot (Me and My Feelings, SCORE-15 and FIDO) provided some initial evidence that outcomes were improving. Results from the measures and practitioner survey indicated they were suitable for measuring the impact of the approach as well as being useful for practice.

Conclusion and recommendations

Evidence gathered from the evaluation suggests the approach being taken by FaASS is working well, with high engagement and satisfaction from children, families and practitioners. Although causal claims on the impact of FaASS's approach could not be made, the evaluation showed indication of promise in improving outcomes for children and families by intervening in a timely way and creating change that is sustainable.

Recommendations on delivering the approach

Evidence from this evaluation points to a number of recommendations that FaASS could consider. These include:

- providing further training to support staff to develop skills further
- exploring why attendance varies across in-house workshops and ensuring content is aligned with practitioner development needs
- improving communication about staff members' expertise to ensure all staff members are aware of who is well placed to support them on specific topics
- expanding capacity of the clinician to ensure input is implemented as intended
- providing further guidance or support on which non-compulsory tools to use when and how to adapt them to meet family needs.

Recommendations on evaluating the approach

Evaluating the impact of the approach FaASS is taking is an important part of understanding how effective it is in achieving its intended outcomes. Part of the evaluation was to assess the feasibility of conducting a future impact study on the approach. The evaluation team was unable to identify or construct a sufficient counterfactual (that is, a control group) which would support a future impact study by the team.

The evaluation team would therefore recommend Greenwich builds on this evaluation and continues to assess the implementation and undertakes more robust impact evaluation to support its evidence of promise.

In terms of evaluating implementation, we recommend continuing and improving management data collection on the main features of the approach, including data on training attendance, delivery of case consultations, and direct clinical work with families. The evaluation team recommend this is supplemented with qualitative data collection with practitioners as well as children and families to understand their perceptions of the support they receive.

In terms of evaluating impact, we recommend that FaASS continues to investigate the impact of the offer on practitioners as well as on children and families through robust quantitative methods. We do not feel that there is currently robust enough data on the approach or its impacts do this. The evaluation team therefore suggest measuring the key outcomes that are articulated in the theory of change through comprehensive administrative data collection and the continued collection of validated outcome measures building on from the pilot conducted as part of this evaluation. This would give strong evidence on promise which could be used to undertake impact analysis in the future.

1. Introduction

Project background

The Supporting Families Programme, funded by the Department for Levelling Up, Housing and Communities (DLUHC), aims to help thousands of families across England to get the help they need to address multiple disadvantages through a whole-family approach, delivered by keyworkers, working for local authorities and their partners.[1] A national impact evaluation demonstrated that the programme has impact on certain outcomes, but local approaches vary substantially, with little current understanding of what is effective within early help more broadly.[2] Local areas also face challenges in evaluating their local early help services and therefore struggle to know whether they are delivering effective practice to support families in early help.[3]

WWEICSC, formerly EIF, has been funded by the Supporting Families Programme to work with local areas to carry out feasibility and pilot studies on promising approaches to supporting families with multiple disadvantages. Building on this work, DLUHC has committed to commissioning a large fund to administer impact studies to produce evidence on an effective approach for areas nationally.

Approaches to test through feasibility and pilot studies were selected based on an initial assessment of the evidence, in which the Department prioritised three topics with potential. The focus of this feasibility study **was psychologically informed keyworker practice built around an evidence-based practice model**. Some of the root causes of poor outcomes for vulnerable families are driven by a complex interaction of different needs. The hypothesis is that providing support to key workers from clinicians via training, supervision and psychological tools, to build supporting relationships and help families identify strengths at the child, family, service/school and community level can support families with complex needs to develop tailored strategies. It is hoped that this will strengthen family relationships and make positive change.

The feasibility and pilot studies aim to:

- test fidelity of the approach as well as reach, participant views and factors affecting implementation (feasibility study element)
- assess the approach's evidence of promise and readiness for trial (pilot study element).

After a joint EIF and DLUHC call-out to local authorities (LAs) and initial scoping, EIF identified four LAs – one LA with a data pilot linking housing providers to early help data, two with clinicians supporting key workers, and one with a psychologically informed Edge of Care team.

This evaluation report focuses on the current implementation of the systemic practice approach embedded within Royal Borough of Greenwich (Greenwich) Family and Adolescent Support Service (FaASS) teams via a feasibility study and an initial pilot study.

1 Department for Levelling Up, Housing and Communities. Supporting Families. https://www.gov.uk/government/collections/supporting-families

2 Ministry of Housing, Communities & Local Government. (2019). National evaluation of the Troubled Families Programme 2015 to 2020: Findings. https://www.gov.uk/government/publications/national-evaluation-of-the-troubled-families-programme-2015-to-2020-findings

3 Taylor, S., Drayton, E., McBride, T. (2019). Evaluating early help: A guide to evaluation of complex local early help systems. Early Intervention Foundation. https://www.eif.org.uk/resource/evaluating-early-help-a-guide-to-evaluation-of-complex-local-early-help-systems

Local context

Greenwich is a borough that experiences high levels of deprivation and there are a large number of children, young people and their families with multiple and often complex needs. The Children's Commissioner estimated that in 2019, 839 0–17-year olds were in households with the 'toxic trio', which consists of domestic abuse, severe mental health issues and alcohol or drug dependency. This equated to 12.2 per 1,000 and was the 87th highest percentile out of 100 nationally.[4]

Greenwich's FaASS supports families with children aged 0–19, or 25 years if the young person has SEND, with whole family support including parenting, employment, family relationships, home finances, housing and education. Many family issues have increased as a result of the pandemic, which has led to increased demand for support.

The systemic approach was first introduced to FaASS in 2017. There was a large reorganisation in the service in which different services for children, young people and families were bought together to deliver an early help offer. The new service was based on the Reclaiming Social Work[5] Model, which includes in-depth training, small units, group systemic case discussions, clinician support and enhanced administrative support.

Approach being evaluated

In line with best practice, we use the template for intervention description and replication (TIDieR) checklist to set out the approach being evaluated.[6] Information included in the description below was gathered through scoping interviews with the FaASS leader and clinical lead and a theory of change workshop as well as data provided by FaASS and evidence gathered on identified activities or approaches.

Brief

The systemic approach being used by Greenwich's Family and Adolescent Support Service (FaASS).

Why

There are a large number of children, young people and their families in Greenwich with multiple and often complex needs which are often rooted in deeper, second-order[7] problems. Families have low resilience and limited alternative support to be able to deal with these issues themselves.

Before systemic practice was embedded, there was felt to be a revolving door of families coming in and out of early help services with the same issues being repeated across generations. There was a perceived lack of alternative support for these families within the borough, with long waiting lists for other services (such as CAMHS (Child and Adolescent Mental Health Services) and some families not meeting thresholds for support. There was also a high level of staff turnover attributed to burnout.

4 Children's Commissioner Office Local vulnerability profiles. https://www.childrenscommissioner.gov.uk/vulnerable-children/local-vulnerability-profiles

5 Reclaiming Social Work (RSW) is a whole-system reform that aims to deliver systemic practice in children's services. Key elements include in-depth training, small units with shared cases and group systemic case discussions.

6 https://www.bmj.com/content/348/bmj.g1687

7 First-order change is change that occurs on the behavioural level without impacting the family or broader social network (ie the system). Second-order change involves not just changes in behaviour but change in the system – for example, not just changing a child's truanting behaviour, but changing their relationship with their family, peers and school to address the underlying reasons behind the truanting behaviour.

There has also been an historical perception that support was done to families rather than with families, with a lack of consistent engagement from many families in services that were available. In initial scoping interviews with the FaASS service leader, it was reported that families being supported by FaASS tend to have already had contact with an array of services before and this can be a barrier to engagement if they have had a negative experience. In addition,

What: procedures

The psychologically informed key worker practice approach being used by FaASS comprises a range of activities, each of which is outlined below.

- **Mandatory workforce training:** There is mandatory training in systemic practice, restorative practice and trauma-informed practice which all staff must complete. The courses are delivered by external providers.
- **In-house training workshops:** Alongside the mandatory training, the practice approach includes in-house training workshops delivered by clinicians, senior practitioners and/or practitioners. The workshops are delivered as standalone workshops or as part of service days. The training is intended to cover content based on the strengths and needs of practitioners.
- **Weekly practice meetings:** These weekly practice meetings are run for each of the eight units in FaASS. Practice meetings are supposed to be chaired by the unit leader or, in their absence, a senior-level practitioner. All members of the unit are expected to attend every meeting. All practice meetings have a clinician in them. Families are discussed during practice meetings every four weeks on a rota unless the family requires additional discussion; therefore, they are responsive to needs and priorities. During practice meetings, the lead practitioner presents details about the family and the other practitioners, unit leader and clinician develop hypotheses about why families may be experiencing certain issues and set action points or next steps.
- **Case consultations:** These are one-to-one sessions between practitioners and clinicians which practitioners can request as needed when they want to discuss a case that might have further complexity with a clinician.
- **Clinician support in family sessions:** The majority of the clinician's work is with practitioners rather than families and they are therefore non-case-holding. However, there may be a small number of instances where practitioners may identify that it is helpful for a clinician to join a session with a family to support them in a specific session.
- **Use of multi-modal tools:** During family support, practitioners use multi-modal tools as part of the mandatory assessments and draw on other tools or techniques to offer tailored support for families. There is an expectation that the tools will be used collaboratively with families during the support.
- **Quality assurance:** The service monitors the delivery of the different components of the support offer. This includes quality-assuring practice meetings, home visits, group work and case files.

Who provided

FaASS is made up of eight units who deliver geographically based intensive support to families. The following members of staff work across multiple units.

- **Group leader** who oversees the running of two to three units.
- **Coordinator** who provides administrative support for two units, such as writing up notes from practice meetings and making contact with schools and families.

- **Clinician** who works across all eight units in FaASS. The clinician attends practice meetings, provides consultations with practitioners and delivers direct work with families. The clinician has experience in social work and formal qualifications in family therapy, restorative approaches and dyadic developmental theory.

Each of the eight units consists of:

- a **unit leader** who is the line manager and supervisor for the unit. They oversee a team of practitioners to ensure the team is following guidelines and work is completed on time. They reinforce the systemic practice approach. The unit leader allocates families to practitioners in the unit, taking into account capacity alongside practitioner experience, skills and interests. The unit leaders accompany the practitioner on the first visit to a family
- a **senior youth and family practitioner** and three to four **youth and family practitioners** who typically work directly with around seven to eight families at a time, with some variations depending on how many referrals the service has received.

How

Support and multi-modal tools are delivered to families face-to-face. Workforce training and workshops, practice meetings and case consultations were designed to be delivered face-to-face either in groups or one-to-one depending on the activity. However, during the Covid-19 pandemic, some activities have been delivered online or using a hybrid model.

Where

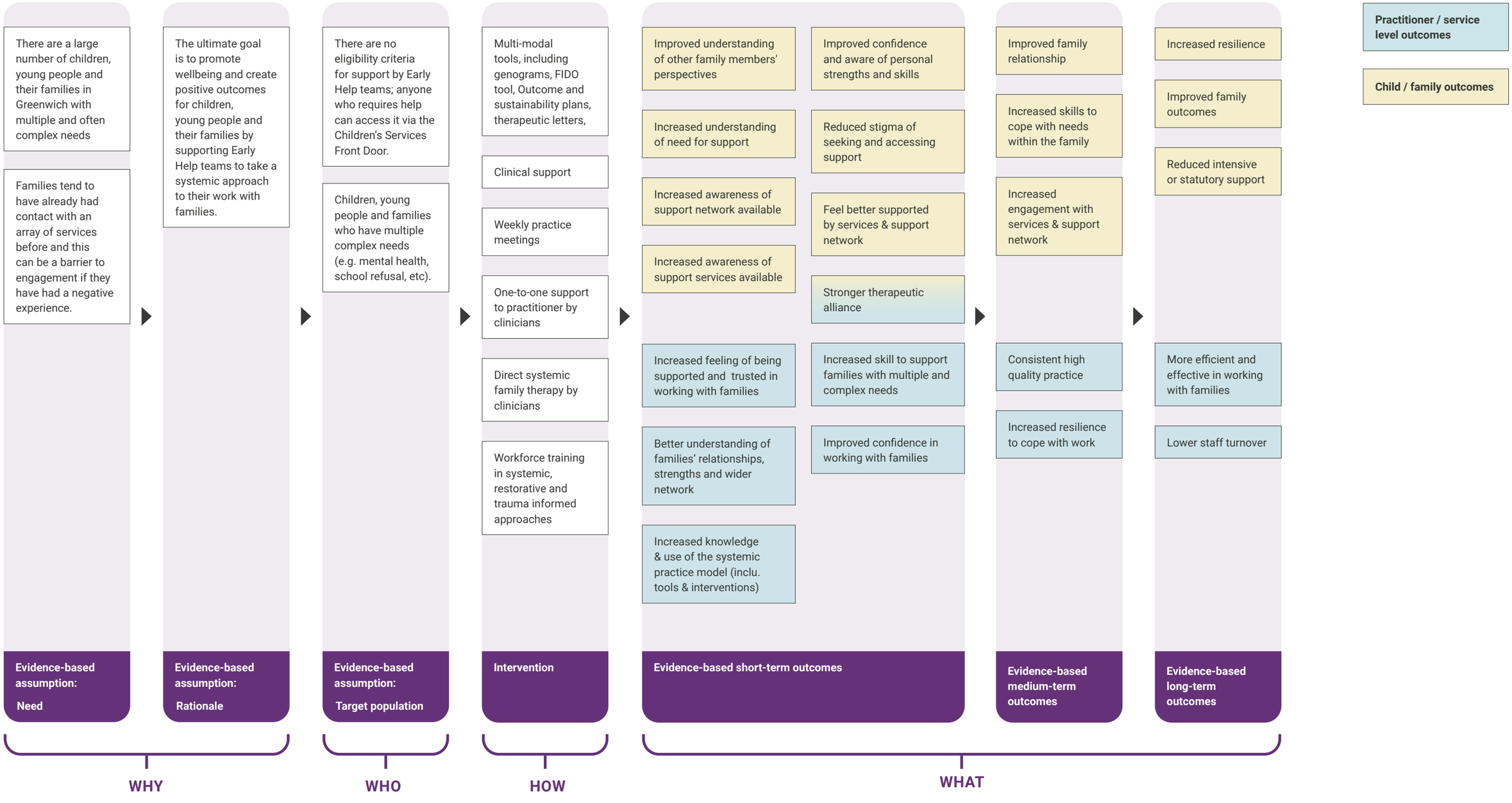
The systemic approach is used by all units in FaASS.

When and how much

The systemic approach has been running since Early Help was restructured in 2017. All staff members receive mandatory training when they join FaASS. Systemic training is delivered over 12 days, restorative practice training is delivered over four days and trauma-informed training is delivered over three days. In-house training is delivered on an ongoing basis with the content according to need. Staff members opt in and out of the workshops depending on how confident and competent they feel in different areas. Practice meetings are held weekly and are supposed to last for three to three and a half hours. Case consultations take place on an ad hoc basis as requested by the practitioner and typically last for 30 minutes to one hour. Multi-modal tools are used at various frequency during direct work with families. There is no fixed length of time for family support and the length of intervention varies depending on need and individual family circumstance. The quality assurance activity involves each group leader observing one practice meeting monthly, one observation of a home visit per quarter by all unit leaders, group leaders and the clinician, one group work observation every six months, the service leader, all group leaders, unit leaders and senior practitioners complete a case file audit per quarter.

Theory of change

Below is the high-level theory of change diagram which was developed as part of the initial phase of the evaluation with FaASS.[8]



8 A more detailed, narrative theory of change was also developed and is available on request.

2. Methods

Evaluation aims and research questions

Evaluation aims

The purpose of the evaluation was to explore the current implementation of the systemic practice approach embedded within Greenwich's Family and Adolescent Support Service (FaASS) via a feasibility study and the feasibility of conducting an impact evaluation of the approach via an initial pilot study.

Research questions

Below is a high-level summary of the research questions that were answered in the evaluation. A full list is available in Annex C.

1. **Evidence of feasibility:**
    - **Fidelity:** Is the practice approach being delivered as intended?
    - **Adaptation:** Does the delivery of the practice approach vary across the eight FaASS units?
    - **Dosage:** How much of the core activities are being delivered?
    - **Reach:** Does the approach reach the target families in need?
    - **Quality:** Is the practice approach being delivered to a high quality?
    - **Participant responsiveness:** To what extent do families and practitioners engage with the approach?
    - **Intervention differentiation:** What is the value-added of the approach and how does it differ from business as usual?
    - **Enablers and barriers:** What are the enablers and barriers to successful delivery of the practice approach?
2. **Evidence of promise**
    - **Potential benefits:** What are the potential benefits of the approach for families, practitioners and the wider service?
    - **Unintended consequences:** What are the actual or potential unintended consequences for families, practitioners and the wider service?

Data collection

The evaluation design involved a combination of quantitative and qualitative methods to address the feasibility study and pilot study research questions.

Quantitative research

FaASS administrative data

We analysed administrative data already routinely collected by FaASS. This data included management data (that is, data collected about staff and implementation of the service) and aggregated family-level data (that is, data collected about families being supported by FaASS). The data was anonymised and shared securely with the evaluation team at the end of the evaluation (June–July 2022).

FaASS survey data

We have included data from a training needs analysis survey conducted by FaASS in May 2022. The survey was completed by staff across the service but only data from participants working within FaASS has been included in the report. This included 39 responses in total (three group leaders, eight unit leaders, six senior practitioners, 20 practitioners and two unit coordinators).

Pilot of validated family outcome measures

To understand the potential benefits of FaASS's systemic practice approach, the following validated family outcome measures were piloted in six out of the eight units.[9]

- **Me and My Feelings**[10] was completed by children under the age of 11. This is comprised of a total score, emotional difficulties and behavioural difficulties.
- **Systemic Clinical Outcome and Routine Evaluation** (SCORE-15) was completed by children and young people over the age of 11 and adult family members.[11] This is comprised of a total score and three subscales: strength and adaptabilities, overwhelmed by difficulties and disrupted communication.

The pilot also aimed to explore whether the **Frequency, Intensity, Duration and Onset tool** (FIDO),[12] which was already being used by FaASS, could be used to measure change over time. This measure was completed by children and young people over the age of 11 and adult family members.

The measures were administered by the practitioner currently working with the child and family. Data was collected from 34 families at the beginning and end of the pilot (approximately six weeks apart), although sample sizes vary across measures (Table 1).

9 Units 7 and 8 did not pilot the outcome measures as they are ReSET Units and were already completing a number of other tools as part of the Your Choice Programme and therefore FaASS did not want to overburden staff.

10 Child Outcomes Research Consortium. Me and My Feelings. https://www.corc.uk.net/outcome-experience-measures/me-and-my-feelings-mmf

11 Child Outcomes Research Consortium. Systemic Clinical Outcome and Routine Evaluation (SCORE-15). https://www.corc.uk.net/outcome-experience-measures/systemic-clinical-outcome-and-routine-evaluation-score-15

12 FIDO is a tool that is primarily used during therapy and has been adapted by FaASS as part of the assessment process. The pilot aimed to explore whether it could be used to measure change over time.

TABLE 1

Number of individuals and families who completed each outcome measure

Measure	Sample size	
	Number of individuals	Number of families
Me and My Feelings	19	12
SCORE-15	31	20
FIDO	35	25

Survey with FaASS practitioners

At the end of the pilot, practitioners completed a short 15-minute online survey of their experiences of using the outcome measures. The survey included questions on previous use of measures, views on training, time taken to administer the measure, views on usefulness and future use (see Annex K).

Qualitative research

Interviews

The evaluation team carried out a total of 11 in-depth interviews with members of FaASS: one interview with the clinician, three with unit leaders, two with senior youth and family practitioners and five with youth and family practitioners. Participants were identified by the service leader and were recruited with the aim of achieving diversity in terms of gender, level of experience and role; however, the approach was also pragmatic and guided by the availability of participants. All interviews took place online and lasted between 55 minutes and an hour. The interviews were guided by a pre-agreed topic guide (which can be found in Annexes H, I and J) and were audio recorded with participants' consent. Interviews took place in May and June 2022.

Observations

The evaluation team undertook observations of some of the core components of the approach in order to explore fidelity, quality, the extent to which practitioners engage with the various components (participant responsiveness), and unintended consequences. The team observed three training workshops, one in-house training workshop, two practice meetings and a service day. Participants in the sessions were made aware that an EIF researcher would be present beforehand and gave their consent to the observations. No recording was made but researchers noted their observations of the sessions in a pre-agreed template (which can be found in Annex L), which was focused on how the activities were delivered rather than collecting personal information. To ensure data protection, initials rather than names were used in the notes. All observations took place in May and June 2022.

Analysis

Quantitative research

Administrative data

Quantitative administrative family data was provided by the Greenwich FaASS team, reported yearly from 2019 to 2022. No statistical analyses were performed on the data; rather, data was summarised across the three reporting years. Data was provided and summarised for a number of individuals referred to and supported by FaASS: the characteristics of those receiving support, including their presenting need, age, ethnicity, reported disabilities, length of support, cases closed/reasons for case closures and, finally, repeat contact rates.

Piloting validated family outcome measures

Data received on family outcomes collected via the pilot was analysed using descriptive statistics and analysis of responses used statistical tests where appropriate (that is, analysis of outcomes at beginning and end of pilot). Data was collated in Excel and subsequently analysed using Python version 3.10.5. The Shapiro–Wilk test was used to examine the normality of the data. All data was normally distributed. Paired-sample t-tests were performed to investigate change in outcome scores from the beginning to the end of the pilot evaluation.

Survey data

Quantitative survey data was collected from practitioners, using Microsoft Forms, regarding their experience using three outcome measurement tools as part of the FaASS pilot: the SCORE-15, Me and My Feelings and FIDO. Data was collected during the period 12 July to 3 August 2022 and 23 practitioners responded to the survey. Survey data was exported to Excel and subsequently analysed in Python version 3.10.5. Descriptive analysis was performed to produce frequency counts of different categorical responses, as well as averages, and minimum and maximum values, for numerical data. Quantitative data was supplemented with free-text qualitative data collected in the survey where relevant.

Qualitative research

All in-depth interviews were audio recorded with participants' permission. Observation notes were written into a pre-agreed observation template. A framework approach was taken to analysing the qualitative data. This involves summarising the data from each research interview into a thematic framework. Columns represent themes and each participant's data is summarised (charted) across a row. The strength of this approach is that it enables systematic and comprehensive analysis of the complete data set in a manageable way. Analysis can be done both thematically and individually. The analysis sought patterns, consistencies and inconsistencies in data collected from different participants to help answer the research questions.

To illuminate the descriptive and explanatory data presented, anonymised verbatim quotes from the in-depth interviews with the clinician, practitioners and team managers are integrated throughout the report. Quotes are labelled with their unique identifier only and do not indicate which group of participants they came from in order to preserve anonymity.

Data synthesis

The findings from the qualitative and quantitative components have been integrated to enable us to provide a comprehensive assessment of the way the FaASS was operating and assess the feasibility for an impact evaluation.

Study limitations

There are a number of limitations that affect the quality of the evaluation data.

Qualitative data

With regards to the qualitative data, it should be noted that practitioners were identified by the FaASS service leader, so it is possible there is an element of selection bias in the sample. However, given the practitioners' heavy workloads, the tight research timescale and the need to use the Early Help service leader as a gatekeeper for recruitment, it was considered that this was the most effective route for recruitment. The evaluation included interviews from over one-third of staff members (12 out of 32; 37.5%) and we reached a good level of saturation in the themes emerging from the data so we can be reasonably confident that we have captured a large number of the views and experiences of FaASS staff.

Evaluation activities were carried out at speed and over a very short period of time. Compressing the evaluation fieldwork may have limited the range of experiences that the research was able to capture. If it had taken place over a longer period of time, for example, it may have captured different types of training activities (for example, systemic training) or changing dynamics within practice sessions. It should be noted that at the point that the evaluation activities were carried out, some of the training sessions were being carried out online due to the ongoing impact of the pandemic. The shorter timescale also impacted the level of analysis that was possible and, for this reason, the report draws out high-level thematic analysis rather than anything more granular.

The qualitative element focused on the views and experiences of FaASS staff members. Although they were asked to reflect on the impact they have on the families they work with, it should be remembered that these were staff reflections on the perceived impact, and we do not have qualitative data capturing the views of families or children themselves. The original intention had been to carry out some qualitative work with families being supported by FaASS. However, this did not go ahead for two key reasons. First, the timescales did not allow for families to be contacted. Second, it was felt that while families would have views on the quality of the service and the impact it had or had not had on them, they would have limited knowledge of the psychologically informed practice, especially as practitioners mentioned they often would not tell families about the clinician's specific role or experience. This meant the relevance of the data would have been limited and might not have justified the potential burden that the research could put on families taking part in qualitative research.

Quantitative data

Outcomes data

The sample size for the outcomes data is relatively small, which limits our ability to identify statistically significant results and means the results need to be treated with caution. The duration of the pilot was also relatively short (six weeks), and it is possible that effects may vary if the pilot were longer in duration. There were variations in the sample with regards to length of time families had been receiving support. While some families had just begun receiving support from FaASS, others had been receiving support for a while, so may have had less distance travelled on outcomes. It should also be noted that this is a pilot evaluation rather than a full efficacy trial with a comparison group. Therefore, we cannot establish a counterfactual, or 'what would have happened otherwise'. The effectiveness of the approach, or impact, can only be measured with an experimental or quasi-experimental design, where counterfactual data from children and families who have not been supported with the approach allows for the extraction of the effect on these other factors. This would

have allowed us to attribute changes in these outcomes over the evaluation period to the pilot itself. In summary, quantitative results should be treated with caution due to the small sample size, and no conclusions should be drawn from them about causal impact.

There were several issues with data collection which led to inaccuracies in the data. On the FIDO measure, there were duplications in the ID numbers used, meaning that beginning and end data was matched using the date of onset as the unique identifier, which may or may not be an accurate metric on which to match. Thus, analyses exploring change over time should be interpreted with caution. Additionally, although practitioners reported that the FIDO measure was beneficial to their practice, its utility as an outcome measurement tool for exploring change from the beginning to end of the pilot is questionable. Without standardising answer options it becomes challenging to compare the beginning and end data at a group level and thus this type of analysis was limited to only the intensity rating scale. There was also a specific error with the Me and My Feelings measure whereby three of the items were not administered to children. This meant there was missing data for these items and, subsequently, it was not possible to score or analyse the data from the behavioural difficulties subscale. The utility of the total score is also in doubt given the three items were missing and could not contribute to the total score.

Administrative data

There were a number of limitations with the administrative data that should be acknowledged. While the data can provide useful insight into the reach of FaASS support, it is not possible to quantify how the FaASS offer compares to other services due to a lack of available data. Even in the presence of data, the varying nature of support provided across different services, as well as the difference in number of children and families that are supported, would make comparisons challenging outside a rigorously controlled environment. The data is also at a high level, making it challenging to quantify which distinct aspects of the FaASS offer may be more beneficial than others, although the qualitative data can and does provide depth to mitigate this shortcoming. The data also does not capture information about families who do not access FaASS, making comparisons impossible.

Usefully, quantitative data was available across a number of years, recorded and reported for each year since 2019. However, the nature of the data is ever changing as cases close or reopen and thus the data reflects the period of time between 1 April 2019 and 31 March 2022, and no period outside this time frame. Two remaining limitations should be acknowledged. First, much of this data is captured by FaASS staff and we thus have no ability to verify the accuracy or validity of the data. Second, the outcomes data collected from the pilot, while extremely useful, is limited in that the sample is small (23 practitioners), which limits the utility and generalisability of the responses.

Ethics

The evaluation has followed EIF's ethical guidelines, which were set out in the evaluation protocol. To ensure all participants were able to give informed consent we provided participants with a clear and accessible information sheet (see Annexes D and E). To gather consent for taking part, we issued participants with a consent form which includes explicit statements about what taking part would involve and how data collected would be used, with tick boxes to allow the participant to consent to each statement and, where appropriate, to decide not to take part in certain aspects of the study (see Annex F). Care was taken to ensure participants understood they did not have to participate in research activities and could withdraw at any time. To reduce research burden, we minimised the burden placed on participants by ensuring qualitative interviews and surveys were kept short and that outcome measures were short and easy to complete. To ensure inclusion in research, we selected appropriate methodology to ensure no group was unreasonably excluded from the research.

When conducting the research, we were aware of and sensitive to cultural, religious, gender, health and other issues in the research population, always acting in a non-discriminatory way.

Data protection

EIF complies with the General Data Protection Regulation (GDPR) when handling and storing data. The legal basis for data sharing for this evaluation was 'legitimate interest' and 'informed consent'. Participants received a link to EIF's privacy policy available on the EIF website, which provides further information on how we collect data, what their rights are as research participants and how they can withdraw their data if they wish. Although the evaluation activities included the observation of training and case reflection and management sessions, the evaluation team did not see or record any family data. This report and other publications arising from this research will not identify any individual practitioner, family or child. FaASS shared case management information and administrative data on the running of the service, including data on training, consultation sessions and practitioner demographics. FaASS removed any identifying information from the data so that names and other identifying information not necessary for the evaluation were removed or replaced with a code. Therefore, all data was pseudonymised or fully anonymised.

3. Findings

Evidence of feasibility

This section explores the extent to which the practice approach was being delivered as intended, including what the various components of the approach look like and their dosage. This section also explores the extent to which and how the elements of the approach are being adapted among the eight FaASS units where possible.

Team structure and staffing

The plan for the team structure and staffing was mostly adhered to during the evaluation. A group leader oversaw the running of two to three units. Each unit was being led by a unit leader who had overall case accountability, managed practitioners within the unit and accompanied the practitioner on the first home visit. Within each unit there were senior practitioners and practitioners who were delivering support to children and families. Senior practitioners and practitioners have a range of formal qualifications (such as undergraduate degree in early years, criminology, biomedical science) and professional experience (such as childcare and education, local authority, charity sector). During interviews, they reflected that their previous experience had provided transferable skills to their current role in FaASS. A unit coordinator supported administrative tasks for two units. At the time of the evaluation, there was one full-time clinician in post, although the plan is to have at least two within the service. The lower number of clinicians was due to recent staff turnover. The service is currently planning to hire an additional clinician.

Workforce training

A key component of the approach being taken in FaASS is the provision of both mandatory training and in-house training workshops available to all staff members.

Mandatory training

The evaluation evidence suggests that the mandatory training programme is mostly being delivered as planned.

It is intended that all staff members across the service receive mandatory training when they join, which includes systemic, restorative and trauma-informed training. The restorative approaches training course was delivered by an experienced restorative practitioner from the local authority and the systemic training was delivered by experienced and qualified trainers from Collective Space.[13]

Data collected as part of the training needs analysis conducted by FaASS shows that a majority of the surveyed practitioners and senior practitioners have attended systemic training (25 out of 26; 96.2%) and restorative training (24 out of 26; 92.3%). Results indicate slightly under two-thirds of practitioners have attended trauma-informed training (16 out of 26; 61.5%). This suggests that overall, training is reaching the intended recipients.

Originally, each of the three training courses were designed to be delivered in person but, due to the pandemic, the courses have been delivered using a hybrid model of in-person and online sessions.

13 Collective Space: Systemic Social Work. https://www.collectivespace.org.uk

Although we did not quality assess the training as part of the evaluation, the restorative training course has been accredited by the Restorative Justice Council and the systemic training has been accredited to a Foundation Level by the Association of Family Therapy and Systemic Practice in the UK. The external accreditation suggests the content and delivery is of high quality.

In-house training workshops

The approach includes ongoing training workshops that are delivered as standalone sessions or as part of the monthly service day. The management data shows that across the last 12 months, 19 training workshops have been delivered across FaASS. The workshops have been delivered by the clinician alongside senior practitioners and practitioners. As training is provided at the service level, there is no variation in delivery across units.

The training covered a range of topics which were in response to the needs and requests from staff members and included: systemic genograms, sustainability plans, ending support, sleep and safeguarding curiosity. The attendance of training workshop varied (see Appendix A, Table 6 for a full list of workshops and attendance) as expected, as staff members can opt in or out depending on how confident and competent they feel in different areas. The systemic genograms training was the best attended (38 attendees in total), with eight unit leaders, seven senior practitioners and 23 practitioners, whereas the compassionate approaches was the least well-attended training session, with only two practitioners in attendance.

CASE STUDY 1

Ending support training workshop

A clinician and two senior practitioners delivered an online workshop via Zoom on how to end support with families based on practitioners requesting further support on this topic during practice meetings and case consultations. The workshop was attended by 24 senior practitioners and practitioners. During the workshop, participants were asked to think about an 'ending' they have experienced in their own lives before four participants fed back to the main group covering themes related to moving out of the family home and leaving a job. The lead facilitator then provided background theory on endings covering when they would occur, the different types of endings and how families would be feeling. In five breakout rooms, participants discussed their personal experiences of endings before discussing as a whole group. The clinician then provided insight into different strategies that could be used when ending work with families and attendees were invited to share their own different practical tips that others could use when ending work with families. Tips included acknowledging the ending, referring to the process as 'stepping back' so families knew that FaASS are there in the future if needed, and referral to other services. The discussion then covered when endings might be difficult, such as feeling attached to a family or having unrealistic expectations about meeting all needs. Participants were split into breakout rooms where they discussed strategies for endings and fed back to the main group. During this discussion, practitioners reflected on how their Social GRACES* might influence their approach to ending support with families. One of the facilitators then provided an outline of how to end with families, emphasising it is important to plan for the ending from the beginning of support. The facilitator asked for any final contributions before finishing the session.

Source: observation of a workshop

* Social GRACES describes aspects of personal and social identity including gender, race, education, sexual orientation, religion, employment, age, ability.

Practice meetings

Practice meetings are intended to occur weekly and attended by all members of the unit, and evidence from the evaluation shows this is the case. We observed two practice meetings which followed the expected delivery model and format. The unit coordinator administered the practice meetings by sending out invitations to unit members, circulating supporting documents and taking notes during the meeting using the practice meeting template. The unit leader chaired the discussion between attendees, who consisted of senior practitioners, practitioners and the clinician. The senior practitioners and practitioners presented cases and contributed to discussions. The clinician asked questions and offered suggestions for how to progress cases (further detail about the clinician's role is discussed below). From observations and reflections during interviews, it was apparent that FaASS staff members engage well with practice meetings, contribute to discussions and listen to and respond to the ideas of other attendees.

> *'Practice meetings, for example, all about thinking outside the box and just being curious and hypothesising and not necessarily knowing what's right, but thinking about, could it be this or could it be that or what's going on there?…so you've got a family of four children and three are boys and one is a girl. And, like, what's the, you know, things like, what's the experience of the girl in the family, compared to three boys, and it's just extending that thinking and keeping it systemic.'*
> – Family and Adolescent Support Service staff member 10

We observed the use of the systemic hourglass model to discuss cases and the use of the safe/unsafe–certain/uncertain model. During both practice meetings, there was reference to Social GRACES throughout the discussion. In one practice meeting, there was a focused session on Social GRACES which involved each attendee selecting a card with a social GRACE listed on (such as gender, sexuality, race, education) and discussing what it means for the family and how it might be contributing to their issues. During the discussions, practitioners also reflected on how the social GRACE may be influencing their perception of the family. During the practice meetings, we observed discussion of evidence and sharing of tools and resources. Practice meetings are delivered at the unit level and there appeared to be some differences in terms of how the unit leader chairs the discussions. FaASS staff members who had worked in more than one unit reflected during interviews that there are some differences in terms of how practice meetings are delivered. However, there was a sense that this was down to different personalities of the unit leaders rather than substantial deviation from the intended approach.

CASE STUDY 2

Discussion of a family during practice meeting

The practice meeting is held in person and is attended by the group leader, one senior practitioner, three senior practitioners, the clinician and the unit coordinator. The practice meeting begins with a check-in, during which each participant reflects on how they are feeling and how that might impact their engagement with the session. Six families are discussed in turn throughout the session with a range of issues including school attendance, alcohol use, domestic violence and physical health issues. For each family, the unit coordinator displays case note discussions on a large screen at the front of the room. The case-holding practitioner begins by drawing a genogram on a large whiteboard and naming the different family members and describing their characteristics (age, gender, mental health, additional needs etc). After the presentation of the genogram, the rest use 'curious questioning' to help them fully understand the case. Then, the rest of the team discusses their hypotheses while the lead practitioner remains quiet. Systemic hypotheses are developed by considering family relationships and patterns across generations in terms of behaviours and experiences. The unit leader and clinician encourage practitioners to draw on their systemic ideas. During discussions, participants consider how Social GRACES may be influencing the issue and their perception of the issue. Then, the lead practitioner rejoins the conversation and gives their views on the different hypotheses that have been presented. They discuss the actions they will take forward. The unit coordinator writes the action points in the case note discussions.

Source: observation of a practice meeting

Clinical input

The clinician provided support to staff across the service via three main pathways: consultation during practice meetings; consultation outside practice meetings via one-to-one consultations; direct engagement with families. As there was only one clinician in post at the time of the evaluation, it was not possible to explore differences in clinical input across clinicians.

Consultation during practice meetings

The practice approach specifies that the clinician will attend every practice meeting to provide therapeutic insight regarding a child's, young person's or parent's behaviour and methods of working with them. However, due to staffing and capacity, the clinician attended practice meetings bi-weekly rather than being at every weekly practice meeting.

The clinician is intended to reinforce the practice approach by encouraging staff to think in a systemic, family-centred way and providing reflective consideration. Evidence gathered for the evaluation from interviews and observations suggests that the clinician is fulfilling this role during practice meetings.

> *'[The clinician will] help us to look at our cases and if there's a case in particular that we're having some concerns around or need further support, they will offer us that support and help us to kind of break down the case and look at it as a whole and then come up with a plan and some suggestions.'*
> – Family and Adolescent Support Service staff member 01

One-to-one consultation

Practitioners had the opportunity to arrange a one-to-one consultation with the clinician to discuss particular cases they are working on in more detail than practice meetings. In line with the intended purpose of consultations, practitioners reported during interviews that they would request a consultation to receive tailored advice about a case they are working on. Common reasons for requesting a case consultation included: seeking advice on how to progress a case; deciding which tools to use with a family and how to adapt their use; seeking reassurance about what actions to take with a family (for example, whether a case should be stepped up to child protection); reflecting on own practice for cases which have been emotionally challenging (for example, to discuss a case where the practitioner has own lived experience of the issue); and reinforcing how to apply learning from training to practice.

As the idea is that practitioners will request support as needed and tailored to a family's needs, the expected frequency of case consultations is not articulated in the practice approach, as this will vary between practitioners and cases. There were mixed views about the factors which appear to influence the extent to which practitioners request case consultation. There was a sense that practitioners were more likely to request case consultations when they first joined the service, and this decreased with length of time in their role as they were more experienced in using the systemic approach. However, it was also highlighted that among practitioners who were not new to the service, those who were more confident in their practice tended to be more willing to request support from the clinician.

Clinician support in family sessions

Practitioners had the opportunity to ask clinicians to meet with a family for a one-off session or a series of sessions to receive direct clinician input. The expectation is that this element of the offer is used for a minority of cases, which is evidenced by the management data. In an eight-month period,[14] there were 33 cases in total across the eight units where the clinician provided direct therapeutic intervention for families.

The expectation is that this element of the practice approach would be requested by practitioners only when there is a clear need. Evidence from the evaluation suggests this is the case; practitioners are requesting the clinician accompanies them on a home visit for clear reasons. Management data collected shows the main reason clinical input was requested for cases between December 2021 and July 2022 (Table 2).

TABLE 2

Main reason for direct clinical input

Main reason for direct clinical input	Number	Percentages (%)
Parenting support	9	27.3
Whole family support	9	27.3
Mental health support	8	24.2
Supporting practitioner to progress case	2	6.1
Supporting practitioner to use tools	2	6.1
Reflection on parents' experiences	2	6.1
Domestic abuse	1	3.0
Total	**33**	**100%**

14 FaASS began collecting management data on direct case consultation after the theory of change workshop in November in anticipation of the upcoming evaluation.

During interviews, practitioners described the different reasons they would request direct clinical input. In line with the management data presented above, reasons included: to provide or support therapeutic intervention for families with specific mental health disorders, such as depression, anxiety or suicide; to support practitioners to use a tool; to provide advice on how to progress a case. Other reasons not captured by the management data included for practitioner's safety.

Practitioners emphasised that they would seek permission from families before bringing the clinician to a home visit and explain the benefits of bringing them. Practitioners explained there was variation in how they would introduce the clinician depending on the families' needs. They noted they would usually introduce them as their colleague rather than the clinician, unless they felt it was beneficial for the family to know about the clinician's distinct role and background.

> *'I would say "I want to bring my colleague along, she's amazing, she's so clever, she's been doing this forever and she is good with me as well. Together we are going to be able to help you achieve this goal on what you want and that's why I need her to come along.'"*
> – Family and Adolescent Support Service staff member 05

It was noted by practitioners that some families decline the offer of direct input from the clinician. The management data showed that out of the 33 families approached for direct clinical work, two of these families had declined. One of these families did not engage initially as they had decided they did not want to continue with early help support, and the other family stopped after two sessions. During interviews, practitioners described further scenarios where families had not engaged with clinical input. The data, alongside the views presented during interviews, suggests only a minority of families decide not to engage with the direct clinical input.

Use of tools

Evidence gathered for the evaluation suggests that the tools are being used as planned with children and families. Practitioners emphasised that they use tools in a way that is consent-based, collaborative and family-led. For instance, they described adopting creative methods, or writing materials in a way that is accessible for families by using language that families will understand and including visual diagrams to assist understanding. This was felt to be particularly important for families with additional needs or with limited English.

Evidence from interviews suggests use of systemic tools varies among practitioners. Some practitioners mentioned using creative methods when administering the tools – for instance, using dinosaurs to represent different family members when constructing a genogram – whereas other seemed to use the tools less flexibly. Less variation among practitioners was observed for outcome measures, such as FIDO, as the tools are more structured, and questions need to be asked in a certain way.

The primary tools practitioners reported using as part of their assessments and to support their practice were the following.

- **Genograms** are developed in collaboration with the family and explore family members, their history and relationships, the challenges, difficulties and any trauma experienced and may help to identify the origins of these.
- **Stakeholder aims tool** captures the views of family members and other professionals such as schools, to understand what they would like their outcomes at the end of support to be.

- **Strengths and Needs tool** involves a family alongside the practitioner identifying aspects where they may need support and also the strengths and positive elements of families' lives.
- **Therapeutic letters** are written at the end of support. The letter is reviewed by the unit leader and/or clinician before it is presented to the family. Practitioners mentioned that they would adapt the format of the letter to meet the needs of children and families – for instance, making posters and including visual diagrams.
- **Timelines** explore family history and significant life events.
- **The FIDO tool** captures with the family's input the frequency, intensity, duration and onset to explore the issues family members are experiencing.
- **Goal setting** involves families setting three goals which are usually centred around education, positive relationships and health and wellbeing. Goals are reviewed throughout support.
- **Outcome and sustainability plans** detail the progress a family has made and ways to sustain change once support has ended. The plan is developed leading up to closure.

CASE STUDY 3

Sustainability plan

A sustainability plan reviews what a family has achieved so far to celebrate their progress, and details what actions the family needs to take to sustain change. For example, the contact details of individuals in their support network. Sustainability plans are developed in different formats to make them engaging and accessible for families. One senior practitioner described the different formats of sustainability plans they have developed:

> *'It's a bit boring if it was just written, so they come in all different shapes and sizes to be perfectly honest. I've done sustainability plans with children where I've presented them with a cup and on their plan, it might be to love my brother so it's like little reminders. So for the children that wouldn't be this long list of how to overcome the fight with the brother, it will be just reminders, "I love my brother", and the other reminder might be "and I need to remember to keep going to school" or whatever it is. So they come in all different shapes and sizes. So I've done cups; I use sometimes cartoon images. If it's for parents, sometimes little pictures depending on kind of the type of person they are or like different letters, like writing colours, that sort of thing. So I try and make it as eye-catching as possible.'*
> – Family and Adolescent Support Service staff member 06

Source: FaASS staff member interviews

There seems to be variation in the extent to which families engage with tools. Although some families engage well with the tools from the outset, others are more wary about the tools, particularly the elements which ask about their family history.

> *'For example, the genogram. Some families would love to tell you their life story and you know they wanna tell you all about, you know, great uncles, so and so. And you know, they love it. Wherever some families ask what you wanna do that for, you know?'*
> – Family and Adolescent Support Service staff member 10

For some families, their concerns about using a tool decrease once they have tried a tool out. However, practitioners described some scenarios where families have found certain tools difficult and overwhelming, which means the family does not complete them.

Audit process

The service has an audit process which takes place on a monthly basis. In January 2022, the service decided to undertake audits in pairs or groups made of group leaders, unit leaders, senior practitioners and the clinician to ensure learning is shared and there is consistency across audits. The service moved to a group mode because staff fed back that they did not find doing case file audits useful alone, and so FaASS listened and changed their model of auditing. The audit process is designed to understand the quality of the practice delivered to families and to understand where the service needs to learn and develop against a practice framework. Those undertaking audits are advised to ensure that families' lived experiences of the service are a focal point of the audit process. Case files, contacts with families and practice meetings are reviewed according to the domains set out within the FaASS Peer Audit Scorecard (PAS) framework, which has been devised in partnership with FaASS, PAS and Children's Services (quality assurance domains are shown in Table 3).

TABLE 3

Domains for case file, contact with family and practice meeting audits

Case file	Contact with family	Practice meeting
Assessment and planning	Did the intervention drive change?	Did the discussion drive change?
Delivery (including timescales)	Was the intervention impactful?	Was the discussion impactful?
Collaborative working	Was the intervention collaborative and systemic?	Was the discussion collaborative and systemic?
Difference to every family member	Did the intervention make a difference to the family?	Did the discussion make a difference to the family?
Clear sense of experience	Overall score	Overall score
Management oversight		
Overall score		

Learning from the audit process is shared regularly with all staff members with the aim to improve the service. For instance, during the service day in March 2022, the service leader presented findings from the audit process. This included reflections on how to support practitioners to be more confident and competent in being curious, ensuring sustainability plans are considered upon closure and understanding why cases requiring housing support are being kept open. Staff members who score 'requires improvement' or 'inadequate' scores in specific areas are offered places on workshop sessions to improve their skills in specific areas.

Number and demographics of children and families who have been supported by FaASS

Greenwich FaASS family data, collected for the period 2019 to 2022, indicated that there were 2,069 contacts in total. Practitioners mentioned a majority of families engage well with the support offer and have spoken positively about their experiences.

Data collected for the period 2019 to 2022 indicates a small number of contacts (291 out of 2,414; 12.1%) do not engage with the service. Among this group of families, the most

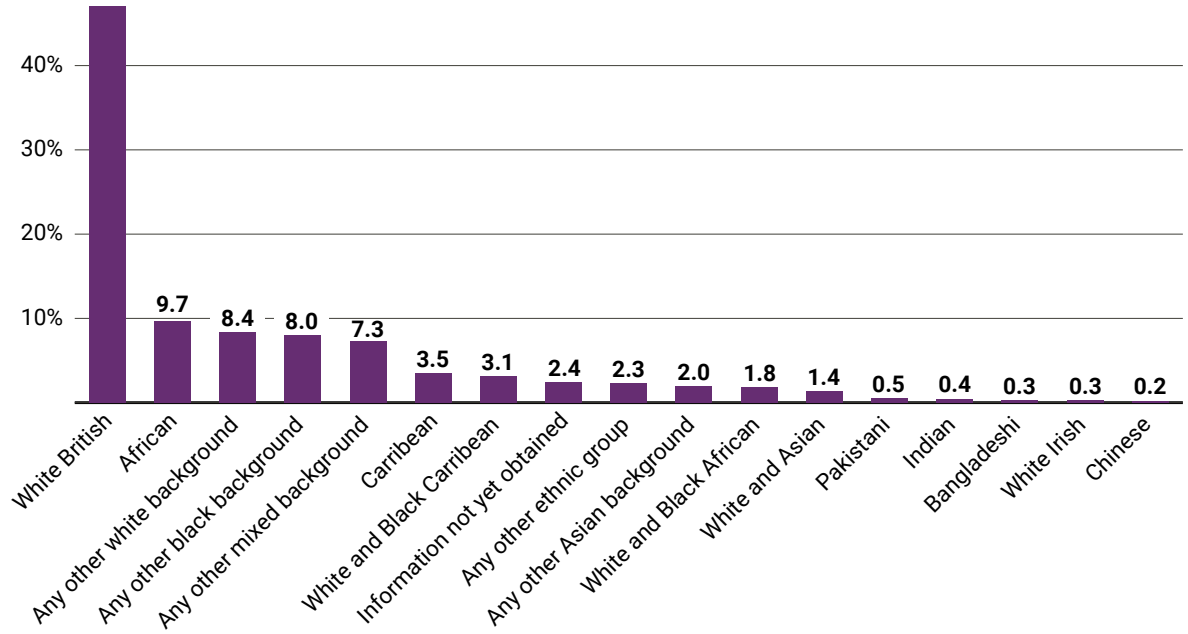
common reason was FaASS failing to engage the family during initial contact (74.4%), families withdrawing consent (12.8%) and unplanned closure due to disengagement (12.8%).

The average age of children being supported by FaASS is 10 years and 8 months. Around one-third of children are in secondary school (35.8%) or primary school (33.39%) and around one-sixth are in early years (13.56%) or aged 16+ (17.17%). There are more males (54.5%) being supported by FaASS than females (45.4%). A majority of children do not have a disability (87.4%).

With regards to ethnicity, overall, 'White British' make up just under half of contacts (48.1%), followed by 'African' (9.7%). While 'White British' are over-represented when compared to the ethnic composition of the overall under-18 Greenwich population,[15] the 'African' group are under-represented, suggesting they are not being reached by the service. Further information on ethnicity is presented in Figure 1.

FIGURE 1

Ethnicity of children being supported by FaASS



Needs of children and families who have been supported by FaASS

During interviews, practitioners and unit leaders reflected that they support families with a wide range of issues, which include education, low-level offending crime, mental health issues, parental loss and interpersonal relationships. In line with the qualitative evidence, data collected between 2019 and 2022 shows FaASS is supporting children and families with a range of different needs. Data shows that among families where the child's primary need was recorded, emotional abuse, neglect, socially unacceptable behaviour, learning disability and mental health were the most frequent, while families whose child's primary need was 'abuse linked to faith or belief' was the primary need least frequently encountered (see Appendix B, Table 7).

Among families with a parent's primary need recorded, the most frequent were parenting issues, mental health, domestic violence and housing issues, while families whose parent's primary need was 'risk to children' was the primary need were least frequently encountered (see Appendix C, Table 8)

15 GLA population estimates.

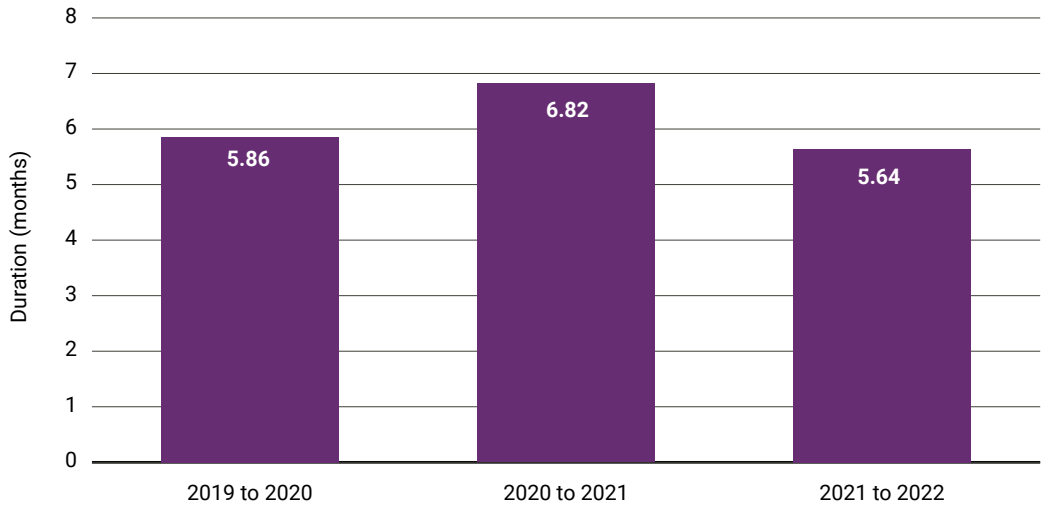
However, it is worth noting that FaASS supports families to identify their own presenting need and address what is important to them, which is often complex and may not fit criteria that are used in family-level data. As part of the pilot evaluation, families completed the FIDO tool, which includes a question asking the respondent to state in their own words what the problem was (see Appendix D, Table 9). Of the 59 individuals who completed the FIDO measure at baseline, the most prevalent problem identified was 'child/young person needs support with their mental health' (n=14; 23.7%). Other prevalent issues were low school attendance (n=7; 11.9%), parents or carers requiring parenting support (n=7; 11.9%) and child or young person has behaviours that challenge within the home (n=6; 10.2%).

Length of support for families being supported by FaASS

The average duration of support provided to families who had case closure between 2019 and 2021 was 6.2 months (n=1,592), with some variation across each year (Figure 1). It is possible the length of intervention was longer in the years 2020–2021 due to the pandemic.

FIGURE 2

Average intervention duration, in months, for each year that a data return was submitted



Family-level data indicates some level of variation in the length of the intervention for families based on their primary need (Table 4). This data reflects cases where there was a planned closure (for example, some or all goals were met, or positive outcomes were achieved) between 2019 and 2021. Families where the child's primary need was 'missing children' typically received support from FaASS for the longest (9.60 months), while families where the child's primary need was 'abuse linked to faith or belief' remained in the intervention for the shortest period of time (0.0 months).[16] Some caution should be taken with the generalisability of these findings due to small sample sizes in some of the subgroups.

16 The length of intervention was based on one case so should not be generalised to all cases with this presenting need.

TABLE 4

Average intervention duration across the categories specified as the child's primary need for the period 2019–2022

Child's primary need	Intervention duration (months)
Missing children	9.6 (n=7)
Child criminal exploitation	9.0 (n=4)
Physical disability or illness	8.2 (n=23)
Female genital mutilation	7.0 (n=2)
Gangs	6.9 (n=13)
Abuse or neglect – neglect	6.8 (n=117)
Drug misuse	6.5 (n=13)
Socially unacceptable behaviour	6.4 (n=156)
Alcohol misuse	6.3 (n=13)
Learning disability	6.3 (n=110)
Child sexual exploitation	6.1 (n=30)
Abuse or neglect – emotional abuse	6.0 (n=128)
Abuse or neglect – physical abuse	5.9 (n=41)
No primary need recorded	5.8 (n=499)
Mental health	5.6 (n=113)
Domestic violence	5.1 (n=11)
Abuse or neglect – sexual abuse	3.7 (n=7)
Self-harm	2.0 (n=1)
Abuse linked to faith or belief	0.0 (n=1)

When considering parent primary need (Table 5), families where the parent's primary need was 'housing issues' typically received support from FaASS for the longest (6.9 months), while families whose parent's primary need was 'learning disability' remained in the intervention for the shortest period of time (4.8 months).

TABLE 5

Average intervention duration across the categories specified as the parent's primary need for the period 2019–2022

Parent's primary need	Intervention duration (months)
Housing issues	6.9 (n=83)
Drug misuse	6.8 (n=14)
Physical disabilities or illness	6.5 (n=15)
Parenting issues	6.4 (n=293)
Domestic violence	6.3 (n=65)
Nil recourse to public funds	6.3 (n=3)
No primary need recorded	6.0 (n=628)
Alcohol misuse	5.8 (n=19)
Mental health	5.0 (n=164)
Learning disability	4.8 (n=5)

FaASS team members noted during interviews that there are other characteristics alongside primary child and parent need which may influence the pace of work and therefore the length of support that is provided, including family characteristics, values and beliefs:

> *'I think we've always got to remember that every family are unique. Every family have different experiences, values, beliefs, where you live…they all factor in to how you may take in information and how you may be able to act on the support and move forward, and for some people it will be a really slow pace.'*
> FaASS team member_06

Intervention differentiation

Before the approach was introduced in 2017, the service leader reflected during scoping interviews that there was a revolving door of families coming in and out of early help services, with the same issues being repeated across generations. Services were set up to support individuals rather than the whole family. Young people and families were often shunted from service to service rather than supported and held by a lead professional. Practitioners reported not seeing the difference that interventions should have made with their families or young people. There has also been a perception that historically support was done to families rather than with families with a lack of engagement from many families in services that were available. There was also a high level of staff turnover attributed to fragmented services and inconsistency in support available to families.

In addition, there was a perceived lack of alternative support for these families within the borough, often with long waiting lists for other services (such as CAMHS) and some families not meeting thresholds for support.

The FaASS staff members we spoke to reflected how the offer compared to other teams and local authorities they had worked in. The direct access to specialist clinical input was regarded as unique. Some practitioners spoke about how the training available in previous roles had been of lower quality and focused on them achieving outcomes rather than improving their practice. Previously there was no consistent training offer as the service for children, young people and families were ran and led separately so they had separate training on assessments, tools and methods for working with families. Access to training was also restricted to those in roles directly supporting families rather than the whole service having access to the same training.

Enablers and barriers affecting delivery of the approach

Practitioners, unit leaders and the clinician identified the following enablers and barriers to delivering the approach, which fell into four overarching themes: service vision and values; provision of training and support; team structure and staffing; and capacity and workload.

Service vision and values

Shared understanding among all staff members

Staff members had a **clear and shared understanding of the service vision and values**. This was achieved by **clear and consistent communication from senior leadership and management**. Staff reported that senior management were visible and communicated clearly.

The **consistent training package available to all FaASS staff members**, including senior leadership and administrative support, helped to ensure staff had a **shared understanding of how to implement the approach and used shared language**.

Staff buy-in and commitment

Findings from the evaluation indicate that senior leadership and unit leaders appeared to have a positive attitude and enthusiasm towards the approach. Practitioners echoed this view that leadership were onboard with the approach, and reported the service was managed well.

FaASS staff members were also largely positive about the approach and reported high satisfaction. For instance, a senior practitioner remarked that the approach is a concept that they 'really buy into and fully believe in'. There was recognition from interviewed staff members that practitioners have delivered the approach with professionalism, humanity and a strong commitment to getting the support for families right. They were described as 'going the extra mile' to support families.

Relationship and communication among staff members

Interviewed FaASS staff members felt that they were **listened to**, and their **ideas valued**. They described **an openness across the service for discussion and challenge of ideas** which provides opportunities to learn what has gone well and what could be improved. Staff members in the service felt able to approach anyone else in the service, including leadership and unit leaders, to discuss ideas, ask for advice and seek support. It was felt that the leadership had put in a lot of work to ensure that practitioners understand there is not a space between themselves and senior colleagues.

There was a sense that **all staff in the service were encouraged to be open-minded, curious, supportive and respectful** during their interactions with families and their colleagues, such as during consultation and practice meetings. For instance, at the beginning of practice

meetings, attendees are given time to reflect on how they are feeling and talk about any personal issues they may be experiencing.

Those in more **senior roles did not regard themselves as experts** and instead recognised the value in the different perspectives that those across the service brought. Unit leaders recognised that they do not hold all the answers about how best to progress a case and instead would work collaboratively with practitioners to develop a solution. The clinician's input during case consultation and practice meetings was viewed to be an opportunity to discuss cases with practitioners and learn from each other rather than the clinician giving advice for practitioners to follow.

Consent-based service

The **consent-based nature of the service** was viewed as fundamental for establishing trusting relationships with families and securing their initial and sustained engagement with the service. With regards to the delivery of clinical input, practitioners highlighted the importance of seeking permission from families to invite the clinician along as this helped families feel respected and listened to. Practitioners also noted the importance of asking for consent before starting and during the use of tools, and not continuing if families feel uncomfortable. They recognised that some families can be wary about tools, particularly as they probe about personal and sensitive information, so it was important to seek permission first.

> *'I think that we are able to demonstrate our care, our compassion and support for families, so that when we do direct tools, it's done with the family leading at their pace. We do a lot of permission seeking. So is it OK to ask you this? How would I know if it's not OK if you don't let me know? How is uncomfortable? How will I see that in you?'*
> – Family and Adolescent Support Service staff member 11

Empowering families to make and sustain changes

FaASS staff members spoke about the **importance of keeping families as experts in their own lives**, which was articulated as a core value of the service. Practitioners felt this was essential to help families make and sustain changes themselves, and to secure their initial and sustained buy-in. To meet this value, practitioners felt it was essential that the assessments are completed in collaboration with families, capturing their perspectives and views.

> *'It's done in collaboration with them, so whatever [families] want it to look like, that's what it's going to look like because it's their tool, it's not ours.'*
> – Family and Adolescent Support Service staff member 04

It was recognised that if a family is involved in writing a sustainability plan, for example, they will be more motivated to follow it through after support ends. Practitioners also noted that by including families in this process, they develop skills to solve their own problems.

Provision of training and support

Sufficiency of training and support

The **high-quality training** available on systemic, restorative and trauma-informed practice was viewed as being fundamental to enabling the service to work systemically. Staff members felt the consistent training package available to all staff members helped them develop a shared understanding and communicate with colleagues using a shared language. For instance, because the unit coordinator had attended the same training as other staff members, they were able to understand and accurately record the content discussed during practice meetings.

Staff members were overwhelmingly positive about the training they had received. They generally reported that training met their needs and was enjoyable. In the training needs analysis survey, the majority of practitioners rated systemic (44 out of 49), restorative approaches (45 out of 47) and trauma-informed (27 out of 31) as 'good' or 'outstanding'. During interviews, practitioners and unit leaders reported high engagement with the training.

> *'People always fed back that they've loved the training on those specific three models and have always been excited to get to the next bit. So to me that's telling me that the quality has been there because it's held their attention, it's held their interests and they're excited to do other things, you know, and they've been buying books on it and things like that.'*
> – Family and Adolescent Support Service staff member 09

Those who had attended training felt that facilitators had delivered content in a style that was **informative and easy to understand**. Another important feature of the training was the **interactive format**, which practitioners thought helped reinforce practical elements that were covered during sessions. For instance, during the restorative practice training, participants were given opportunities to practice what they had learned in small group role play sessions, such as facilitating a restorative justice session.

It was noted by unit leaders that **introducing new ideas learned in training slowly** helped to ensure practitioners did not feel uncomfortable, particularly as some of the training covers personal or sensitive topics, and to help practitioners break it down into steps that could be implemented in their practice.

> *'Because if we go slowly with it and we've not been kind of like forcing it down them and making them feel uncomfortable about it, it's just kind of breaking it down in a way that's adaptable for them to be able to do it. …it doesn't have to be worded how the therapist might word it as long as you you're trying to kind of implement little bits.'*
> – Family and Adolescent Support Service staff member 09

There was a strong preference for **in-person training**. FaASS staff members felt that the virtual delivery of training that was necessitated by the Covid-19 pandemic was a barrier to fully engaging with the training content. Practitioners felt that online delivery made it harder to develop relationships with others in the group and participate in group discussions as conversations did not flow as easily. In light of the limitations with online delivery, the service has begun delivering more training in person.

As the mandatory training is content heavy, practitioners mentioned that **refresher training** was important for revisiting concepts they may have forgotten or not taken forwards immediately. There was a sense that **formal refresher workshops** were useful alongside **discussions in practice meetings** to help reinforce concepts and translate learning into practice. Practitioners also valued having colleagues they could go to for support who had particular expertise and experience in topic areas covered in training.

> *'There are people I know within the service that I could ring and say…I'd actually quite like a bit more of a refresh or someone I can consult about a case and which I have done…I do know that there's people that I can go to that could then help me get the ball rolling if I was going to implement it with a family.'*
> – Family and Adolescent Support Service staff member 07

Support to use tools

To ensure quality standards of tools, practitioners pointed to the **value of training to introduce the tools and ongoing support to reinforce best practice** for using the tools. Practitioners found it useful to receive formal training and also opportunities to share ideas about how to implement and adapt tools in line with the needs of each family during discussions and practice meetings. Practitioners noted it was important for them to have the

knowledge and skills gained from training and practice meetings to explain to families why certain tools were being used and what the anticipated outcomes were to help secure buy-in from families.

Audit process

The audit process was viewed as an important component to **identify areas of strengths and development at the individual and service level and tailor training accordingly**. Depending on needs, the service may offer training to the whole service, for instance during service days, or invite specific practitioners to training or workshops.

Team structure and staffing

Unitary model

Interviewed staff members emphasised that the **division of the workforce into distinct units promotes systemic practice** because practitioners do not feel completely on their own with cases and are able to develop hypotheses with the input of others. Practice meetings foster a sense of belonging and connection which provide a foundation to enable staff to make informed decisions in the interests of children and their families. The shared responsibility was felt to reduce anxiety about how best to support a case.

Administrative support

Unit leaders emphasised the importance of the **unit coordinator to provide administrative support – for instance, to help with running practice meetings**. In particular, their role in noting down action points that practitioners can refer back to after the meeting. The administrator also plays a key role in supporting practitioners with administrative tasks, such as contacting schools or preparing tools and materials for families.

Diversity of workforce

The **diverse background, characteristics, values, beliefs and lived experiences** of unit leaders, practitioners and the clinician (for example, different Social GRACES) was important for bringing **different ideas and perspectives for discussing cases**.

> *'Everyone will always have a slightly different lens, no matter what background we're from, we've all got different experiences and we can all have different ideas or different approaches and having the dedicated space every [week] to explore that is really really useful.'*
> – Family and Adolescent Support Service staff member 07

Clinician's role

The **clinician's distinct non-case-holding role** was perceived to be an important aspect of the approach. As the clinician sits on the periphery of cases, they are able to bring a fresh perspective to cases and ask practitioners curious questions about families.

As the **clinician does not have a managerial role**, practitioners acknowledged that they are able to offer different advice than their unit leader or senior practitioner might offer. In particular, practitioners valued the safe and confidential space for discussion about cases.

Availability of clinician

The **availability of the clinician** was viewed to influence the extent to which practitioners requested clinical input. At the time of the evaluation, there was one clinician working across eight units, whereas previously there have been two clinicians. The clinician's high workload appeared to contribute to a reluctance among practitioners to request direct clinical work as they mentioned being mindful of the clinician's limited capacity to take on extra work. There was a shared view among interviewed FaASS staff members that it would be beneficial to have additional clinicians in the service.

Practitioners acknowledged they found it easier to ask for support from a clinician they had **built a relationship** with over time. They mentioned it was harder to ask for support from a clinician they did not know very well or had not seen very many times in person.

Clinician's skills and experience

It was felt the **clinician's skills and experience** were fundamental to the approach being delivered effectively. The clinician's training means they have a different expertise from practitioners, which helps them approach family needs from a different perspective. It was also noted that clinicians have a deeper level of training and experience around certain areas – for instance, family therapy and counselling.

> *'There's a marked difference between the therapeutic approach and the way that they might approach something. And so they've got the ability to kind of look at things and say have we thought about this longer term or kind of have we explored everything about this family that would be helpful, and they bring a totally different element to our practice meetings.'*
> – Family and Adolescent Support Service staff member 04

Practitioner past experience

FaASS staff members have a **diverse range of previous roles and qualifications**. Previous roles included working in education, childcare, Early Help, community outreach, hospitality and therapy. During interviews, all interviewed staff members were able to articulate how skills and knowledge gained from their previous experience had been beneficial for their role in FaASS. For instance, those who had worked in education described that knowledge of the education system had been useful when supporting families with school-related issues. There was a group of interviewed staff members who had limited formal qualifications but felt they brought lived experiences to the role which helped them empathise with the families they were supporting.

Unit leaders remarked that some practitioners were able to grasp systemic ideas learned in training and apply them easier to practice than others. It was felt that **practitioners who had come from roles working specifically just with young people** (for example, youth offending service) **were more reluctant and found it more difficult to work with the whole family** in a systemic way.

Capacity and workload

Size of caseload

It was acknowledged that to deliver the approach effectively, practitioners need to have a **small and protected caseload**. There was a sense that when caseloads are higher, practitioners do not have enough time to plan how to use and adapt the tools for the families they are supporting. A unit leader noted that a reduced caseload would give practitioners more time to spend writing case notes for each family, which would mean they would be able to write notes in a way that reflects the systemic work that has been completed.

Allocation of families

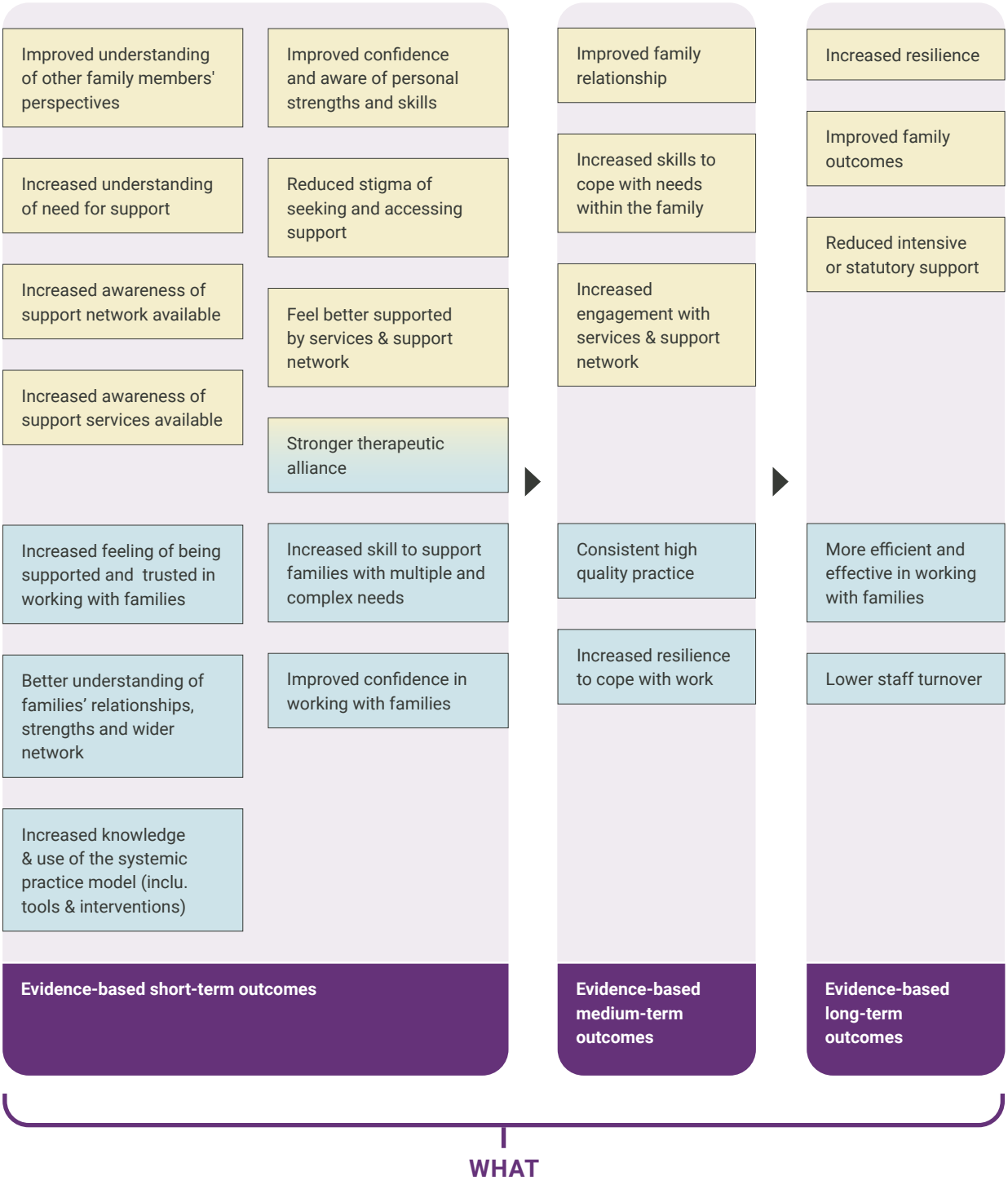
Across units, allocation of families by unit leaders was based on **capacity in conjunction with practitioner skill set and interest**. Unit leaders gave careful consideration to ensure practitioners were assigned cases that they were interested in and cases that would help them develop skills. Practitioners said that they liked the fact that their skill and interests are taken into account.

Impact of the approach

The following section explores early indications that the approach is making progress towards its intended aims for families, practitioners and the wider service based on the outcomes identified in the theory of change developed before the evaluation fieldwork (Figure 3 Outcomes presented in the theory of change). For each group, this includes perceived outcomes identified by unit leaders, practitioners and the clinician during interviews, and evidence of outcomes from family data and outcomes data. The section also explores unintended consequences of the approach.

FIGURE 3

Outcomes presented in the theory of change



Perceived outcomes for practitioners and the wider service

Short-term outcome: increased feeling of being supported and trusted working with families

A key perceived benefit to practice meetings is that they **encourage collaborative working among members of the unit and the clinician**. Practitioners noted that practice meetings helped them feel supported by their colleagues in progressing cases and managing risk, and the joint working makes them feel reassured.

> *'They are not practicing on their own. Actually they feel supported by the units. They feel that if they were to go away, the unit will have an understanding of the family and they could support the family in their absence.'*
> – Family and Adolescent Support Service staff member 08

Short-term outcome: increased knowledge and use of the systemic practice model

The majority of practitioners who responded to the training needs analysis survey agreed or strongly agreed **that they had made changes to the way they work with families because of what they have learned in the systemic training** (46 out of 48). In interviews, practitioners said that the systemic training had encouraged them to be more reflective in their practice and not sticking to a single viewpoint, for instance, being more curious about a family's history and the reasons why a family might be experiencing certain issues. They mentioned the training had encouraged them to take a more holistic approach to supporting families. They also felt the training had improved their ability to consider the family in context by exploring family histories and patterns and remove the focus away from first-order patterns.

There was a sense among practitioners that the systemic training had enhanced all areas of their practice.

> *'I think it really weaves through in every part of our work. So it's kind of like once you start learning about it, you can't switch it off and it just oozes out into everything you say.'*
> – Family and Adolescent Support Service staff member 04

Interviews highlighted that many practitioners were already instinctively using systemic practices in their previous roles before receiving any formal training. However, the systemic training helped them to understand these were systemically informed practices and the rationale for taking such an approach with families, which provided reassurance that they were practicing in a way that would help families. The training encouraged them to be more mindful when using systemically informed approaches in their day-to-day practice.

The clinical input during practice meetings and case consultation **reinforces systemic practice and helps practitioners and unit leaders think about the issues families are experiencing in a different way by challenging and extending their curiosities about families**. For instance, by prompting thinking in a systemic way, or encouraging practitioners to think about Social GRACES (for example, gender, culture etc). This was felt to encourage practitioners to be more understanding about the issues families might be experiencing and less judgemental in their practice. The clinician has a central role in encouraging practitioners to slow down and reflect how best to support a family.

Short-term outcome: better understanding of families' relationships, strengths and wider network

There was a shared view that the **use of tools helped practitioners understand family perspectives and stories**. They noted that the use of genograms in practice meetings help the unit get a clear sense of the background of the family, their relationship and what might be impacting the issue. Representing the family visually helps to ensure all family members, and particularly those who may either be contributing to the problem or could provide support, are not missed during discussions. The genogram was perceived to be a useful tool

for gathering information quickly from families to understand relationships within families, generational patterns and past issues. Timelines improve understanding of key events that have occurred in families' lives. Practitioners felt this helped them to be more understanding in their practice as they are able to consider different perspectives better. Results from the pilot evaluation indicated that a majority of practitioners used the SCORE-15, Me and My Feelings and FIDOs to engage children and/or families in discussion (as outlined in the Outcome measurement section below). The stakeholder aim tool means practitioners capture what the family would like to achieve from the support in their own words.

Short-term outcome: increased skill to support families with multiple and complex needs

Practitioners spoke about how the training had developed their **knowledge around supporting families** generally as well as around the specific areas covered by the training sessions. Interactions with the clinician were thought to reinforce themes that had been covered in training and develop knowledge on how to support families with mental health difficulties or complex issues. Practice meetings also enhanced knowledge as they provided an opportunity to learn from each other.

Practitioners felt they had **developed their practical skills** by receiving support and modelling from the clinician during home visits. For example, they felt more skilled using tools or asking circular questions as they had been able to learn directly by observing the clinician.

Refresher training improved specific skills. One practitioner reflected that the ongoing workshops provided opportunities to learn about a range of different tools and share ideas with each other.

Short-term outcome: stronger therapeutic alliance

Practitioners felt that the training had **enhanced their communication skills**. They pointed to systemic training improving their ability to explore how families are feeling and hear their untold stories. They also mentioned the training had provided the language to talk about issues – for instance, the terminology introduced as part of Social GRACES.

Unit leaders commented that the training had improved communication among practitioners – for instance, being more supportive to one another and valuing different perspectives and ideas.

Short-term outcome: improved confidence working with families

There was a clear theme around the clinical input helping to **develop practitioners' confidence**. Part of this was felt to come from the fact that the clinician provides reassurance to practitioners during their decision-making about the best actions to take with a family. Another aspect was improved confidence in how to use specific tools with families. They acknowledged they would feel more comfortable using the tools in future without the clinician's input. A further aspect was improving confidence in supporting families with mental health difficulties or complex issues, particularly as practitioners recognised they had not necessarily received extensive training in this area.

> *'For instance, with that particular family, with the mum, that I'm helping mental health. I didn't wanna open a Pandora's box, so I wanted to do it safely and the clinician's got kind of a good way to kind of they'll say no, what you can do is you can ease into it by doing this or we can start having conversations about mums, mental health, and then we can start going into that and it's just frames it in a totally different way. It feels safer.'*
> – Family and Adolescent Support Service staff member 04

Medium-term outcome: consistent high-quality practice

There was a shared view that families receive high-quality support from the service. Practitioners are skilled and confident in applying systemic, restorative and trauma-informed ideas during support. This is because they receive high-quality training and ongoing support during practice meetings and in-house workshops.

> *'I'm really, really impressed with the work that my colleagues are doing…the professionalism and the way that it's being delivered. I am constantly telling them that they are absolutely brilliant because they are not only thinking and working in a way as a social worker, they are also thinking and working in a way as a family therapist.'*
> – Family and Adolescent Support Service staff member 08

Data provided to the evaluation on the outcomes of the audit process[17] provides further evidence on the quality of practice. Between April and June 2022, a total of six casefile audits were completed with one case overall deemed to be 'requiring improvement', one case deemed to be 'inadequate' and the remaining four graded as 'good'. Collaborative working was the strongest area of practice identified, with two cases having outstanding practice in collaborative working and also in management oversight. In general, auditing activity between 2021 and 2022 demonstrates strength in direct work and practice with families, evidenced in both home visit observations and group work sessions all receiving a scoring of 'good', with four of these home visits having features of 'outstanding practice'. Scorings for practice meetings also showed high-quality practice, with over half (53.3%) of meetings scoring 'good' and one-sixth (13.3%) scoring outstanding.

Medium-term outcome: increased resilience to cope with work

A unit leader reflected that the progress of cases helped to improve practitioners' satisfaction with their jobs as they feel a sense of achievement which leads to increased resilience to cope with work.

> *'There is that sense of achievement when they have those breakthroughs with those families…it's kind of that joy.'*
> – Family and Adolescent Support Service staff member 10

Practitioners acknowledged that closure can be emotionally difficult for them as they have spent time getting to know a family. They noted that therapeutic letters can support them during closure as the letters provide an opportunity for practitioners to reflect on the time spent with the family and express themselves in their own words, which they felt helped process their emotions.

> *'I think when you're going into a family's home, you're a big part of their life. You're asking them really personal questions. You need to make sure that that ending is done in the right way because it is a long process. It's a big process that you've gone on with them and you've built really strong relationships with them as well, so I think it's so vital to have a proper ending.'*
> – Family and Adolescent Support Service staff member 07

Long-term outcome: more efficient and effective working with families

Practitioners felt the approach enabled them to **reach closure in a productive way** with families. Outcome and sustainability plans provide a 'pathway' for practitioners to follow which helps them remain focused on what they need to achieve in order to reach closure with a family.

17 The audit process is described in the 'Evidence of feasibility' section above.

Long-term outcome: lower staff turnover

Management data collected from FaASS suggests that once staff join FaASS, **they tend to stay working in the service for a relatively long time**. In the training needs analysis survey, a majority of respondents had been working in the service for two years or more (41 out of 54; 75.9%).

Perceived outcomes for families

There was a shared view among FaASS staff members that the approach being taken leads to positive outcomes for families. The outcomes identified were mostly consistent with those articulated in the theory of change.

Short-term outcome: improved understanding of other family members' perspectives

Practitioners were believed to encourage **families to think beyond the immediate presenting need** (that is, first-order issues) and consider the underlying factors (that is, second-order issues). By considering generational patterns and history of issues across the family network, it was felt that families begin to understand how different family members may be contributing to the issues they are experiencing. The genogram was perceived to be a particularly useful tool for encouraging families to think about the reasons why they or their family members might behave in a certain way.

FaASS staff members felt that by having a better understanding of issues helps families get to the root of the issue and stop problems reoccurring.

Short-term outcome: increased awareness of support network available

Practitioners felt that the approach and specific tools encourages **families to reflect on their family network**. Practitioners explained during interviews that the genogram provides a visual representation of family members and their relationships which helps families understand who is in their support networks and what might be contributing to issues. Another tool which practitioners felt was helpful for reflecting on families' support networks was the outcome and sustainability plan which details family members who they may be able to turn to for help with issues, improving their ability to manage problems themselves and reducing the need to contact support services in the future.

Short-term outcome: improved confidence and awareness of personal strengths and skills

Practitioners fed back that a key part of the approach was that families are supported to **identify their strengths alongside their needs**. This was particularly the case when using tools such as the Strengths and Needs tool. Also during support, the FIDO tool helps families track how the frequency, intensity and duration of issues are changing over time. Practitioners noted that when there is an improvement of issues, families begin to see that they are making progress which improves their confidence in managing the issue.

> *'If they're seeing that this was happening on a daily basis and now it's only happened in two days a week and they're reflecting on that…I think it's good for them because it gives them that kind of self-worth and self-achievement to see that they're managing it and what they're doing is working, so it kind of gives parents confidence.'*
> – Family and Adolescent Support Service staff member 03

Towards the end of support, families receive a therapeutic letter which celebrates the progress that has been made. Practitioners felt this provides ongoing motivation to families to sustain change.

Short-term outcome: feel better supported by services and support network

Practitioners mentioned during interviews that they are able to use what they have learned in training to explain the reasons for using the systemic approach and what the support will involve using language families understand. Interviewed staff members believed this contributed to **families feeling reassured that they were receiving support that would help solve their issues**.

Practitioners believed explaining the role and experience of the clinicians to families, where appropriate, **improves families' confidence in support** because they are made aware that they are receiving input from a professional who has clinical training and experience.

Another advantage of the clinical input that was identified by FaASS staff members is that families do not have to wait for referral to external agencies but can receive timely clinical support from the clinician.

Interviewed staff members reflected that they are encouraged to use the service's approach to support flexibly in line with needs of families. They described the following tools which facilitate this.

- The stakeholder aims tool means practitioners understand what the family would like to achieve from the support. It also helps them set the work at the pace which is appropriate for the family.
- Completing the FIDO tool at different points throughout support enables practitioners to track progress and identify ongoing support needs in order to tailor support accordingly.
- Goal setting helps practitioners set the direction and pace of work that is going to support the family in the best way.
- The Strengths and Needs tool helps practitioners to identify the areas which are going well for families and the areas where they may need focused support.

Short-term outcome: stronger therapeutic alliance

The approach encourages practitioners to consider family circumstance and history in detail, which was believed to contribute to **families feeling as if practitioners understand their family context**. Practitioners also felt exploring the family history helped families feel less blamed for the issue because it emphasises contextual rather than personal factors. Practitioners are encouraged to reflect on their own Social GRACES, which means they are able to approach support in a way that is sensitive to each family's characteristics.

Practitioners reflected that the in-house workshops had enhanced their communication skills, which in turn had helped **families feel listened to**. For example, one practitioner mentioned that the workshop about ending support had made them realise the importance of having a conversation about the ending of support. As a result, the family had reported that they felt respected by the practitioner as the ending had been approached in a compassionate way which was in contrast to how other professionals had ended support.

Interviewed staff members felt that when families feel understood by practitioners, they will be more receptive and engaged with the support being offered.

Medium-term outcome: improved family relationship

Practitioners reflected that restorative approaches had helped them to support families, resolve difficulties and repair harm within the family. This outcome was also explored using the SCORE-15 measure, discussed below in the 'Evidence of outcomes' section.

Medium-term outcome: increased skills to cope with needs within the family (increased resilience)

Practitioners reflected that the approach resulted in sustained changes which meant families did not return for further support from FaASS, leading to a low repeat contact rate.

> *'It makes such a difference because it is sustainable…we don't see kind of that loop of families coming back in and constantly needing support. You really see families flourishing and professionals that are involved in their life see that difference as well.'*
> – Family and Adolescent Support Service staff member 04

Data collected by FaASS indicates a consistently low re-referral rate across the service. The proportion of contacts who had previously received support and returned to FaASS within 12 months was 7.3% (41 out of 563) in 2019–2020, 13.9% (88 out of 633) in 2020–2021 and 4.3% (34 out of 798) for 2021–2022. The service leader hypothesised that the pandemic resulted in a higher re-referral rate in 2020–2021 due to changes in practice (for example, prioritising support for the most vulnerable families) and issues with recording data accurately due to some staff not having access to laptops to work from home.

Long-term outcome: improved family outcomes

Evidence from Greenwich FaASS family data, collected for the period 2019 to 2022, provides evidence of improved family outcomes at the point of closure. Data indicates a majority of families achieve all or some of their goals at the point of planned closure (Table 10). Across the three-year period, data from 2,414 families indicated that over half achieved all their goals (52.3%) and an additional one-sixth of families met some of their goals (14.8%) and one tenth achieved positive outcomes (8.2%).

Long-term outcome: reduced intensive or statutory support

FaASS staff members felt the approach prevented problems from escalating and reduced the need for children to be stepped up to statutory services. In support, family-level data showed that the proportion of children who are stepped up to children's social care by FaASS has remained relatively low (2019–2020: 91 out of 835, 11%; 2020–2021: 50 out of 784, 6%; 2021–2022: 41 out of 840, 5%). The service leader reflected that the step-ups are appropriate as they are ordinarily going straight to children's social care statutory frameworks.

Evidence of outcomes for families

As part of the pilot evaluation, we explored indications that the approach is potentially helping towards its intended aims using data collected from the pilot. It is worth noting that while observing changes in outcomes over time provides evidence of promise, they do not provide evidence of impact. Across three outcome measures, the sample size was small, and the pilot was relatively short in duration (six weeks), which limits our ability to identify statistically significant results (see the 'Limitations' section for further detail).

Medium-term outcome: improved family relationship and functioning

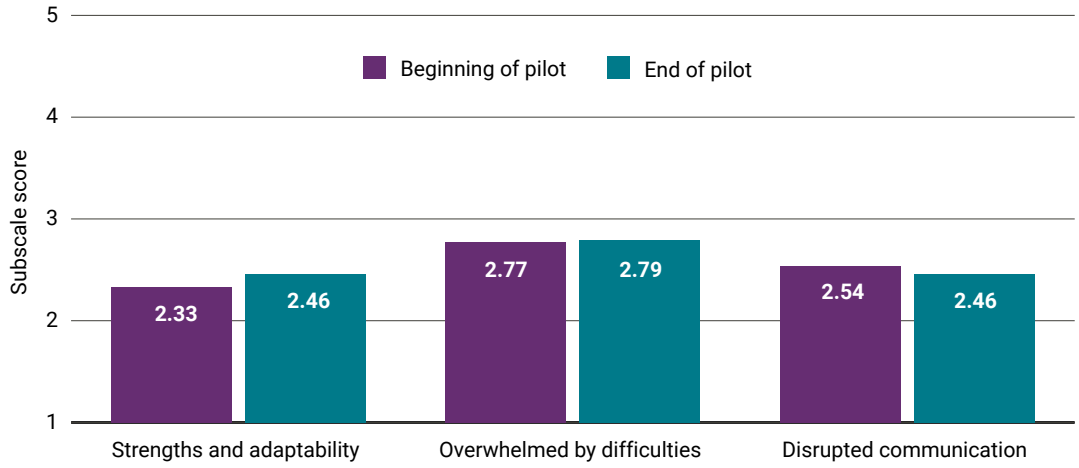
Family functioning outcomes were captured using the SCORE-15, with 32 respondents completing the measure both at the beginning and the end of the pilot. For the total score, the maximum score is 75 and the minimum score is 15. The higher the total, the worse the individual is rating their family functioning. The average total score at the beginning was 38.19 and at the end was 38.56. The change was not statistically significant.

For each subscale, the maximum score is 5 ('not at all') and the minimum score is 1 ('describes us very well'). The lower the score, the most positively an individual has rated their family functioning (when items that require reverse scoring have been accounted for). Results showed that for each of the subscales, average scores were halfway between 'describes us well' (2) and 'describes us partly' (3), as shown in Figure 4 SCORE-15 subscale

scores at the beginning and end of the pilot. There were no statistically significant changes on any of the subscales of the SCORE-15 (strengths and adaptability scale, the overwhelmed by difficulties scale, the disrupted communication) from the beginning to the end of the pilot. See Table 11, Appendix F for results from the statistical tests.

FIGURE 4

SCORE-15 subscale scores at the beginning and end of the pilot

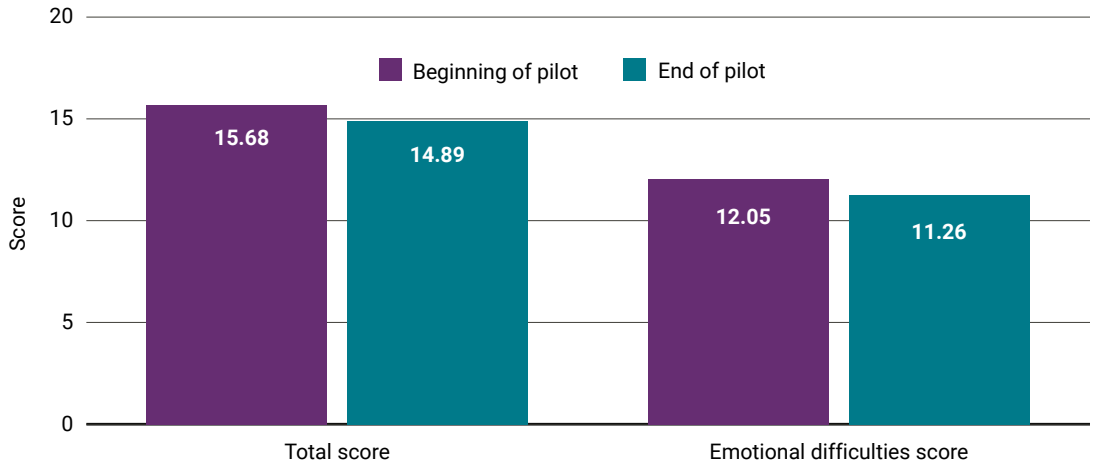


Long-term outcome: improved family outcomes (emotional and behavioural difficulties)

Emotional and behavioural difficulties were captured using the Me and My Feelings outcome measure. There was an observed reduction in total scores and in emotional difficulties scores (Figure 5), although this change was not statistically significant (see Table 12 for results from the statistical analysis). Notably, a score of 12 or more (that is, at the beginning of the pilot) on the emotional difficulties subscale indicates clinically significant difficulties, whereas a score of 11 (that is, at the end of the pilot) indicates borderline difficulties. Thus, although this finding was not statistically significant, there was a shift from clinically significant difficulties down to borderline difficulties following FaASS support, and it is possible that a larger sample, or a longer pilot duration, may result in a statistically significant reduction in scores. This finding is promising and lends support to the utility of the work that FaASS does to support families.

FIGURE 5

Me and My Feelings total and emotional difficulties scores at the beginning and end of the pilot



Long-term outcome: improved family outcomes (reduced frequency, intensity and duration of issues)

The frequency, intensity, duration and onset of issues family members were experiencing were captured by the FIDO tool at the beginning and end of the pilot. Regarding the frequency of problems, descriptive statistics are hard to report due to the varied nature of the data collected (see the 'Limitations' section). Occurrences of the reported problem ranged from daily, to weekly, to monthly, to yearly. This data is better suited to be used in practice, to compare change in problem frequency on an individual basis.

Regarding the intensity of problems, individuals rated, on a scale of 1 to 10, how intense the problem felt on the day of report. At the individual level (n=25), a paired-sample t-test revealed a statistically significant reduction in intensity ratings ($t = 2.27$, $p = 0.03$) from the beginning of the pilot with an average of 7.8 to the end of the pilot with an average of 6.7. This suggests that respondents were perceiving the intensity of problems as less intense after the six-week time period when they had been receiving support from FaASS.

At the end of the pilot the majority of participants indicated that compared to the beginning of the pilot, the duration of the problem had reduced (n=10; 43.4%) or stayed the same (n=10; 43.4%), while a minority indicated that the duration had increased (n=3; 13.0%).[18]

Other family outcomes listed in the theory of change

There were a number of other family outcomes highlighted in the theory of change which we were unable to collect evidence on. This included: increased understanding of need for support; increased awareness of support services available; reduced stigma of accessing support; increased engagement with services and support network; families kept safe within families. Recommendations on how to capture evidence on these outcomes are explored in the 'Recommendations for future evaluation' section at the end of this report.

Unintended consequences

Practitioners, unit leaders and the clinician were asked to reflect on the potential or actual unintended consequences for families and practitioners.

Practitioners

The key unintended consequence identified for practitioners was the impact of workforce training on workload and capacity for new staff members. For instance, one practitioner explained that when they joined the service, they attended the training course for systemic practice and restorative practice concurrently, which meant they only had around two and a half days per week to work with families. This meant they had to catch up on work outside their working hours.

Another disadvantage related to workload mentioned by practitioners is that the tools can sometimes feel burdensome and can bring anxieties about ensuring they are completed on time, especially when there are challenges with completing the tools to the deadline. To overcome this perceived disadvantage, practitioners acknowledged it would be useful to have more flexibility in the deadlines set for each stage of the assessment process.

> *'When you have a family that sometimes are not engaging very well or you just have an extremely busy week where you're not able to meet a family or a young person or to complete the stages in that time that's suggested and then become really anxious and worried about the after effects and I'm worried about getting that email reminding me that I need to meet this deadline and see the flexibility would just help eliminate some of their anxieties.'*
> – Family and Adolescent Support Service staff member 01

18 Note that due to missing data, the sample size used to describe change in problem duration was 23.

Families

It was mentioned during interviews that the clinician attending a home visit could feel overwhelming for families and increase their sense of anxiety. This was felt to be particularly pertinent among families who have had a high number of professionals involved in supporting them.

There was a view that instances where the tools had unintended consequences were infrequent because tools are only used with consent, and they would not be used if a family did not feel comfortable. However, it was recognised there may be instances where the tools could bring up past experiences or trauma which could be painful for families to talk through.

There was also recognition that in certain circumstances, the tools could have unintended consequences. For instance, it was noted that it can be detrimental to use the tools with families who are then stepped up to children's social care because they may feel like they have shared personal information about themselves and their family which they think may have then been used against them.

Outcome measurement

In order to understand Greenwich readiness for using outcome measures as part of practice and evaluation, practitioners have undertaken a pilot which involved the administration of several outcome measurement tools: the SCORE-15, the Me and My Feelings questionnaire and the FIDO measure. Practitioners were subsequently surveyed by EIF regarding their experience of using the tools. Responses were received from 23 respondents in total. Fifteen respondents were youth and family practitioners, two were senior youth and family practitioners, five were unit leaders, one was a student social worker. Seventeen respondents had joined FaASS more than two years ago, five had been at FaASS between six months and one year, and one joined within the last six months. What follows is a summary of their experience using each of the tools.

SCORE-15

Out of the 23 respondents, only one had administered the SCORE-15 measure before taking part in the pilot. **All of the respondents who reported attending the training either agreed or somewhat agreed that they were satisfied with the training they received**. Few comments were given on how the training could be improved, with only two practitioners indicating that the training could have 'given more time and detailed explanations of the steps involved in administering the forms' or provided more detail on 'how to rephrase/help young people and families understand the questions, or how it could be adapted for different needs'.

Out of the 23 respondents, 20 administered the SCORE-15 as part of the pilot and, on average, those 20 respondents used the SCORE-15 with 5.8 individuals (minimum = 1, maximum = 20). On average, **practitioners spent 39.85 minutes using the SCORE-15 measure per family member** (including preparation, administering the measure, data entry and troubleshooting). This appeared to be how long the majority of practitioners expected to spend using the measure, with 12 reporting the duration was about the same as anticipated, six reporting it was more and three reporting it was less than anticipated.

Regarding how difficult practitioners found using the tool with parents or carers, **the majority found the tool somewhat easy** (n=8) **or easy** (n=7) **to use**. Only three respondents reported the tool being somewhat hard to use, and two were indifferent. Similar findings were reported for **using the tool with children, with the majority finding the tool somewhat easy** (n=10) **or easy** (n=4) **to use with them**, while three reported finding it somewhat hard and three reported being indifferent. Importantly, **the majority of practitioners reported** that they

somewhat agreed (n=8) or agreed (n=6) **that families responded positively to the use of the tool**. Four reported being indifferent and two somewhat disagreed that families responded positively to the use of the SCORE-15. Comments regarding why families found the tool difficult to use were few and included reasons such as the scoring was confusing, they did not understand all the questions, families did not like negative questions or families could not understand the importance of each question.

The majority of practitioners reported using the tool to engage children and/or families in discussion (n=11) or to monitor progress (n=6). Only one practitioner reported not using the data from the tool at all. Importantly, **the majority of practitioners found the tool was useful in their practice to support families** (somewhat agree n=10, agree n=6). Only two practitioners disagreed that the tool was useful in supporting families and two were indifferent. Finally, **12 out of the 20 practitioners using the tool said they would like to continue using the tool in their future practice**. These practitioners reported that the tool can open up discussion with families, it can give an overview of how the family are feeling and it can be used to measure change over time. Seven practitioners reported they were unsure about using the tool again (only one said they would not use it again) because they reportedly 'already have a lot of paperwork', they questioned the sustainability given the time commitment and one respondent wanted to know more about the data and what it shows.

In summary, the response to the use of the SCORE-15 is positive, with the majority of practitioners finding the tool useful in supporting families in their practice, and many would like to continue using the tool beyond the pilot, which is a testament to its utility.

Me and My Feelings

Out of the 23 respondents, only two had administered the Me and My Feelings measure before taking part in the pilot. **All of the respondents who reported attending the training either agreed or somewhat agreed that they were satisfied with the training they received**. None gave comments on how the training could be improved.

Out of the 23 respondents, 16 administered the Me and My Feelings measure as part of the pilot and, on average, those 16 respondents used the measure with 2.4 individuals (minimum = 1, maximum = 5). On average, **practitioners spent 32.19 minutes using the Me and My Feelings measure per family member** (including preparation, administering the measure, data entry and troubleshooting). This appeared to be how long the majority of practitioners expected to spend using the measure, with 10 reporting the duration was about the same as anticipated, four reporting it was a bit less than anticipated and two reporting it was more than anticipated.

Regarding how difficult practitioners found using the tool with children, **the majority found the tool somewhat easy** (n=6) **or easy** (n=5) **to use**. Only two respondents reported the tool being somewhat hard to use, and one reported it was hard, while two were indifferent. Importantly, t**he majority of practitioners reported that they somewhat agreed** (n=7) **or agreed** (n=5) **that families responded positively to the use of the tool**, with none disagreeing and four reporting being indifferent. Comments regarding why families found the tool difficult to use were few (n=2) and included reasons such as the tool using negative statements, or some children having difficulty understanding some of the language.

The majority of practitioners reported using the tool to engage children and/or families in discussion (n=12) or to plan session content (n=3). Only one practitioner reported using the data to monitor progress. Importantly, **the majority of practitioners found the tool was useful in their practice to support families** (somewhat agree n=17, agree n=6). Only one practitioner somewhat disagreed that the tool was useful in supporting families and two were indifferent. Finally, **12 out of the 16 practitioners using the tool said they would like to continue using the tool in their future practice**. These practitioners reported that **the tool is easy for**

young people to understand, it gives them a voice and **can help to understand children's feelings**, and it proved **useful for starting conversations with children and young people**. One practitioner reported they were unsure about using the tool again because they felt they needed longer to see if the tool would be useful. Three practitioners reported not wanting to use the tool again; one of these practitioners provided no explanation and the remaining two report using other tools or assessments with children that are sufficient for their needs.

In summary, as with the SCORE-15 measure, the response to the use of the Me and My Feelings measure is positive, with the majority of practitioners finding the tool useful in supporting families in their practice, and many would like to continue using the tool beyond the pilot.

FIDO

Out of the 23 respondents, 16 had administered the FIDO measure before taking part in the pilot. **Most of the respondents who reported attending the training either agreed or somewhat agreed** (n= 11 and n=1 respectively) **that they were satisfied with the training they received**. Three respondents were indifferent about the training. Consistently, few comments were given on how the training could be improved, with one practitioner indicating that a refresher on completing the form correctly would be helpful.

Out of the 23 respondents, 18 administered the FIDO measure as part of the pilot and, on average, theyused the FIDO with 2.9 individuals (minimum = 1, maximum = 9). On average, **practitioners spent 30.28 minutes using the FIDO measure per family member** (including preparation, administering the measure, data entry and troubleshooting). This appeared to be how long the majority of practitioners expected to spend using the measure, with 12 reporting the duration was about the same as anticipated, three reporting it was more, one reporting it was much more and two reporting it was a bit less than anticipated.

Regarding how difficult practitioners found using the tool with families, **the majority found the tool somewhat easy** (n=8) **or easy** (n=5) to use. Only three respondents reported the tool being somewhat hard to use, and two were indifferent. Importantly, **the majority of practitioners reported that they somewhat agreed** (n=9) **or agreed** (n=7) **that families responded positively to the use of the tool**. One reported being indifferent and one somewhat disagreed that families responded positively to the use of the FIDO measure. Comments regarding why families found the tool difficult to use were few and included reasons such as 'they can find it hard to pinpoint when things occur and duration', or that they found the tool 'too complicated'.

The majority of practitioners reported using the FIDO tool to monitor progress (n=8) or toengage children and/or families in discussion (n=7). Only one practitioner reported not using the data from the tool at all, one reported using the tool to plan session content and one practitioner reported using FIDO to both engage families in discussion and monitor progress. Importantly, the **majority of practitioners found the tool was useful in their practice to support families** (agree n=10, somewhat agree n=7). Only one was indifferent about the usefulness of the tool. Finally, **15 out of the 18 practitioners using the tool said they would like to continue using the tool in their future practice**. These practitioners reported that the **tool is useful, it can identify what problems families are experiencing and how often, which can support intervention planning, and it can be good to demonstrate impact and help families to understand progress**. Three practitioners reported they were unsure about using the tool again; two reported that although there is an expectation to use FIDO with every family, the tool is not always relevant.

In summary, as with the SCORE-15 measure and the Me and My Feelings measure, the response to the use of the FIDO measurement tool is positive, with the majority of practitioners finding the tool useful in supporting families in their practice, and many would like to continue using the tool beyond the pilot.

4. Discussion

Discussion of findings

This section sets out the findings in relation to the key research questions.

Evidence of feasibility

Fidelity

- Is the approach being delivered as intended?

The evaluation data suggests there is a clear, shared vision for what the approach involves and how it is expected to lead to positive outcomes for children and families. There is broad agreement that key components of the approach include having practitioners assigned to units, weekly practice meetings, service-wide high-quality training on systemic practice, restorative approaches and trauma-informed practice, ongoing in-house workshops, clinical input from a clinician and the use of systemic tools during support with families.

Adaptation

- Does the delivery of the practice approach vary across the eight FaASS teams?

Overall, the approach appears to be delivered as planned with little variation in delivery across units and practitioners. Some adaptations had been made as a result of the Covid-19 restrictions, rather than practitioner request or need. There was general consensus that moving training online had not been a positive move and had resulted in it being less engaging than expected. The service has now begun delivering more training in person.

Dosage

- How much of the core activities are being delivered?

Data showed that practice meetings were happening weekly as planned. The mandatory training was delivered according to the specified number of sessions (for example, systemic training takes place over 12 weeks). In-house training was being delivered on an ongoing basis. Case consultations and direct clinical support for families take place on an ad hoc basis in response to requests from practitioners and family need. In the 10 months between December 2021 and July 2022, practitioners requested direct clinical input 33 times, which suggests an average of three per month.

Reach

- Does the approach reach the target families in need?

Data provided by Greenwich suggested that FaASS was working with the families they intended to work with: that is, families with a range of issues including emotional abuse, neglect, parenting issues, child and parental mental health, domestic violence and housing issues. This was echoed by interviews with practitioners, clinicians and unit leaders.

Quality

- Are the core activities being delivered to a high quality?

There was a strong sense among interviewed staff members that the components of the approach are being delivered with high quality. They held the view that training, practice

meetings and clinical input were meeting their needs and supporting them to develop their skills as a practitioner. Although the training was not quality-assessed as part of the evaluation, the training courses have received accreditation, which suggests the content and delivery is of high quality. Results from the audit process supported findings that in general, members of staff deliver components of the approach to a high quality.

Participant responsiveness

- To what extent do families and practitioners engage with the approach?

From interviews and observations, it was clear that FaASS staff members were very engaged and positive about the approach being taken.

Families were not interviewed as part of the study, making it difficult to assess their engagement. However, data provided by Greenwich showed that there was a low level of families who do not engage with the service and the sustained length of time FaASS works with families was a good indication that a majority of families do engage with the support. In interviews with FaASS staff members it appeared that most families were engaged with the support being offered.

Intervention differentiation

- What is the value-added of the approach and how does it differ from business as usual?

FaASS introduced a new approach when the service underwent a restructure in 2017. Key differences from the previous way of working included introducing whole family working, access to clinical input and the provision of high-quality training for all staff members in the service.

Enablers and barriers

- What are the enablers and barriers to successful delivery of the practice approach?

A number of core enablers and barriers to the delivery of the approach fell into the following four categories.

  - **Service vision and values:** All staff had a clear understanding of the service vision and values which they were committed to. This included strong communication between all staff members, operating as a consent-based model and empowering families to make and sustain changes themselves.
  - **Provision of training and support:** The provision of high-quality training and ongoing support was viewed to be fundamental to the successful delivery of the approach. There was a shared view that remote delivery of training was not as effective as in-person training and was a barrier to fully engaging with the training content.
  - **Team structure and staffing:** The structure of the service and the characteristics of staff were felt to be important for the effective delivery. Key features were the unitary model, the role of the unit leader to provide oversight, administrative support provided by the unit coordinator, diversity of workforce, and the experience and expertise of staff members. The clinician was viewed as a vital part of delivering the approach and therefore their limited availability was a barrier for the clinician attending every practice meeting and contributed to a reluctance among some practitioners to ask for support.
  - **Capacity and workload:** Interviewed staff members pointed to the importance of having a small and protected caseload to ensure they had sufficient time and capacity to plan and reflect on the support they were providing for families. Careful consideration of allocations within each unit helped to ensure that workload was manageable, and practitioners had the opportunity to work on cases that were suited to their interests and professional development.

Evidence of promise

Potential benefits

- What are the potential benefits of the approach for families, practitioners and the wider service?

During interviews, interviewed staff members identified a number of benefits for practitioners. Outcomes centred on an increased feeling of being supported, better understanding of families' relationships, strengths and wider network, increased knowledge and use of the systemic practice model, improved confidence working with families, high-quality practice, increased resilience to work with families, more efficient and effective work with families and lower staff turnover. Practitioner outcomes were consistent with those set out in the theory of change.

Although we did not interview families, a number of benefits were identified by FaASS staff members, which included improved understanding of other family members' perspectives, increased awareness of support network, improved confidence and awareness of personal strengths and skills, stronger therapeutic alliance, increased resilience, improved outcomes and reduced intensive or statutory support. Data collected by FaASS provided further support for some of these outcomes. For instance, FaASS family data shows a majority of families achieve all or some of their goals at the point of planned closure and rates of re-referral to support are low.

As part of the pilot evaluation, outcome measures were used to explore changes in family functioning (SCORE-15), emotional and behavioural difficulties (Me and My Feelings) and frequency, intensity, duration and onset of issues (FIDO tool). Although the pilot was short in duration, data from these outcome measures provided initial evidence that the outcomes were improving.

Unintended consequences

- What are the actual or potential unintended consequences for families, practitioners and the wider service?

Interviewed staff members reflected that there were minimal unintended consequences of the approach. Some of those identified included the impact of training on capacity and workload when they first started, the clinician's presence during home visits feeling overwhelming for families and the use of tools bringing up past trauma which can be painful for families to talk through.

Conclusions and recommendations for approach

Evidence gathered from the evaluation suggests the approach being taken by FaASS is achieving its intended aim of improving outcomes for children and families by intervening in a timely way and creating change that is sustainable. While causal claims on the impact of FaASS's approach could not be made, both qualitative and quantitative data provides early indication of promise.

The approach appeared to be working well, with high engagement and satisfaction from children, families and practitioners. The evaluation team would recommend the components of the approach are sustained and built on.

- **Mandatory training was viewed as fundamental to upskill staff and ensure a consistency in understanding and application of the approach across the service.** Staff spoke very positively of the training offer, and it was clear it was meeting their needs and helping to improve their practice. There was a strong desire among some unit leaders and practitioners to have the opportunity to complete further training, particularly in systemic

practice, to enhance their practice further. Practitioners really valued the opportunities for training in the service and so we would recommend FaASS gathers further information from staff about their ongoing training needs and considers providing additional training for staff for their continued professional development.

- **In-house workshops appeared to be successful in achieving their aims of supporting staff members to deepen their knowledge and enhance their skills** for specific areas of practice. We would recommend FaASS continues to provide ongoing training to staff members, ensuring the topics are aligned with practitioner development needs. There was considerable variability in the attendance of workshops (min = 2, max = 38), so FaASS may want to explore the reasons why attendance for some topics was so low.
- **FaASS staff members spoke very positively about the informal support and advice they receive from colleagues across the service** on specific elements which they feel others have expertise on. FaASS may want to consider communicating the different specialisms of staff members so that those working across the service are aware of who might be well placed to answer their questions on specific topics. This may be particularly beneficial for new staff members who have not had the opportunity to get to know their colleagues.
- **Practice meetings were viewed as an important aspect of the approach for managing risk and developing hypotheses about how best to support a family.** Interviewed FaASS staff members reflected that practice meetings were meeting their needs and so we recommend they continue with their planned delivery. There was some indication from interviewed staff members that units run practice meetings differently, so FaASS may want to explore whether this is leading to differences in practitioner satisfaction and outcomes. Although practice meetings are assessed as part of the quality assurance process, this is done by group leaders who assess units they manage. There may be some benefit in group leaders assessing units they do not directly manage to explore whether there is variability across units.
- **Clinical input was regarded as a vital part of the approach,** but the availability of the clinician appeared to impact successful delivery. We would recommend that FaASS considers expanding capacity to ensure clinical input can be implemented as intended. This could be through the recruitment of another clinician, for example. While practitioners value hugely the skills and expertise that clinicians bring to their practice, their ability to form strong trusting relationships with colleagues was seen as equally valuable, so FaASS should continue to consider these attributes during the recruitment process.
- There were a **host of tools that were used by the team which appeared to be working well**. We would recommend the continued use of the tools across the service with ongoing training to ensure consistent high-quality use. While practitioners had a clear and shared understanding about when to use tools that were part of the assessment process, there was less clarity about when other tools should be used. FaASS may find it worthwhile developing a list of tools which practitioners can choose from with explicit guidance on when each tool could be used. There was some variability in the extent to which practitioners use the tools creatively, so FaASS may wish to consider reviewing guidance on how best to use and adapt tools for different families.

Finally, the evaluation team suggest that these findings are shared with FaASS staff members, even if in a summary form.

Recommendations for future evaluation

Evaluating the approach FaASS is taking is an important part of understanding how effective the approach is in achieving the benefits it is designed to provide and understanding whether it is operating as planned, which can provide information for improved delivery of the offer going forward.

Part of the evaluation was to assess the feasibility of conducting a future impact study on the approach. The evaluation team was unable to identify or construct a sufficient counterfactual (that is, a control group of either practitioners or families with similar characteristics who had not been supported by FaASS, either from Greenwich or from other comparison areas) which would support a future impact study by the team.

As a result, the evaluation team would recommend FaASS continues to assess both the implementation and the outcomes of the approach, focusing on the outcomes specified in the theory of change. Below we provide specific advice for how this could be achieved. The evaluation team would also recommend that any differences between the theory of change and findings from evaluation or further evaluation of the approach be reflected in a revised theory of change.

Implementation of the approach

The evaluation team recommend FaASS continues to monitor the delivery of the approach by investigating whether the key components are being delivered as intended using both quantitative and qualitative means.

We recommend **continuing and improving management data collection on the main features of the approach** to support ongoing monitoring of delivery. We would recommend FaASS continues to collect attendance data for training. We would also recommend collecting additional data on the delivery of case consultations and direct clinical work with families, including the number that have taken place and attendance. We would recommend that the frequency and the type of support provided is collected, along with duration – that is, whether the support was for a one-off or for a period of time. This would enable FaASS to understand the dosage and reach of the clinical offer as well as factors which might influence engagement of practitioners (for example, level of experience) and families (for example, type of need).

In this evaluation, we collected substantive qualitative data from practitioners to understand their perceptions of the approach. However, to robustly track practitioner outcomes, we would recommend **continuing and expanding qualitative data collection**. Undertaking a similar exercise, every year for example, could help explore perceptions of the approach and provide useful recommendations. Topic guides used in this evaluation could be used as templates. If these take place, we recommend that personnel skilled in interviewing and independent of FaASS be chosen to undertake these.

The evaluation team suggest FaASS **considers gathering qualitative data from children and families to understand their perceptions of the support they received**. During interviews, we'd recommend that children and families are encouraged to discuss their experience of the support, including use of tools and involvement of the clinician, as well as perceived outcomes they think the support has had on their needs (for example, social and emotional needs, school attendance etc). It would also be useful to explore any unmet needs that they feel FaASS could support them better with.

Outcomes of the approach

The evaluation team recommend FaASS continues to investigate the potential for improving child, family and practitioner outcomes through robust quantitative methods. We would emphasise measuring the key outcomes that are articulated in the theory of change. FaASS should look to establish which key outcomes can be tracked using **data that is already routinely collected**, which includes outcome at closure and rates of repeat contacts that were reported in this evaluation. FaASS could conduct subgroup analysis to explore factors which may influence these outcomes, such as primary need or length of intervention.

For outcomes that are currently not captured by FaASS, we would recommend the **use of valid and reliable outcome measures** to track changes over time. The current evaluation measured change over a relatively short period of time with a small number of families, which made the likelihood of finding statistically significant changes low. Gathering data from all families before and after they receive support would provide more valuable data to monitor outcomes.

Family outcomes

- We recommend FaASS considers using an outcome measure to explore **family functioning** for all families who receive support. The small outcome measure pilot indicated that practitioners were comfortably able to use the SCORE-15 measure and saw its benefit both in terms of supporting their practice and tracking progress over time.
- We recommend FaASS implements a standardised measure to track changes in **emotional and behavioural** difficulties as improving child outcomes is a key aim of the service. The evaluation showed that Me and My Feelings was fit for purpose so FaASS could continue to use this measure or consider other measures, such as the Strengths and Difficulties questionnaire.
- **Frequency, intensity, duration and onset of issues** were measured using the FIDO tool. Although the FIDO was reported to be useful for practice, in the current format, it is not suitable for evaluation. If the FIDO were to be used in evaluation to track changes over time, the answer options for 'frequency of problem' and 'duration' would need some standardisation. For instance, when asked whether the duration has stayed the same, reduced or increased, restricting answers to one of these three options, rather than having free text would improve data quality. It was also not possible to compare changes in frequency as there were inconsistencies in how it was reported. To track whether there has been change over time, an additional question could be added which asks respondents at the end of the support whether the frequency has stayed the same, reduced or increased in the same way this is asked about duration.
- **Improved relationship between family and practitioner**. A key outcome in the theory of change is improved therapeutic alliance, so we would encourage FaASS to consider using a tool to measure this. For instance, the Working Alliance Inventory-Short Revised[19] (WAI-SR) measures three key aspects of the therapeutic alliance: agreement on the tasks of therapy, agreement on the goals of therapy and development of an affective bond. This measure could be completed by both the practitioner and the family receiving support.

There were a number of other child and family outcomes highlighted in the theory of change which we did not collect quantitative outcomes data on, including improved understanding of support network and improved confidence and awareness of personal strengths. Further work could be undertaken to pilot the collection of valid and reliable measures for these outcomes.

19 https://wai.profhorvath.com/sites/default/files/upload/WAI%20Ts%20k.pdf

Practitioner outcomes

While the evaluation findings from interviews with FaASS staff members were critical in understanding their perceptions on the impact the approach had on practitioners and the wider system, no robust impact data was collected.

A key part of the theory of change is that practitioners have the knowledge and confidence to take a systemic therapeutic approach and are more skilled in their practice. FaASS currently has a comprehensive quality assurance process in place which seems fit for purpose and FaASS could explore how the quality assurance could be built into continued evaluation. FaASS may wish to consider aligning their quality assurance process with the Systemic Family Practice Systemic Competency Scale,[20] which has been designed to provide a structure for the assessment of systemic family practice skills, either for whole sessions or during training and supervision to explore particular areas of competence.

Improved relationship between families and practitioners is a key outcome in the theory of change so, as mentioned above, we would recommend measuring therapeutic alliance from the perspective of practitioners as well as families.

While not part of the theory of change, **practitioner wellbeing** was identified as an important element to effective practice. Measuring this through validated outcome measures could greatly enhance continued evaluation of the team. This could include administering validated measures such as the Professional Quality of Life Scale (ProQOL) looking at work-related secondary trauma, burnout and compassionate job satisfaction, which could take place once or twice a year.[21]

We would recommend **continuing to run the training needs analysis survey** as this provides useful insight to practitioner perceptions of training, skill and confidence. In addition, we would recommend that mandatory training and in-house workshops be evaluated to understand satisfaction with the training as well as its impact on practice.

Using outcome measures

Once FaASS has decided on which outcome measures to use, plans should be made to ensure they are implemented correctly. Data should be collected from families both **before and immediately after they have received support**. We would also recommend **collecting follow-up data** to see whether changes are sustained, for instance, six months after support has ended.

Data should be collected from practitioners routinely to track outcomes over time. For instance, a practitioner survey might be conducted twice yearly.

Analysing outcome measures

Data should be analysed using **statistical testing** (for example, a paired-sample t-test) on whether differences between the 'before' and 'after' data are significant, or if they are likely to have been due to chance[22].

Monitoring use of outcome measures

We recommended that the **implementation of the outcome measures is monitored**, through regular feedback both formally (via surveys as was used in this evaluation) and informally (in practice meetings or supervision). Refresher training at regular intervals could also be useful to ensure high-quality administration. In addition, feedback from families could be gathered on the use of outcome measures. Again, we would recommend formal and informal feedback be obtained.

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20 Systemic Family Practice Systemic Competency Scale (SFP-SCS). https://www.ed.ac.uk/files/atoms/files/systemic_family_practice_-_systemic_competence_scale.docx

21 Through our evaluation work with other local areas, we have identified another Early Help service successfully using the ProQOL to explore practitioner outcomes and so although it was not piloted by FaASS, there is some initial evidence that it would be appropriate for measuring outcomes.

22 Further guidance on how to complete this type of data analysis is provided in Appendix D of *10 steps for evaluation success*: https://www.eif.org.uk/resource/10-steps-for-evaluation-success

Glossary of terms

Theory of change terms

Activities. These are the actions undertaken as part of the intervention to encourage/create the outcomes. For example, completion of a genogram or the undertaking of practitioner training.

Mechanisms. These are what you want your target group to be thinking, feeling or doing while they are engaging with your activities to make an outcome more likely. They are how you want your activities to be experienced by your target groups (that is, families feel that their voice is heard, or practitioners feel trusted to make decisions).

Outcomes. The change, sometimes attributable, as a result of an action. They are often changes in the knowledge and/or skills, attitudes or behaviours in the target group as a result of your activities. They could be:

- short-term outcomes occurring during or directly after an activity or intervention (that is, improved understanding of other family members' perspectives after creating a genogram)
- medium-term outcomes occurring a set period after an intervention (that is, improved confidence and awareness of personal strengths and skills in the first six months after working with a practitioner)
- long-term outcomes occurring some time after the intervention (that is, 18–24 months after working with a family and beyond, such as improved mental health). These are sometimes called impacts and are the sustained effects for the target group that they achieve themselves beyond the term of the intervention.

Qualities. These are how you plan to deliver your activities so that your target group experience them in the way you want (to create your outcomes). They are things that maximise the chance of change mechanisms being experienced, and outcomes achieved.

Practice terms

Restorative practice is a term used to describe behaviours, interactions and approaches which help to build and maintain positive, healthy relationships, resolve difficulties and repair harm where there has been conflict. It aims to create a respectful and collaborative relationship context which both challenges and supports users by working with people, rather than doing things to them or for them. Restorative practices range from formal to informal, solutions-focused processes.

Social GRACES is an acronym that describes aspects of personal and social identity which afford people different levels of power and privilege. It was developed in the UK in the 1990s by J. Burnham and other family therapists.[23, 24] It is seen as a way to deconstruct the power relationship between people (for example, therapist and client, supervisor and social worker, and social worker and family members). While power differentials cannot be obliterated

23 Burnham, J. (1992). Approach–method–technique: Making distinctions and creating connections. *Human Systems, 3*(1), 3–27.

24 Roper-Hall, A. (1998). Working systemically with older people and their families who have 'come to grief'. In P. Sutcliffe, G. Tufnell and U. Cornish (Eds.), *Working with the dying and bereaved: Systemic approaches to therapeutic work*. London: Macmillan.

altogether, it makes positions explicit and helps explore their effects, enabling people to make better choices in their future actions.[25]

Systemic practice involves working collaboratively with a family to understand their family system and relationships. Its basis is that family problems are based on dysfunctional patterns of relations between individuals or their interactions with the wider system. There is an emphasis on the importance of the language that is used.

Trauma-informed practice involves considering how trauma affects individuals differently and the long-lasting effects.

25 Birdsey, N., & Kustner, C. (2021). Reviewing the Social GRACES: What do they add and limit in systemic thinking and practice? *The American Journal of Family Therapy, 49*(5), 429–442.

Appendices

Appendix A: Training workshop attendance

TABLE 6

Training workshop attendance 2021–2022

Training workshop	Number of attendees by role			
	Unit leaders	Senior youth and family practitioners	Youth and family practitioners	Total
Systemic genograms	8	7	23	38
Sustainability plans	7	7	18	32
Endings	7	5	19	31
Triage	8	5	16	29
Non-violent resistance	6	6	17	29
Managing risk: safe uncertainty	8	5	15	28
Sleep (service day)	4	5	17	26
Summary car record for Young Peoplewith medical conditions	3	2	10	15
Contextual safeguarding	3	3	9	15
Police powers and accountability	3	2	7	12
DUST training	3	3	6	12
Young women, girls, gangs and county lines	2	3	6	11
CBT	2	3	6	11
Cyber awareness	3	1	4	8
Tri-borough harmful sexual behaviour	0	2	5	7
Safeguarding curiosity	0	0	7	7
County lines workshop – CACT	1	1	5	7
Reducing parental conflict	0	4	1	5
Compassionate approaches	0	0	2	2

Appendix B: Number of contacts per child primary need

TABLE 7

Count of contacts across the categories specified as the child's primary need for the period 2019–2022

Child's primary need	Number of contacts	Percentages (%)
No primary need recorded	821	39.7
Abuse or neglect – emotional abuse	242	11.7
Abuse or neglect – neglect	212	10.2
Socially unacceptable behaviour	211	10.2
Learning disability	173	8.4
Mental health	171	8.3
Abuse or neglect – physical abuse	57	2.8
Child sexual exploitation	40	1.9
Drug misuse	22	1.1
Physical disability or illness	21	1.0
Missing children	19	0.9
Gangs	18	0.9
Alcohol misuse	16	0.8
Domestic violence	14	0.7
Abuse or neglect – sexual abuse	11	0.5
Self-harm	8	0.4
Child criminal exploitation	8	0.4
Female genital mutilation	2	0.1
Young carer	2	0.1
Abuse linked to faith or belief	1	0.0
Total	2,069	100%

Appendix C: Number of contacts per parent primary need

TABLE 8

Count of contacts across the categories specified as the parent's primary need for the period 2019–2022

Parent's primary need	Number of contacts	Percentages (%)
No primary need recorded	1,000	48.3
Parenting issues	492	23.8
Mental health	248	12.0
Domestic violence	114	5.5
Housing issues	107	5.2
Alcohol misuse	53	2.6
Physical disabilities or illness	22	1.1
Drug misuse	18	0.9
Learning disability	6	0.3
Criminal history	5	0.2
Nil recourse to public funds	3	0.1
Risk to children	1	0.0
Total	2,069	100%

Appendix D: Count of problems identified by children and families completing the FIDO

TABLE 9

Count of problems identified for each individual by children and families completing the FIDO as part of the pilot of outcomes

Problem	Count	Percentage
Child/young person needs support with their mental health	14	23.7
Child/young person low school attendance	7	11.9
Parent/carers require parenting support	7	11.9
Child/young person who displays behaviour that challenges within the home	6	10.2
Adult needs support with their mental health	5	8.5
Child/young person not able to participate and engage with education	4	6.8
Child/young person violent in the home to parents/carers or siblings	3	5.1
Child/young person with physical health needs	3	5.1
Family require support due to financial hardship	2	3.4
Child/young person going missing from home	2	3.4
Harmful levels of parental conflict	2	3.4
An adult has a drug and/or alcohol problem	1	1.7
Child/young person verbally abusive in the home (to parents/carers or siblings)	1	1.7
Child/young person identified as at risk of, or experiencing, sexual exploitation	1	1.7
Adult with physical health needs	1	1.7
Total	**59**	**100.0**

Appendix E: Count of closures

TABLE 10

Count of closures across the categories specified as the reason for closure for the period 2019–2022

Reason for closure	Count of families	Percentages
Planned closure – all goals achieved (Early Help (EH))	1,263	52.3
Planned closure – some goals achieved (EH)	358	14.8
Planned closure – goals not achieved but achieved positive outcomes (EH)	197	8.2
Failed to engage/service could not engage family	163	6.8
Stepped up to social care	172	7.2
Threshold met for social care	69	2.9
Planned closure – family withdrew from intervention	62	2.6
Consent withdrawn or family disengagement	56	2.4
Stepped up to Youth Offending Services (YOS)	21	0.9
Moved to another LA	17	0.7
Unplanned closure – other*	16	0.7
Planned closure – other* (EH)	13	0.5
Transferred to SafeCORE (EH)	4	0.2
None	3	0.1
Total	**2,414**	**100.0**

*** Note that the categories defined as 'other' include closure reasons such as stepped up, signposted to Fair Access Protocol (FAP), below threshold, school providing support, goals not achieved, support no longer needed, moved to children with disabilities team, relationship improved following CAMHS input, YP moved into foster care, moved out of borough, parent engaging with other services and YP attending school or moved overseas.**

Appendix F: SCORE-15 and Me and My Feelings paired-sample t-test results

TABLE 11

Paired-sample t-test results comparing SCORE-15 total and subscale scores at the beginning and end of the pilot

Score 15	Beginning of pilot		End of pilot		Degrees of freedom (df)	t	p*
	M	SD	M	SD			
Total score	**38.19**	**9.05**	**38.56**	**13.19**	**31**	**0.23**	**0.821**
Strengths and adaptability	2.33	0.82	2.46	1.41	31	-0.91	0.257
Overwhelmed by difficulties	2.77	0.90	2.79	1.79	31	-0.41	0.912
Disrupted communication	2.54	0.87	2.46	1.90	31	-0.0.9	0.568

*** a p value of 0.05 was used.**

TABLE 12

Paired-sample t-test results comparing Me and My Feelings total and Emotional difficulties subscale scores at the beginning and end of the pilot

Me and My Feelings	Beginning of pilot		End of pilot		Degrees of freedom (df)	t	p*
	M	SD	M	SD			
Total score	15.68	4.15	14.89	4.55	18	0.96	0.348
Emotional difficulties	12.05	3.24	11.26	3.56	18	1.51	0.148

*** a p value of 0.05 was used.**