

# A Sustainable Children's Social Care System for the Future

Annual Report of the Director of Public Health 2017



## List of Abbreviations

<b>Abbreviation</b>	<b>Full form</b>
CFAT	Child and Family Assessment Team
CiN	Child in Need
CPP	Child Protection Plan
LAC	Looked After Child
MASH	Multi-Agency Safeguarding Hub
NICE	National Institute for health and Care Excellence
PASS	Prevention and Support Service
SEND	Special Educational Needs and Disabilities

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## Foreword

Public Health as a professional discipline encompasses a unique skill set that includes epidemiological expertise such as the quantification of need, demand and supply, the assessment of evidence, and the predictive modelling of health and care systems. In the UK these skills have historically been applied to healthcare systems in order to assist the NHS to commission and deliver more efficient, effective and equitable health services. However the move of public health to local authorities has presented opportunities for these skills to be applied more widely.

My Annual Public Health Report last year used this public health skill set in answering the question, ‘what would make our adult health and care services more sustainable in financial and operational terms?’ By mapping how our residents, and the funding that accompanies their journeys, flow through different constituent organisations, we were able to understand how clinical and professional practice in each organisation impacted on the system as a whole. This led to a series of recommendations to reduce demand for the most expensive and high intensity interventions by improving clinical practice ‘upstream’ in primary and community care to prevent avoidable events such as strokes, heart attacks and falls. The findings and recommendations within the report were seized upon by our local clinicians and system leaders, and have resulted in a comprehensive programme of system transformation and improvement that will ultimately lead to a new Accountable Care Partnership for Thurrock, reduced demand on local hospital and adult social care services, and demonstrable improvements in the health of our population.

This year I asked my team to apply the same skill set to children’s social care services, with a view to answering a similar question: how can we make our children’s social care system financially and operationally sustainable, and more effective? There were two reasons for my choice of topic. Firstly, it has long been known that children and young people who enter the care system typically experience poorer health and wellbeing outcomes than those in the general population. Experiencing care as a child or young person is associated with poorer educational attainment, poorer mental health, an increased risk of teenage parenthood and an increased likelihood of entering the criminal justice system. Indeed children and young people who become ‘looked after’ by the state experience some of the worst health inequalities of any group in society. Secondly, demand on children’s social care services is increasing at an unsustainable rate both nationally and locally. Modelling famously done in the London Borough of Barnet suggested that if action is not taken to address this, local authorities will need to spend their entire budget on social care by 2025.

This report aims to understand our local children’s social care system, the factors that are driving demand and most importantly, the actions that we can take to address that demand and improve health and wellbeing outcomes for the children and young people we care for. The work has been led by Tim Elwell-Sutton, Consultant in Public Health and his team and I commend it as one of the highest quality and most detailed pieces of public health practice in this field. I trust that the findings and recommendations contained within the report will be useful to colleagues in children’s social care in understanding our care system, and will continue the conversation on how we improve that system and the life chances of children and young people who enter it in the future.

*Ian Wake*

**Director of Public Health, November 2017**

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## Introduction

### Why focus on children's social care?

One of the main goals of our Health and Wellbeing Strategy is to make Thurrock a place offering "Opportunity for All". Central to this goal is making Thurrock a place where children can flourish and achieve their full potential in life.

It is increasingly recognised that improving health and wellbeing for our population has to start early in life, even before birth. We now have a better understanding than ever of how distressing experiences in childhood are linked to poor health and wellbeing in adulthood. For example, it has been found (Bellis, et al., 2014) that adults who had several adverse childhood experiences, such as child abuse, parental separation, and household members with substance abuse are:

- nine times more likely to be incarcerated ;
- likely to have significantly worse mental health;
- three times more likely to develop diabetes ;
- six times more likely to have a stroke.

It is also increasingly understood that poor experiences in childhood can create intergenerational cycles of deprivation and poor health. People who have multiple adverse childhood experiences are also more likely to make poor educational progress, have unplanned pregnancies and be unemployed. This in turn can have a negative impact on their parenting ability, perpetuating the cycle across generations.

The role of the children's social care system is to ensure that all children have the opportunities they deserve and that, when things go wrong, children are kept safe. The local authority has a legal duty to intervene where there are concerns for the welfare of children in Thurrock. These can include cases of abuse or neglect. They also include situations where parents have problems with issues such as mental health or substance misuse which affect their ability to care for their children. In such cases, the social care system is there to safeguard the interests of the child. In the most extreme cases, courts may decide that a child should, for their own wellbeing, be taken into the care of the local authority and become a 'looked after child' (LAC).

Children's social workers have not traditionally been considered part of the public health workforce, yet their work has at least as much impact on the current and future health and wellbeing of children in Thurrock as that of health professionals.

Pressures on social workers and the whole social care system are growing each year. There is evidence that a growing number of families and children are coming into contact with the social care system. The reasons for this have not been well understood but the pressures that this puts on the social care system are clear: social workers are increasingly over-burdened and the cost to the Council is growing.

Last year's Annual Public Health Report considered ways in which the health and adult social care system could be made more sustainable. This year, we consider the children's social care system, the pressures on it, and how we can create a system which gives every child in Thurrock the best possible start in life.

## How this report is organised

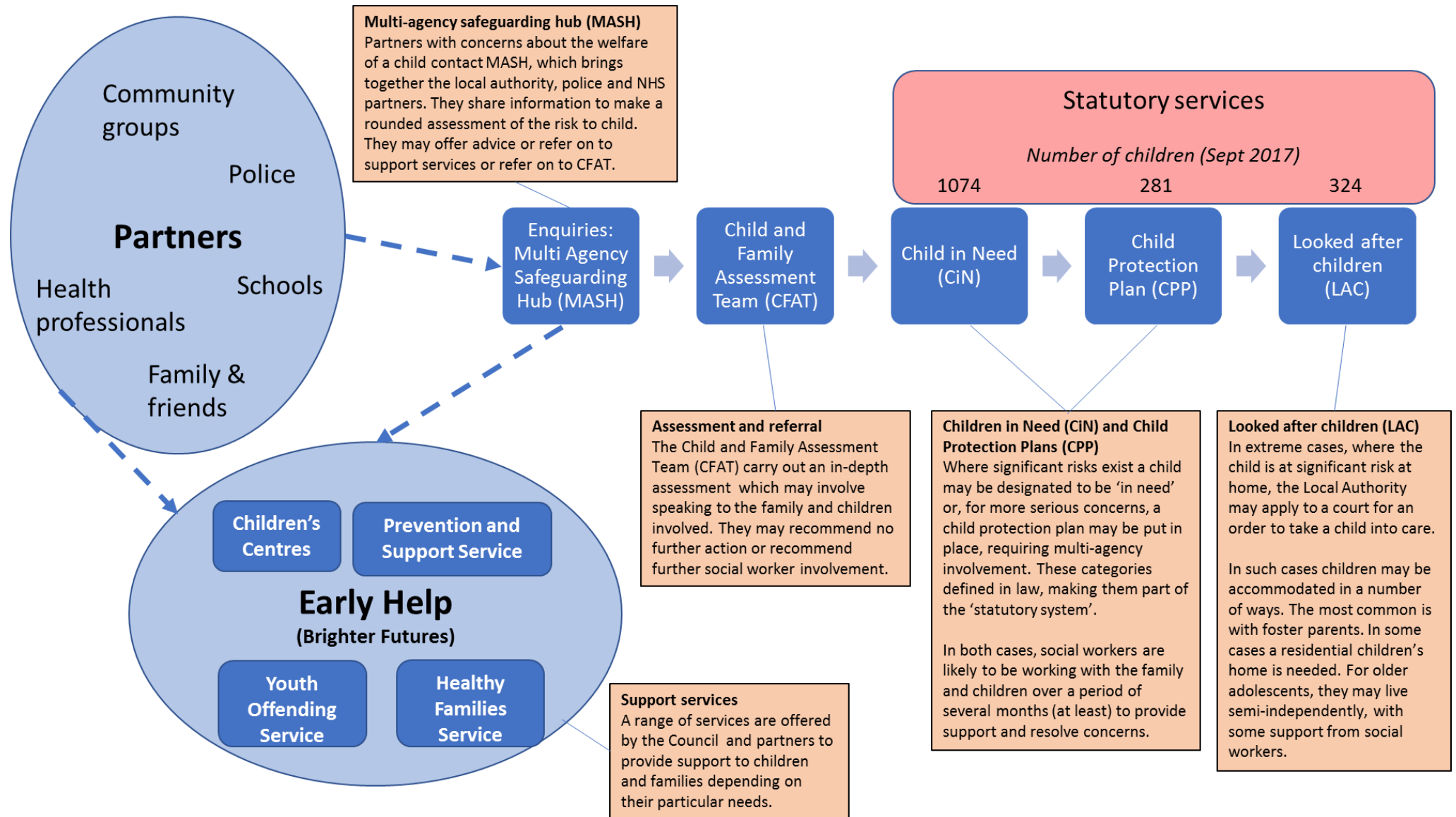
This report sets out to answer a number of key questions about the children's social care system and is organised the following way:

- A guide to how the children's social care system works;
- A summary of our recommendations and the financial opportunities identified by our work;
- Section 1 explores the pressures on children's social services. It aims to answer key questions including:
  - Is the number of children in the social care system rising faster in Thurrock than in other areas?
  - Why are the numbers rising so fast?
  - How many children are likely to be in the social care system in future?
- Section 2 looks at how we can reduce the number of children in the social care system. In particular, it considers what can be done to prevent children from being taken into care and finds that there are actions which can be taken at every stage of the system to prevent this outcome;
- Section 3 sums up the key findings and gives detailed recommendations.

## Questions not addressed in this report

In this report we focus on ways of reducing the number of children in the social care system. Other ways of reducing the costs of social care are not covered. These may include, for example, reducing the number of agency staff or more efficient procurement of foster care places.

Figure 1. How the children's social care system works in Thurrock





## Summary of recommendations and financial opportunities

### Summary of recommendations

Based on our analysis, we make the following three strategic recommendations for managing the pressures on the children's social care system in Thurrock:

#### *1. Make a long-term strategic commitment to invest in prevention*

To reduce the number of children in the social care system, a high-level strategic commitment must be made to re-balance investment towards preventative activities. In recent years investment in preventative services has been eroded whilst spending on high-cost care placements has increased. By rebalancing investment towards preventative services, we can prevent children from ending up in care unnecessarily and, over time, relieve financial pressures on the social care system. This rebalancing has already begun but must be continued over the long-term to ensure sustainability.

The change must be seen against the background of continuing cost pressures particularly due to rapid population growth. However, we have demonstrated that the cost of doing nothing is likely to be much higher than the costs of investing in preventative services.

#### *2. Invest in the most effective preventative services*

Making a strategic commitment to invest in prevention will only be effective if that investment is made in the right areas. Based on our review of evidence we recommend:

- **Early help:** Making efforts to expand the number of families benefiting from early help services by increasing capacity of existing services, strengthening referral systems and expanding inclusion criteria;
- **Children in Need & Child Protection Plans:** Investing in an 'edge of care' service to work intensively with children at greatest risk of coming into care; expanding the capacity of existing parenting and domestic violence programmes; more targeted drug and alcohol outreach to families of Children in Need or on a Child Protection Plan;
- **Looked After Children:** Working systematically with families who have had children removed to increase the chances of Looked After Children being reunited with their families; providing intensive support to mothers (especially young mothers) who have had babies removed from their care to prevent this from re-occurring in future.

#### *3. Improve information on activity and spending*

Reducing the number of children in the system and controlling costs can only be achieved if reliable activity and financial information are available, allowing us to understand current patterns of activity and spending. For the purposes of this report, a new way of forecasting future activity and spending has been developed. This kind of forecasting can help to make good strategic decisions and financial plans for the future. The model used here is relatively simple and its accuracy could be improved with more work in future. Moreover, a number of weaknesses in existing data systems have been identified during the course of this report, which hinder effective planning and cost control.

**Further details on these recommendations are given in Section 3.**

## Financial Opportunities Identified

Implementing the recommendations above, especially investing in prevention, could have a measurable impact on costs on the cost of providing children’s social care services. We have identified three key drivers of cost in the system: the rate of Looked After Children; the length of stay in care; the cost of care placements. The table below shows the potential financial impact of changes in these key determinants of the costs of Looked After Children alongside the interventions which could influence these cost drivers.

*Savings calculations include reductions in the amount of money spent on placements for Looked After Children. These are “directly cashable” – that is, the Council would immediately spend less money as a result. Other savings (e.g. reductions in staff time) are less easily cashable but can be translated into lower spending over time.*

**Table 1. Potential annual savings from changes in key cost drivers and interventions**

Cost driver	Change	Savings per annum	Directly cashable savings*	Recommended Interventions
<b>LAC rate</b>	11.6% reduction (to the same level as statistical neighbours)	£2.58M	£1.38M	Implement a new edge of care service possibly including short stay residential care for adolescents; support for mothers who have had babies removed from their care.
	5% reduction	£1.13M	£0.60M	Increase referrals and capacity in: parenting services and domestic violence programmes.  Targeted drug and alcohol outreach to families of Children in Need or on Child Protection Plans.  Successor to current Troubled Families programme designed to reduce LAC numbers.
<b>Length of stay in care</b>	1-week reduction to 34 weeks	£0.65M	£0.34M	Targeted re-unification work carried out by a new edge of care service.
	3-week reduction to 32 weeks	£1.93M	£1.02M	Extending the remit of early help and CP/CIN services to work with families who have had children removed from their care.
<b>Cost of care placements</b>	5% reduction	£0.6M	£0.6M	Enhancing procurement of placements.  Continued efforts to recruit more in-house foster carers.

\* See box at the top of this page for an explanation of ‘directly cashable savings’

Where possible we have estimated the impact and financial savings that would result for implementing specific interventions.

**Table 2. Impact and expected savings from investing in prevention interventions**

<b>Intervention</b>	<b>Recommendation</b>	<b>Estimated Impact</b>	<b>Net savings</b>	<b>More details found in:</b>
<b>Edge-of-care service</b>	Based on Functional Family Therapy or Multi-Systemic Therapy, working with 135 families per year	Preventing 22 children from coming into care per year	£1,225,153	Section 2.3.3
<b>Pause</b>	A service working with 10 women per year	Preventing 2 – 3 children from being taken into care at birth.	£128,520 - £307,945	Section 2.4.2
<b>Domestic violence victims programme</b>	Expand existing STEPS programme from current capacity of ~75 per year to ~135 per year	Preventing 144 additional incidents of domestic violence	£133,220	Section 2.3.1
<b>Domestic violence perpetrators programme</b>	Expand current programme from 10 to 20 places per year	Preventing 19 additional incidents of domestic violence per year	-£7,293	Section 2.3.1

## 1. The pressures on children’s services

### 1.1. Is the number of children in the social care system in Thurrock rising and is it higher than in other areas?

We can understand the pressures on the children’s social care system in two main ways: the number of children in the system, and the amount of money being spent on it. In this section, we consider first the trends in numbers of children in the system in Thurrock and secondly the cost of the social care system overall. In order to understand whether the numbers in Thurrock are growing faster than in other areas, we make comparisons with both national figures for England, regional figures for the East of England, and with ‘statistical neighbours’; that is, a group of local authorities which are statistically similar to Thurrock in terms of their population, levels of deprivation and other relevant factors.

#### 1.1.1. Numbers of Looked After Children

There has been a steady rise in the number of Looked After Children (LAC) in Thurrock in recent years from 210 in March 2012 to 345 by March 2017 (Table 3). Numbers have also been rising in other areas. In one sense, then, Thurrock is not unique.

In order to understand whether the rise seen in Thurrock is greater than in other areas, however, we need to look at the rates of LAC per 10,000 children (aged 0 to 17). These rates are shown in Figure 2. This shows that for England and Thurrock’s statistical neighbours, rates have been fairly steady in recent years. In Thurrock, however, the rate began to rise after 2011 and has increased by almost 50% since then (from 55 to 82 per 10,000 population). More recently, the rate of LAC in Thurrock has levelled off. However, this is primarily due to reductions in the number of Unaccompanied Asylum Seeking Children (UASC) in the system (Figure 3). The underlying rates of non-UASC have continued to rise. This is discussed below (section 1.2.1).

The fact that the numbers of Looked After Children have continued to rise nationally and amongst Thurrock’s statistical neighbours, whilst the rates have stayed the same suggests that, in other areas, the rising number of LAC over the past 5 years has been driven primarily by population growth, whilst in Thurrock other, local factors have been at work, driving up the rates as well as the numbers of Looked After Children.

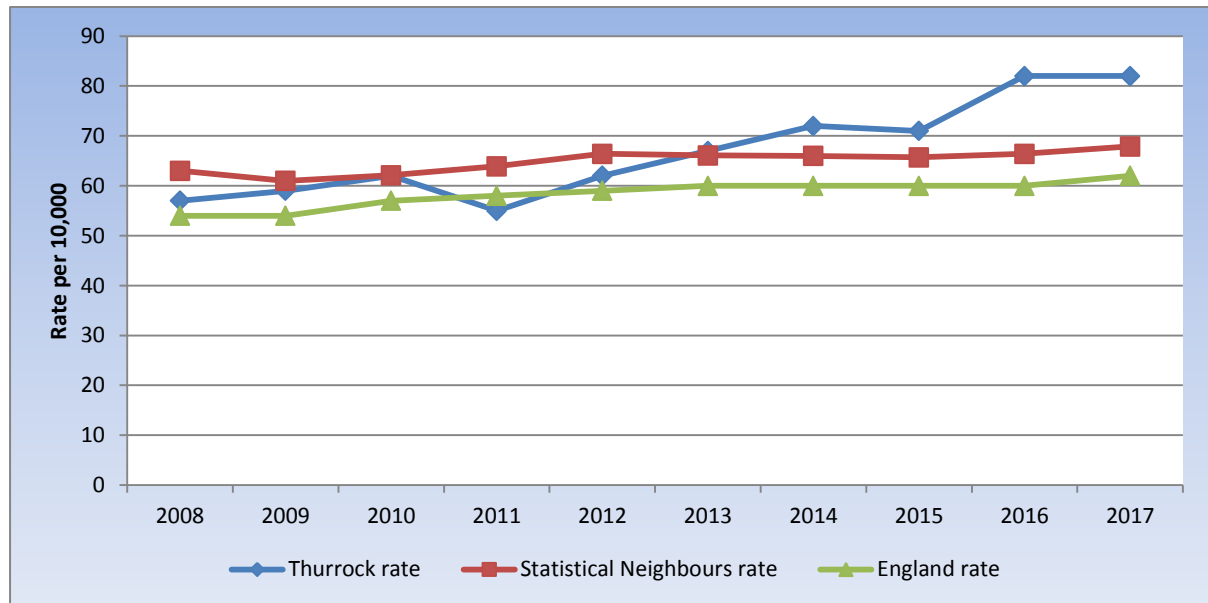
**Table 3. Numbers of Looked After Children for Thurrock and comparator areas (2011 – 2017 – as of 31<sup>st</sup> March each year)**

	2011	2012	2013	2014	2015	2016	2017
Thurrock	210	240	260	285	285	335	345
Statistical Neighbours	362	377	374	376	380	384	392.5
East of England	6410	6420	6300	6350	6140	6330	6460
England	65510	67070	68060	68810	69480	70440	72670

More recently, however, there does appear to be a levelling off in the rates in Thurrock which may suggest that the long-term upward trend is now coming under control. The latest data available at the time of writing is shown in Figure 4 below. This shows that since the start of this financial year (April 2017) rates have declined slightly from their 2016/17 levels. Much of this has been due to lower numbers of Unaccompanied Asylum Seeking Children (UASC) though the non-UASC rates also

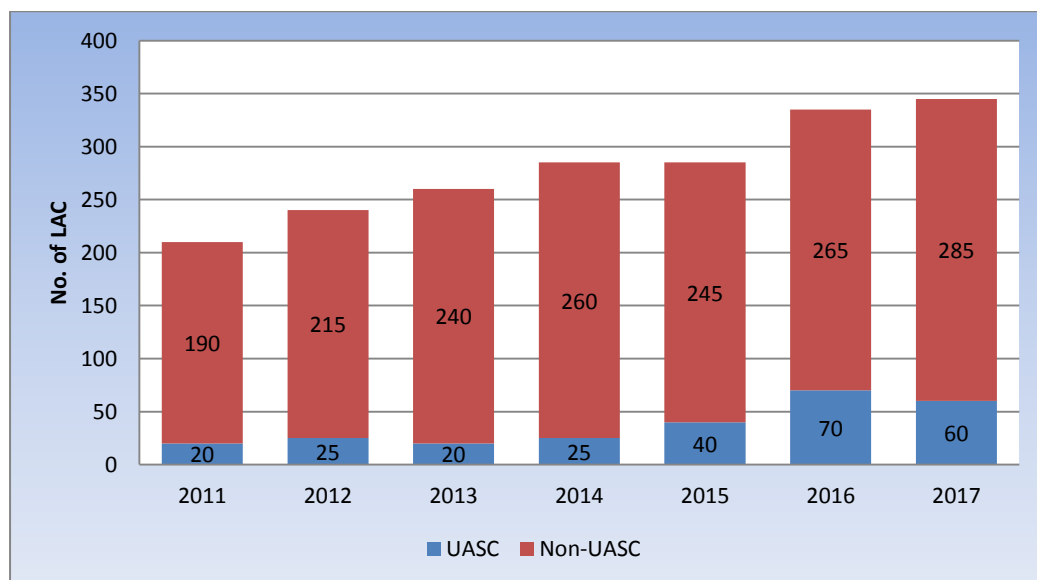
appear to be stable or declining. It is too early to tell at this stage whether these recent changes represent the beginning of a long-term change the trajectory of LAC rates but there are some encouraging signs.

**Figure 2. Rates of Looked After Children in Thurrock, England and Statistical Neighbours at year end for 2008/9 to 2016/17**



Source: LAIT

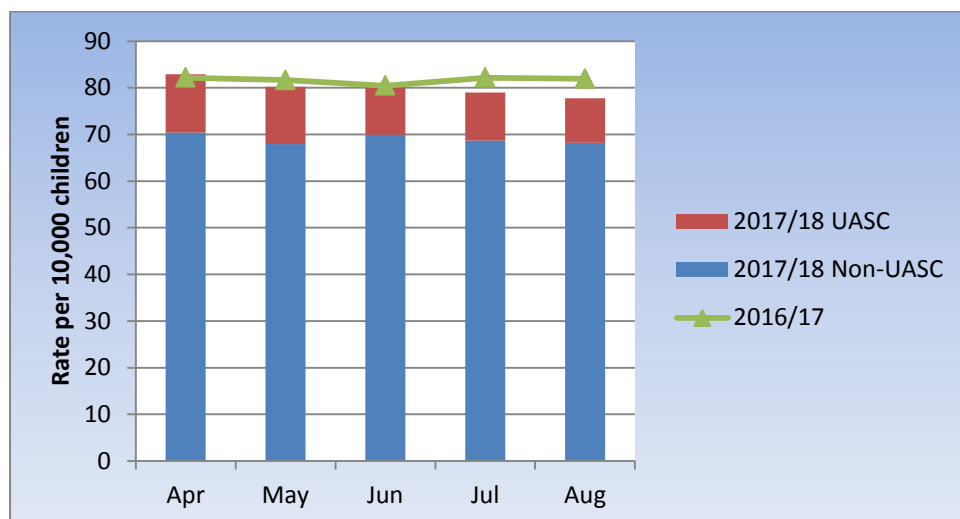
**Figure 3. Number of Looked After Children in Thurrock by UASC\* and non-UASC category, 2011 – 2017**



Source: Department for Education Children Looked After Returns, 2011/12-2016/17

\* UASC: Unaccompanied Asylum Seeking Children

Figure 4. Rate of Looked After Children in Thurrock by month for 2017/18.

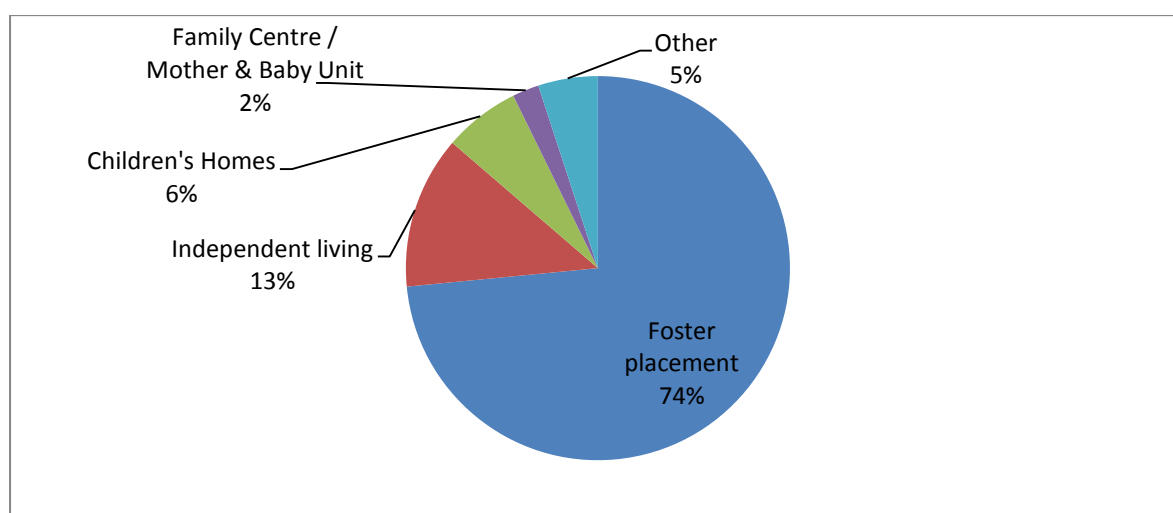


Source: Thurrock Council data

### 1.1.2. Caring for Looked After Children

Looked after children can be cared for in a number of ways. Figure 5 (below) shows that at the time of writing 74% of Looked After Children in Thurrock were in foster placements. In cases where a foster placement is either unsuitable or unavailable, children may be cared for in residential children’s homes. Some older teenagers in care may be able to live semi-independently in settings where they are supported to learn important skills such as budgeting and cooking for themselves. In cases where a baby is at risk at home, it is possible for them to be accommodated in mother and baby unit which allows the bond between mother and baby to be continued in a safe environment.

Figure 5. Looked after children placements in Thurrock (August 2017)

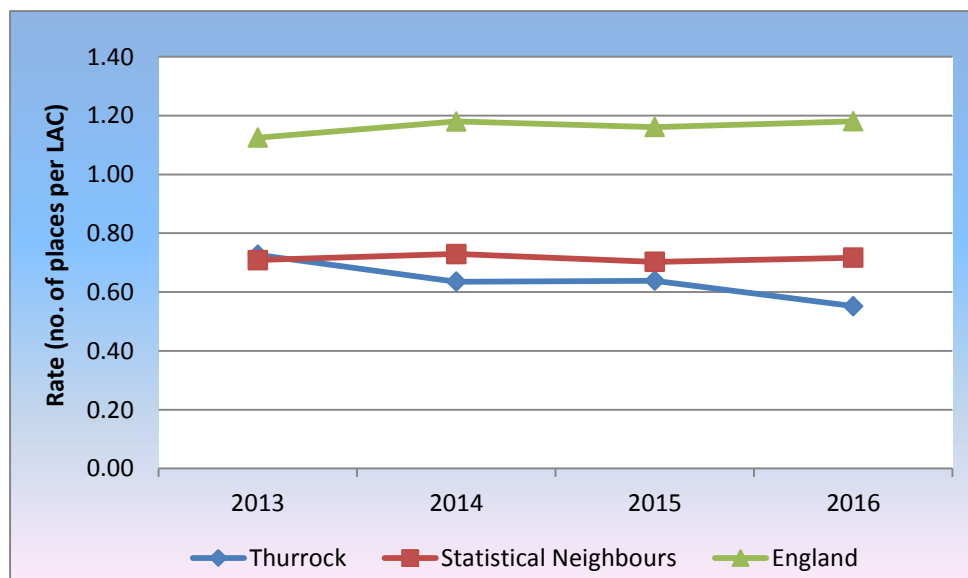


Recruiting and retaining sufficient foster carers is a major challenge for many local authorities including Thurrock. Some foster carers are employed directly by the local authority and others work through agencies known as IFAs (Independent Fostering Associations). It is significantly more expensive for the local authority to employ foster carers through agencies but a shortage of in-house foster carers sometimes makes this necessary.

Even taking into account agency provision, there is a shortage of foster carers available in Thurrock. Figure 6 indicates that this shortage has been getting worse for several years now, declining from 71 places available per 100 LAC in 2013 to just 55 in 2016. Thurrock now has the lowest rate of foster places available among all its statistical neighbours and a rate which is about half the national average. This can be attributed to an increase in the number of Looked After Children, alongside no significant change in the number of foster places available.

This shortage has implications for both the quality and the cost of care. The shortage of supply means that social workers have little choice when trying to match Looked After Children with suitable foster carers and often have to make compromises such as placing children far out of the borough. As Thurrock social workers have a duty to visit and support LAC even when they are living out of the borough, these arrangements take up a lot of social worker time and incur high travel costs.

Figure 6. Rate of approved foster places for Thurrock, England and statistical neighbours at year end, 2013 - 2016



Source: Fostering in England Statistics

### 1.1.3. Children in Need and Child Protection Plans

Although it is possible for children to become looked after soon after their first contact with the local authority, most children who end up being looked after have previously been classified as Children in Need (CiN) or, where concerns were more serious, have been on a Child Protection Plan (CPP). The length of these plans can vary from a few months to several years. In some cases they are ended when concerns are addressed and it is possible to 'step down' the care of that child (i.e. end social care involvement in their lives). In other cases, these plans end when the children reach the age of 18 or are taken into care.

During the course of a CiN or CP plan social workers are regularly involved with the child and their family with the aims of ensuring the child's safety and supporting families to make any changes needed to care for their child.

Similar to the trends for LAC, from a low point in 2011, the rate of Children in Need (CiN) appears to have risen in Thurrock in recent years and is now well above the national average and the average

for statistical neighbours (Figure 7). National rates, and those for statistical neighbours, meanwhile, appear to have stayed fairly stable over the same period.

The pattern for Child Protection Plans is similar, in that rates in Thurrock have increased over the past 6 – 8 years (Figure 8) and are higher than for comparators. One difference here, however, is that there does appear to have been a steady rise in CP plan rates nationally and amongst statistical neighbours over the same period. Overall, the data suggest that there are local factors at work keeping the amount of activity in Thurrock’s social care system high and rising.

Figure 7. Rate of Children in Need per 10,000 population (0 – 17) for Thurrock, England and statistical neighbours (2009 - 2016)

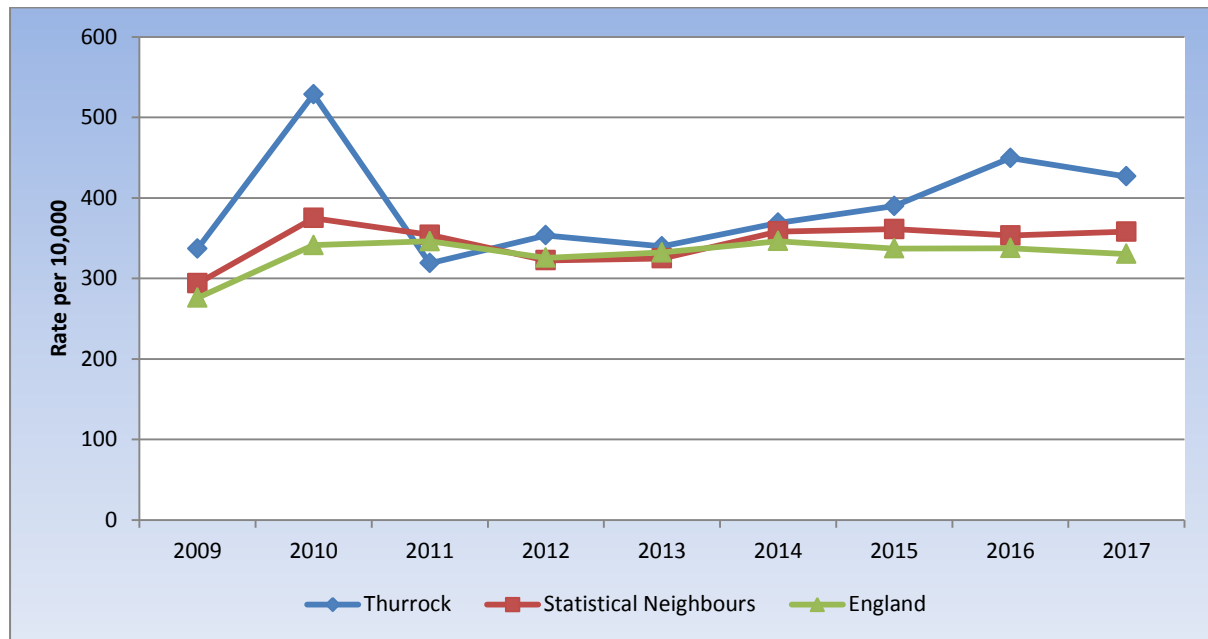
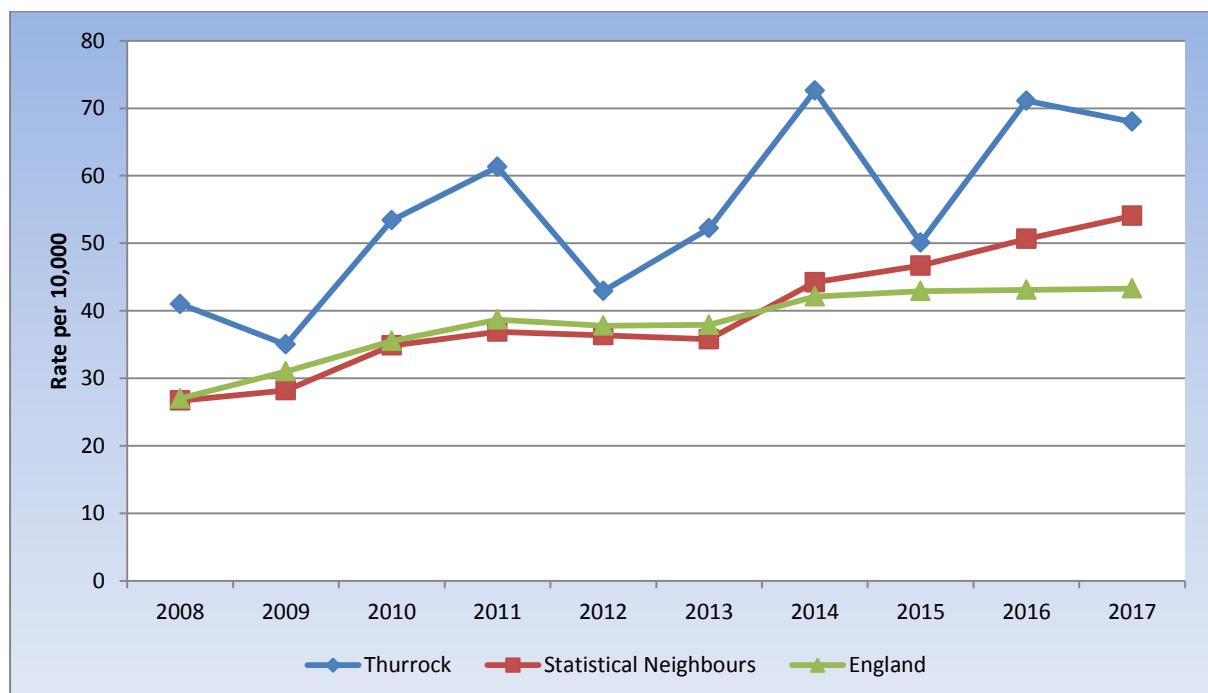


Figure 8. Rate of children subject to a Child Protection Plan per 10,000 for Thurrock, England and statistical neighbours (2008 - 2016)





### *Multi-Agency Safeguarding Hub*

MASH (the Multi-Agency Safeguarding Hub) is the 'front door' for most children's social care work.

The MASH was established in 2014 with the aim of providing better inter-agency working and information sharing. As the first point of contact for most safeguarding enquiries, the MASH controls, to some extent, the flow of demand into the children's social care system. There is some evidence that the complexity of cases being referred into the MASH is increasing, with the proportion of enquiries rated as *Red* (the highest risk category) at the start doubling from 16.7% to 34.4% between 2015/16 and 2016/17. This has an impact on the workload of the statutory services, as the proportion of MASH enquiries that were transferred into social care increased from 64.9% to 76.2% in the same period.

#### **1.1.4. Budget and Spending**

##### *The National Picture*

Spending on children's social care has been rising nationally and many Local Authorities are struggling to continue to fund the current system. Analysis for the Department of Education (2016) looking at how Local Authorities have responded to these pressures since 2010 found that the main strategy pursued by most local authorities was to place greater emphasis on early help and integrating services. Both of these strategies are designed to reduce the numbers of children in the system and to prevent cases from escalating to the most expensive part of the system where children are taken into local authority care.

Although most authorities believe that early help (prevention) is vital for managing rising costs, analysis of actual spending shows a different picture. Between 2010/11 and 2013/14 national spending on statutory services (CiN/CPP and LAC) rose in real terms (from £5.659 billion to £5.890 billion) and as a proportion of total spending on children's services (from 57% to 65%) whilst spending on other areas decreased. One conclusion of the report was that:

*Spending on some service areas was difficult or impossible for participating councils to change, for example where there were contractual constraints or statutory responsibilities, as for Looked After Children... however local councils had greater flexibility to decide spending changes on other areas, such as children's services early help. (Department for Education, 2016, p. 14)*

##### *The Local Situation*

Analysis of local spending is not simple (see Data warning!) but the following conclusions are reasonably certain:

## **Data warning!**

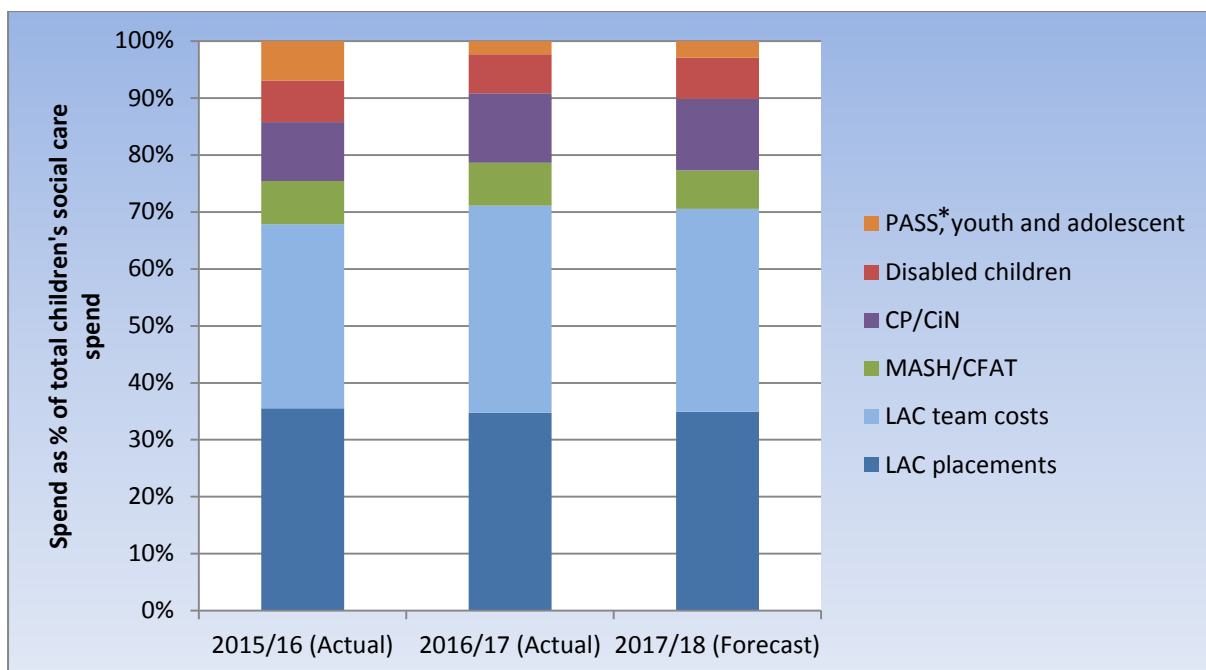
Analysing spending on children's social care is complex. It requires a number of assumptions to be made about what constitutes 'social care'. Moreover, categorisation of spending in this area has not always been consistent over the years, making it challenging to analyse trends over time. The analysis presented here, therefore, should be treated with some caution but represents our best estimate of how spending on children's social care has changed over recent years.

Also, for the purposes of this report spending on Looked After Children has been separated from other costs. This is based on a high-level analysis of budgets. A financial deep dive is needed to get a more accurate picture of the true costs to the Council of Looked After Children.

- In Thurrock, as nationally, investment in Early Help services has declined as a proportion of spend in recent years. For example, spending on Early Offer of Help services in Thurrock has fallen from £0.93 million in 2015/16 to £0.39 million in 2017/18. At the same time spending on external purchasing of placements for Looked After Children rose from £8.9 million to £9.3 million. Much of the reduction in early help services followed the withdrawal of £450,000 of NHS funding previously contributed by Thurrock Clinical Commissioning Group (CCG).
- By far the biggest area of spending on children’s social care is on Looked After Children (see Figure 9). Although the number of LAC at any one time is relatively small, the associated costs make up around 71% of all spending on children’s social care (see Figure 9). This is a rough estimate and further financial analysis is needed to obtain an accurate figure for the costs of LAC to the Council. Much of this cost is associated with ‘placements’ (e.g. the cost of foster care or children’s homes places).
- The most recent national data indicates that Thurrock’s rate of spend per looked after child has reduced over the last three years and is now similar to the average for England and for our statistical neighbours (Figure 10).

Overall, it is clear that controlling the costs of children’s social care in future will depend to a great extent on the ability of the Council to control costs associated with Looked After Children since this makes up the majority of spending. Reducing costs in this area, however, is likely to require greater investment in early help services and other strategies which reduce the number of children who end up being taken into local authority care.

Figure 9. Spending in Children’s social care by category from 2015/16 to 2017/18

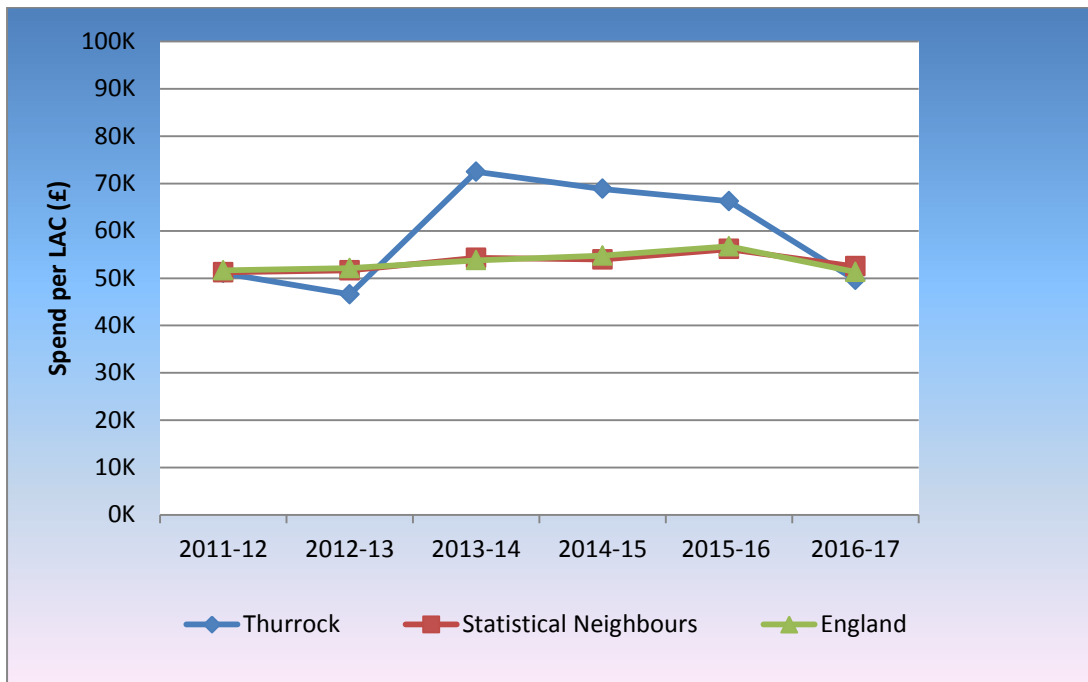


Source: Thurrock council finance

Note: “LAC team costs” are budgets for the social care teams working primarily with LAC. This will include some placement costs but further work is needed to separate these out from other team costs including staff and travel costs.

PASS: Prevention And Support Service

Figure 10. Spending on Looked After Children in Thurrock, and comparators, from 2011/12 to 2016/17



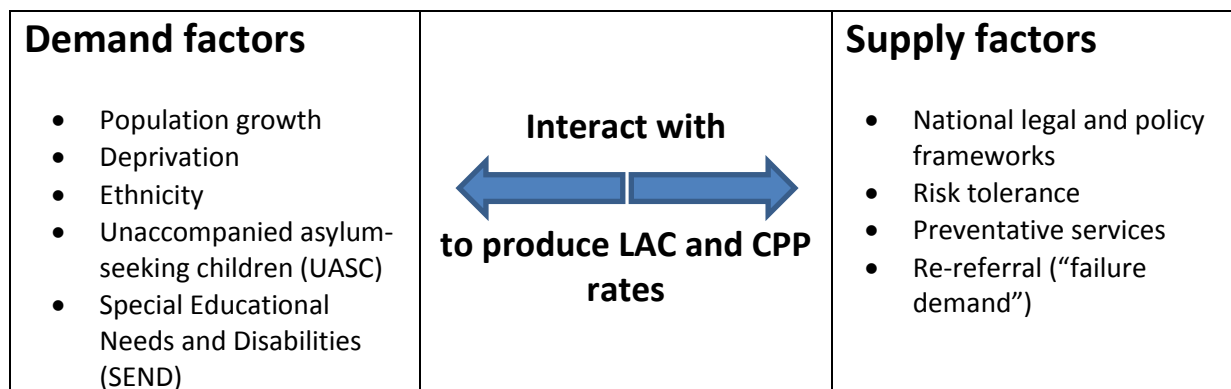
Source: Department for Education Local Authority and School Expenditure statistics and Children Looked After Returns, 2011/12-2016/17

## 1.2. Why are the numbers of children in the social care system rising in Thurrock?

We have seen that the numbers of children in the system are growing in Thurrock, faster than in other comparable areas. In trying to understand the rise that has occurred in recent years, it is helpful to consider two types of force which may result in children ending up in the social care system. It might be that more children need a social care intervention than in the past (demand factors), or it could be that the social care system is more likely to intervene than in the past (supply factors). Therefore, we can address this question by considering the demand and supply factors (Bywaters P. , et al., 2017) which may be at work in Thurrock.

Based on a review of the research literature we have identified the factors shown in Figure 11 as a framework for understanding growing demand for social care in Thurrock. The following sections try, where possible, to quantify the impact of each of these factors in Thurrock in recent years.

Figure 11. Demand and supply model adapted for Thurrock



Source: adapted from (Bywaters P. , et al., 2017)

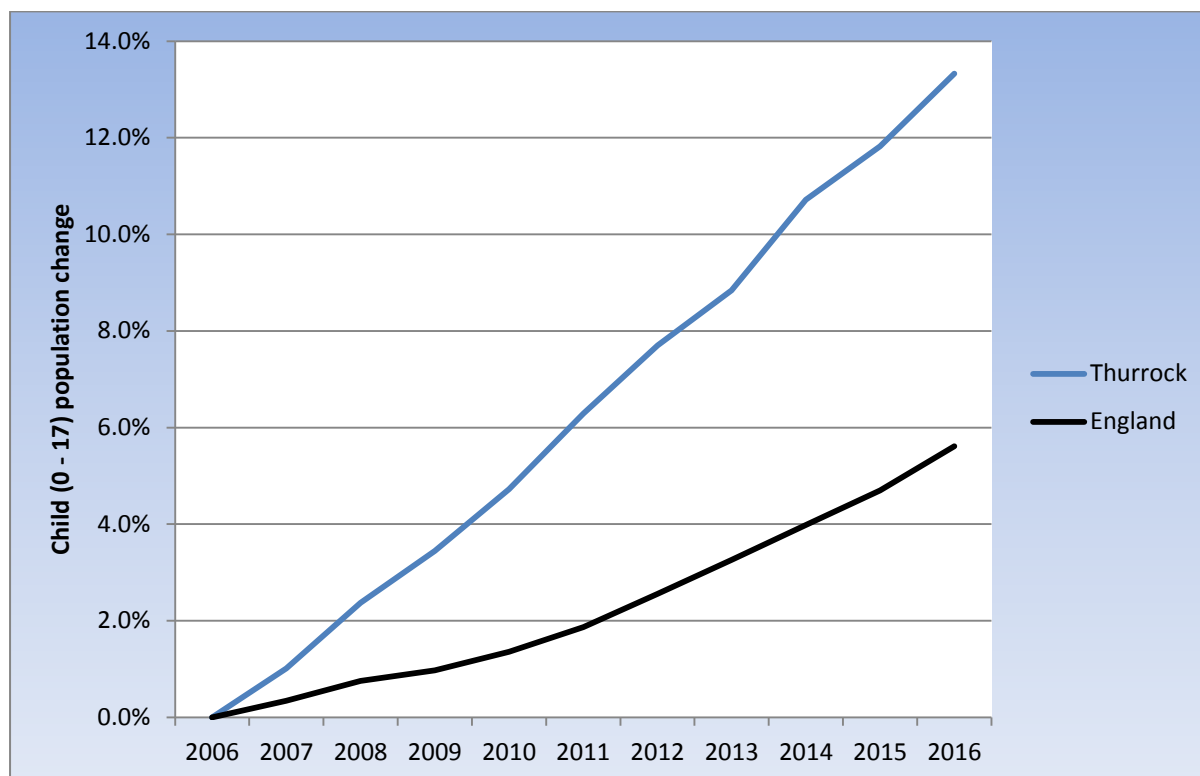
### 1.2.1. Demand factors

#### *Population growth*

Possibly the most important reason for the growing number of children in the social care system in Thurrock is growth in the child population. The high level of economic and housing development taking place makes this a particularly strong pressure in Thurrock. Moreover, this growth in population is likely to continue into the future, placing increasing pressure on the social care system and other services.

Figure 12 below shows the growth of the child (0 – 17) population in Thurrock and England between 2006 and 2016. This shows that the rate of growth in Thurrock has been much faster than the national average. Whereas England’s child population grew by 6% over that ten-year period, in Thurrock growth was more than double that at 13.3%. This, then, may account for a significant portion of the growth in the number of children in the social care system in recent years.

Figure 12. Percentage change in the child population in Thurrock and England, 2006 - 2016



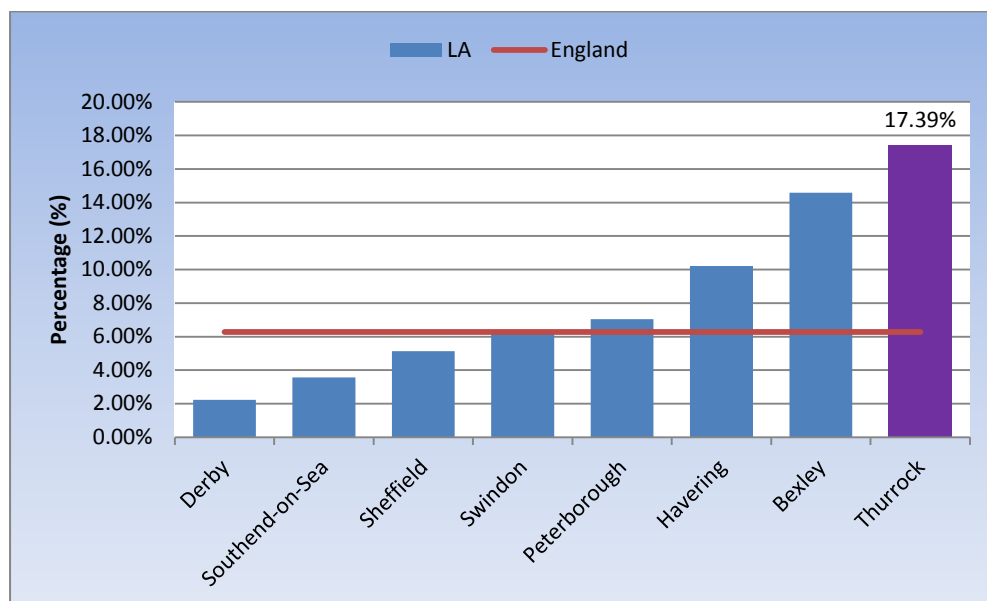
Source: Office for National Statistics mid-year population estimates

### *Unaccompanied Asylum Seeking Children*

Another factor which has certainly contributed to the rise in the number of Looked After Children in recent years has been a higher number of unaccompanied asylum seeking children (UASC) arriving in Thurrock from abroad. Thurrock is particularly likely to receive such children due to the presence of two major shipping ports in the borough. If they are not accompanied by parents or guardians, asylum-seeking children become looked after by the local authority. Figure 13 shows that Thurrock has a much higher proportion of UASC in its LAC population than any of its statistical neighbours.

An arrangement to allow the dispersal of UASC across the region (the Interim National Transfer Protocol for Unaccompanied Asylum Seeking Children) came into force in July 2016. This has resulted in a significant reduction in the number of UASC in Thurrock. From a peak of 103 in 2016, the numbers have fallen to 38 in August 2017. This agreement also means that over the next 1 – 2 years, the numbers of UASC are likely to continue to fall to around 28.

Figure 13. Percentage of Looked After Children who are unaccompanied asylum seekers (UASC), 2017



Source: Department for Education Children Looked After Returns, 2016/17

The high number of Unaccompanied Asylum Seeking Children entering Thurrock in recent years has had a significant impact on Thurrock’s headline rate of LAC. The financial impact, however, has been mitigated to some extent by the provision of central government funding for this purpose.

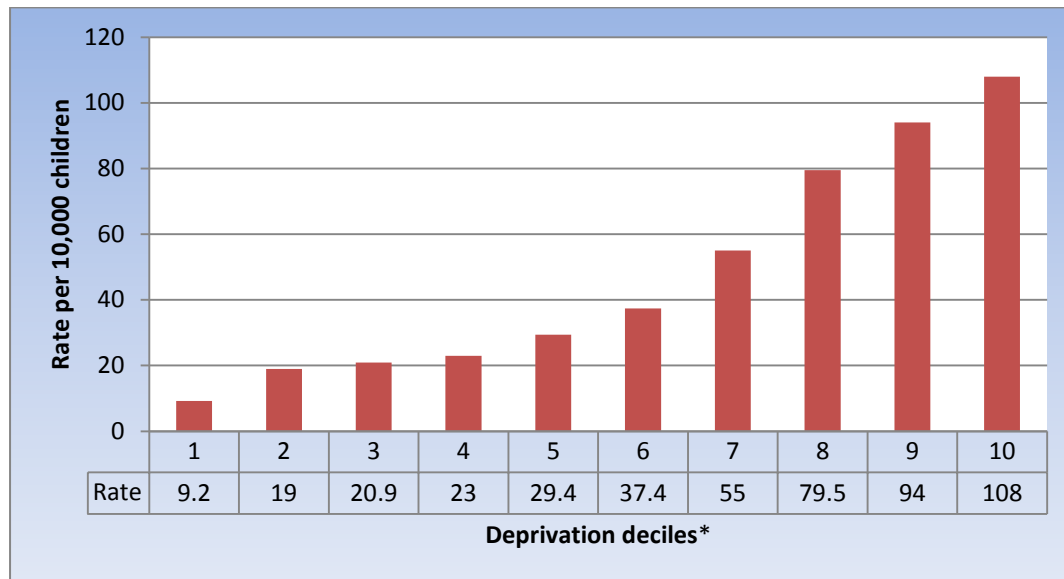
Nevertheless, there has been a significant impact on finances and on staff time, as the funding provided to the local authority for UASC does not cover the full cost of care.

Just as the financial pressure of rising UASC numbers was mitigated to some extent by central government funding, the potential benefits of falling numbers will, to some extent, be offset by a decline in this funding stream. Further work is needed to calculate the likely financial impact of this trend.

### *Deprivation*

There is a large body of evidence showing that socio-economic deprivation is strongly associated with social care intervention rates. This is not only true in the UK, but internationally. A two-year project funded by the Nuffield Foundation found that children living in the most deprived areas of England were 13 times more likely to be on a Child Protection Plan and 11 times more likely to be looked after than children in the least deprived areas (Bywaters P. , Brady, Sparks, & Bos, 2016). This study also found that, on average, each 10% increase in neighbourhood deprivation levels was associated with a 30% increase in rates of Looked After Children (see Figure 14). The reasons for this strong association between deprivation and social care intervention are less clearly understood though there is evidence that both supply and demand factors play a part (Hood, Goldacre, Grant, & Jones, 2016).

Figure 14. Looked-after children rates per 10,000 children by deprivation decile\*, midlands sample, 31 March 2012

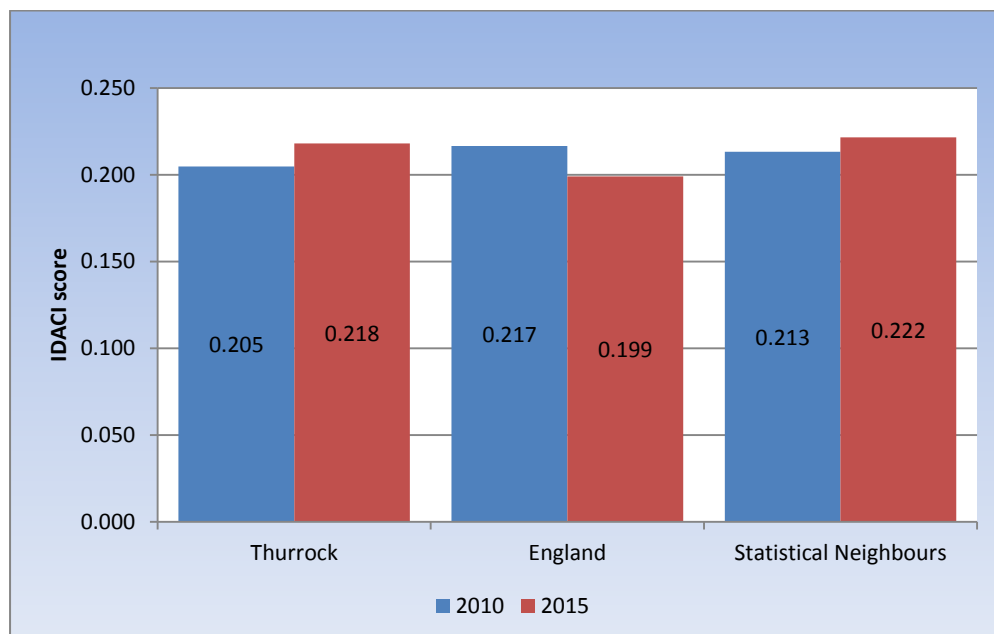


Source: (Bywaters P. , Brady, Sparks, & Bos, 2016)

\* Deprivation deciles, 1 = most affluent, 10 = most deprived.

Given that deprivation is a strong driver of demand for social care, to what extent can this help to explain increases in social care activity in Thurrock in recent years? A useful measure of deprivation related to children is the IDACI (Income Deprivation Affecting Children Index) score which is a measure of the proportion of children (age under 16) living in low income households in an area. Figure 15 shows IDACI scores for Thurrock and comparator areas. The most recent data suggest that the level of child deprivation in Thurrock is slightly above the national average, though it is similar to statistical neighbours. Moreover, whereas nationally child deprivation rates appear to have declined between 2010 and 2015, in Thurrock and similar areas, child deprivation has become more common. We would, therefore, expect some increases in the level of social care activity in Thurrock due to increased levels of deprivation.

Figure 15. IDACI score for Thurrock, England and statistical neighbours (2010 and 2015)



Source: Department for Communities and Local Government

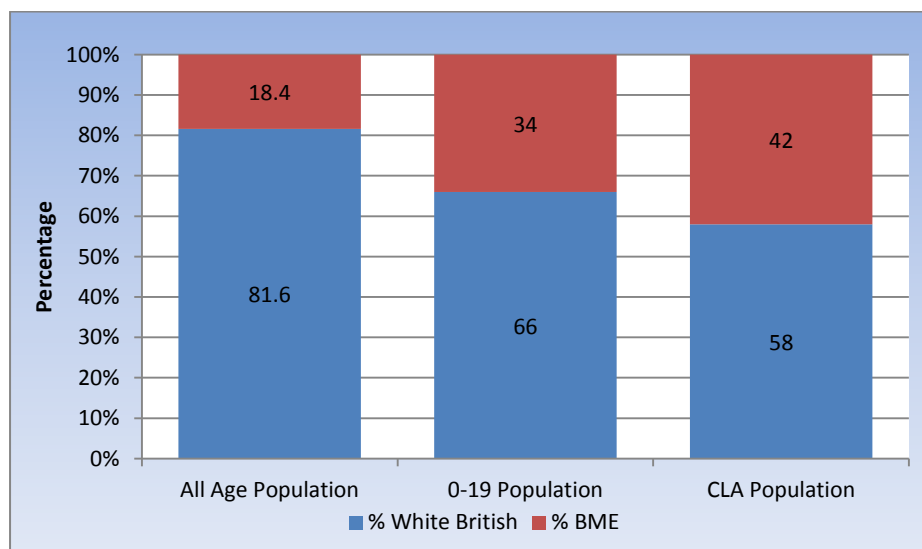
### *Ethnicity*

A variety of evidence suggests that ethnicity is a major factor influencing demand for children’s social care services. For example, Harrow Council (2017) conducted a review of its Children’s services and concluded that the two key factors driving demand within the borough were population growth (particularly increase in wards with higher levels of deprivation) and increases in the diversity of ethnic groups within the borough. Similarly, it is clear in Thurrock that children from ethnic minorities are over-represented in the LAC population (see Figure 16).

However, we need to be cautious about assuming that greater ethnic diversity in the borough means that more children are likely to have contact with social care. Table 4, for example, illustrates that the relationship between ethnicity and social care activity is patterned by deprivation in a complex way. Further research is needed in this field to disentangle the effects of deprivation and ethnicity with any certainty.

If we were to assume that children from ethnic minorities are more likely to be known to social care, it might offer some explanation for rising social care activity in Thurrock. Data from the school census shows that the proportion of children from ethnic minority backgrounds in Thurrock is rising steadily at a faster rate than in England or Thurrock’s statistical neighbours. Similarly, future demand may be affected by how the ethnic make-up of the population changes in future though it is hard to be sure what effect (if any) this might have.

Figure 16. Ethnicity of Thurrock’s all-age, 0 – 19 and LAC populations



Sources: Census 2011, School Census 2017 and Thurrock Council



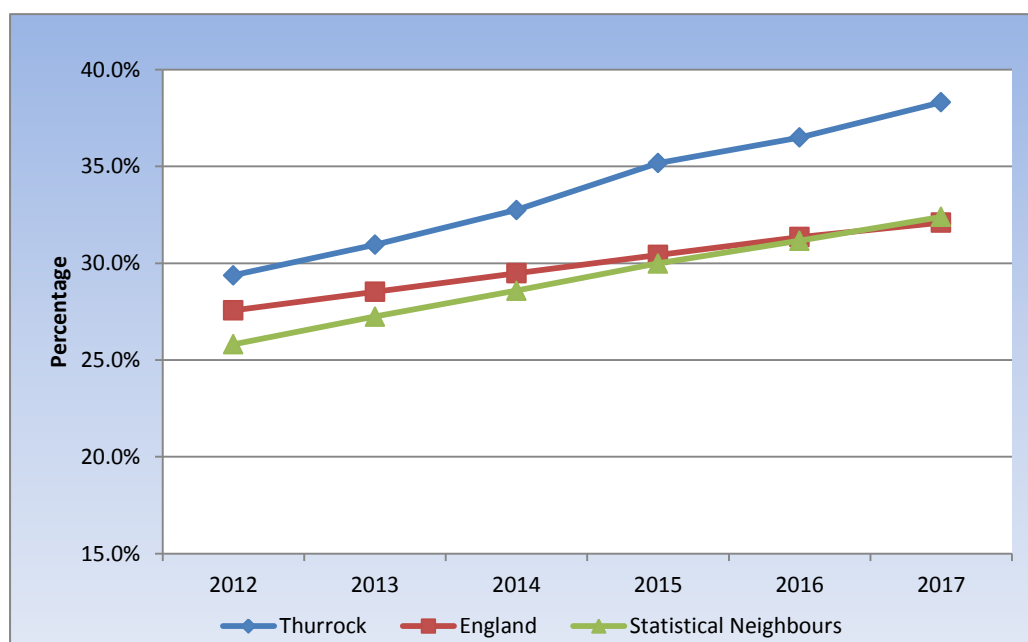
Table 4. Looked after children rates per 10,000 children by deprivation quintile and ethnic category, England sample

Deprivation quintile*	1	2	3	4	5	All
White	15	28	42	77	162	64
Mixed	27	47	62	103	164	99
Asian	7	18	15	21	34	22
Black	12	97	62	96	92	87
Other	46	90	52	41	111	74

Source: (Bywaters, Jones, & Sparks, 2017)

\* 1= least deprived, 5 = most deprived

Figure 17. Proportion of primary school pupils from minority ethnic groups in Thurrock, England and statistical neighbours (2012 - 2017)



Sources: Department for Education School Census returns, 2012-2017

### Special needs

There is a long-term downward trend in infant and child mortality rates in this country. Whilst this is extremely positive, one consequence is that the number of children with complex needs is growing as more children with severe health problems survive into later childhood. One recent report (Pinney, 2017) estimated that there has been an increase in the number of disabled children and young people of over 50% since 2004 (49,300 to 73,000). A small proportion of these children will become looked after because their disability is so severe that they cannot be cared for at home. At local authority level the number of such children is always likely to be small, meaning that the impact on the overall rate of LAC is modest. However, children with special needs may require highly specialised care, provided in high-cost placements meaning that a small change in the number of cases can have significant financial implications. Further analysis is required on this topic to understand the long-term trends, as well as the service and financial implications, locally.

### Summary of the impact of demand factors on social care activity in Thurrock

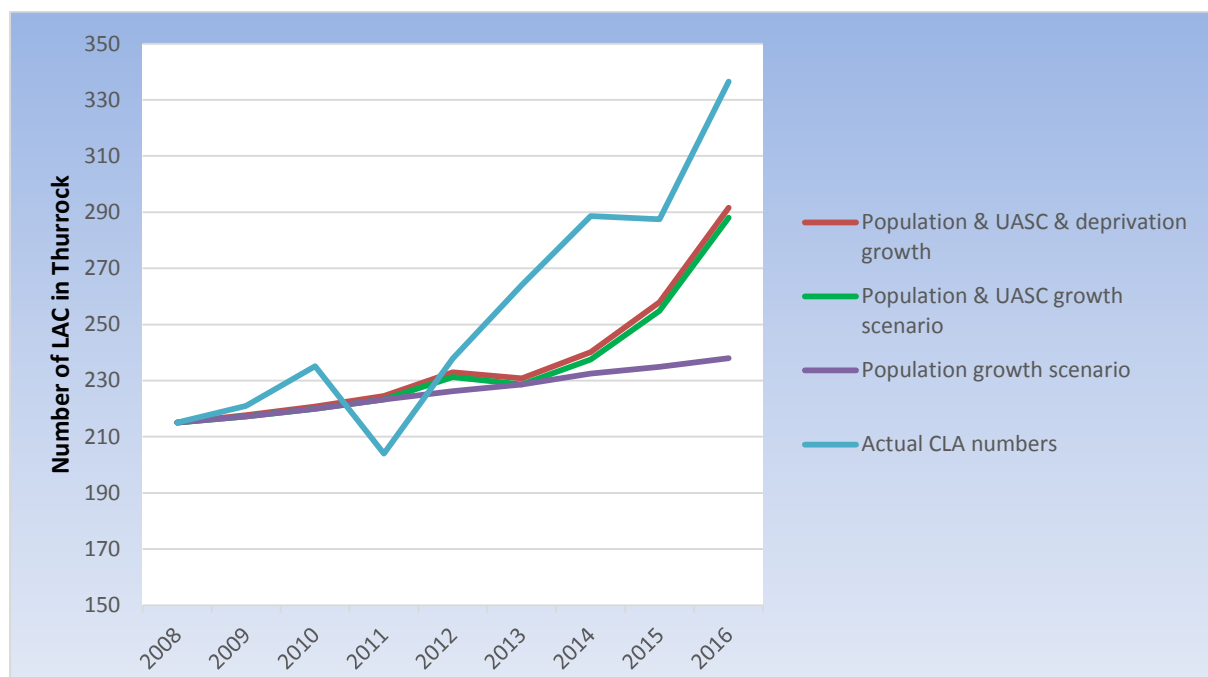
In trying to explain the growth in activity in children's social care in recent years, it is clear that a number of demand factors need to be considered. The most significant of these are population growth and Unaccompanied Asylum Seeking Children. A modest rise in the number of children living

in deprivation may also have contributed. More work is needed to understand the impact of a growing number of children with special educational needs and disabilities in Thurrock, though it is clear that this is likely to be a long-term cost pressure which drives up the complexity of care provided. The impact of increasing ethnic diversity is less clear. Further research is required to understand whether this is likely to increase demand.

In order to understand the potential impact of these demand-side factors on the numbers of LAC in Thurrock in recent years, we carried out modelling of various scenarios. The results are shown in Figure 18. This shows the actual number of LAC compared what might have been expected given known changes in demand factors. The impact of population growth on the expected number of LAC is illustrated by the purple line below<sup>1</sup>. This suggests that a modest proportion of the rise in LAC numbers is likely to have been due to population growth.

The green line ('population & UASC growth') shows the number of Looked After Children that can be accounted for by population growth and UASC. The red line ('population & UASC & deprivation') additionally adds an estimate of the impact of increased levels of child poverty (see Appendix 1 for more details). Together these suggest that a significant proportion of the increase in numbers seen since 2008 can be attributed to these three factors: population growth, UASC, and increased deprivation. However, this leaves a significant amount of the growth unaccounted for. It is possible that unmeasured demand factors (such as ethnic diversity and SEND) contributed but it is also highly likely that supply-side factors have played a part in increasing the number of Looked After Children in Thurrock. Therefore, it seems likely not only that more children are in need of social care intervention than before but that the social care system has become more likely to intervene. The possible supply-side factors involved are discussed below.

Figure 18. Actual number of LAC in Thurrock vs modelled scenarios for different demand factors, 2008 – 2016



Sources: ONS (population data), Local Authority Information Tool (LAC and UASC numbers)

<sup>1</sup> The population growth model shows what the number of LAC been if the rate of LAC had stayed constant since 2008 and the population had grown in line with ONS mid-year estimates.

### **1.2.2. Supply factors**

Our review of evidence found that the two main forces at work on the supply side are likely to be: changes in national policy frameworks and risk tolerance amongst staff; and reductions in key preventative services.

#### *Policy change and risk tolerance*

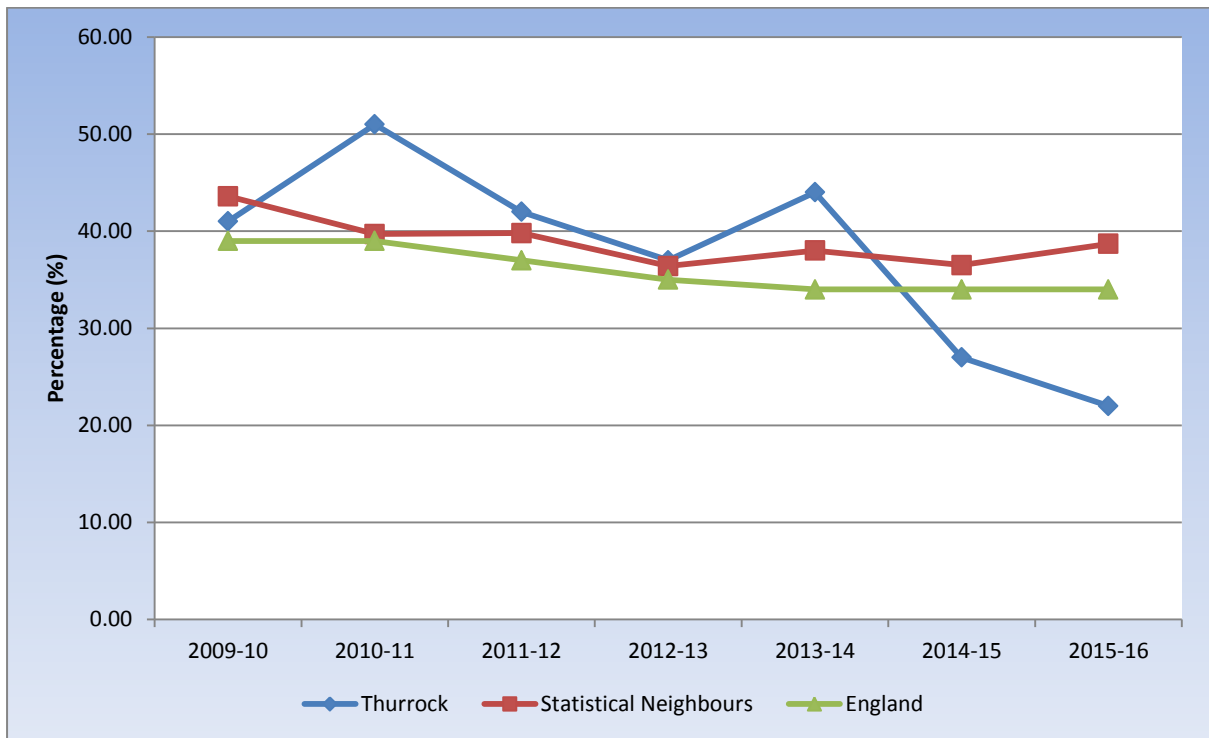
Nationally, new legislation, guidance and regulation have placed additional responsibilities on local authorities in recent years. Policy decisions of this kind are often informed by high profile, national events such as Serious Case Reviews or public inquiries. The widely-reported case of Baby Peter Connelly and the subsequent Munro Report on Child Protection (2011) are examples of how national policy responds to high profile events. Whilst it is hard to quantify the impact of such changes over the years, it is generally believed there has been a decline in risk tolerance in children's social care systems (Bywaters P. , et al., 2017) and that this has had an effect on the amount of activity in the national social care system. More specifically, the iMPower review of Thurrock's social care system commented on the existence of 'risk averse' culture in the Council and beyond, in the partners who refer into the social care system.

#### *Preventative services*

As noted above, investment in preventative services has been significantly reduced in recent years both nationally and in Thurrock. The most significant cut to preventative services occurred in 2015 after removal of £450,000 of CCG funding of early help services. This resulted in the decommissioning of services such as the Family Intervention Programme (FIP) and a tier 1 substance misuse service provided by Open Door. Quantifying the impact of such services is difficult but it is reasonable to assume that removing these preventative services (whilst at the same time spending more money on LAC) may have resulted in more children ending up being looked after, and that this might have been prevented if their families had been given more support at an early stage.

Even once children become looked after it is sometimes possible for them to return to their own families once significant issues have been resolved. There is evidence that this outcome is not as common as it used to be in Thurrock. Figure 19 shows a dramatic decline in the proportion of LAC returning to their families in Thurrock in recent years from a high of over 50% in 2010/11 to just 22% in 2015/16. More recent data were not available at the time of writing so further work is needed to understand if this trend has continued. The reasons for this decline also need to be investigated further. It is clear, however, that this trend could have had a significant impact on the number of children who remain looked after by the local authority.

Figure 19. Percentage of children returning home after a period of being looked after for Thurrock, England and statistical neighbours 2009/10 – 2015/16



### 1.3. How many children are likely to be in the social care system in future?

Forecasting future numbers is a challenging task. A survey of local authorities carried out by the Department for Education (Department for Education, 2016) found that most councils make limited use of forecasting methods or rely on simple extrapolations from previous budgets. However, attempting to understand future activity is crucial both for financial planning and for evaluating the impact of efforts to manage demand. For example, against a background of rapidly rising demand, it may be that modest growth is a sign that demand management efforts are having some effect.

For this report we have developed a new methodology for forecasting future activity. Technical details of the modelling methodology are given in Appendix 1. In summary, the models allow us to take into account not only historical trends but future factors such as population growth or changes to the cost of care. Inevitably, forecasting the future involves a significant degree of uncertainty. None of the forecasts presented below, therefore, should be considered definitive. Rather, the alternative scenarios represent a best estimate of what activity is likely to be in future if a given set of assumptions holds true.

#### 1.3.1. The Thurrock Public Health Team Forecasting Model

A diagram representing the model used to forecast future demand and spend is shown below in Figure 20. The model forecasts activity and spend on Looked After Children only. Other elements of social care are not, at present included. However, given that it is estimated that around 70% of children's social care spending each year is directly or indirectly related to Looked after Children, modelling cost and activity in this area is particularly important.

The model presented here is designed to demonstrate the possible effects of changes in key factors which influence activity and cost. For example, as discussed above, one of the main drivers of increasing activity and cost in future will be population growth. Other factors include, the rate of children in care and the how long they stay in care, once they become looked after. Costs factors include the costs of placements (cost per week) and the staffing costs needed to work with the Looked After Children population.

## Limitations of the forecasts

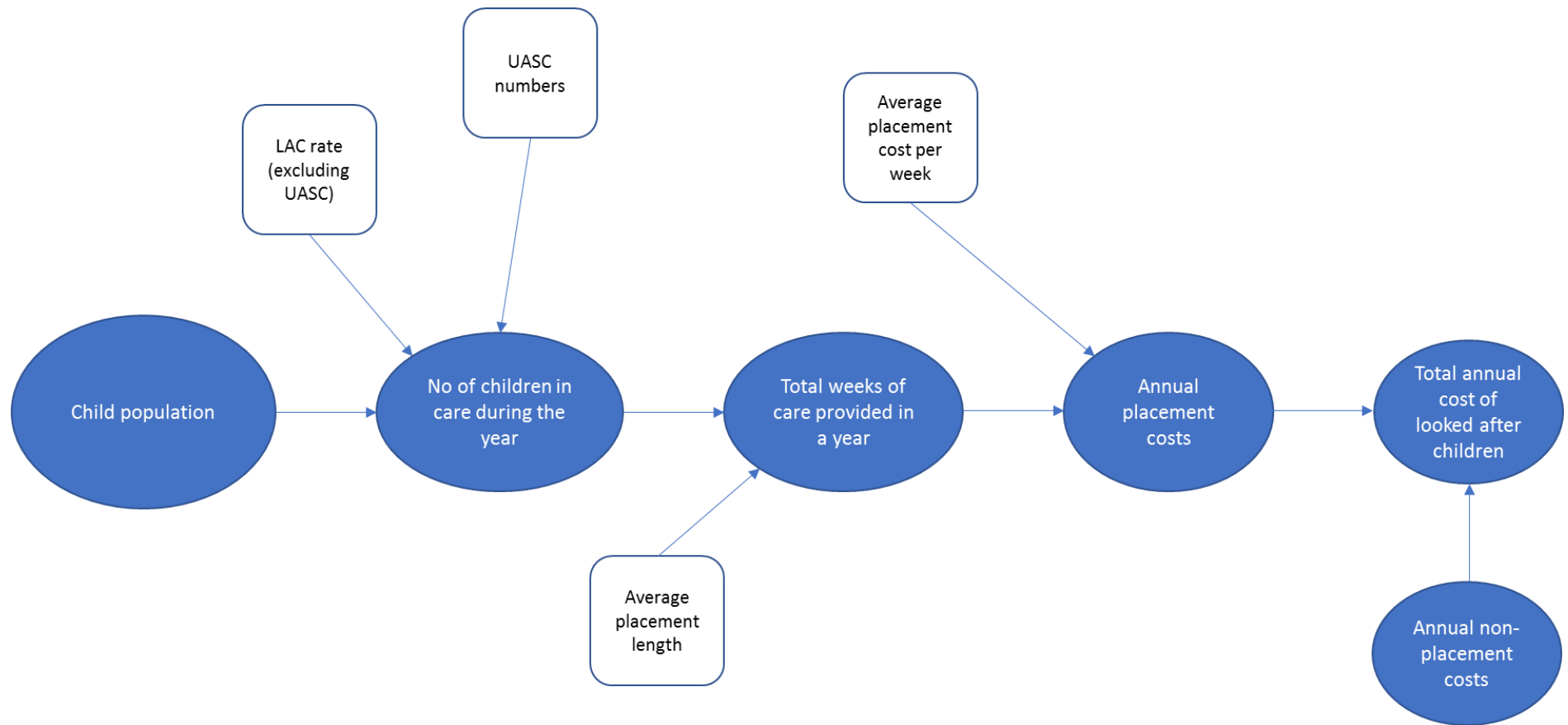
This model should be seen as a starting point, which illustrates possible future scenarios. A number of limitations should be kept in mind when examining its results:

First, the outputs from any model are only as accurate as the assumptions which are used to construct it. This model is no different. The assumptions underlying the models are set out in an appendix so that readers can examine them critically.

Second, modelling dynamic systems such as children's social care involves a huge amount of complexity. The model here is greatly simplified. For example, placement costs have been modelled as a single, average figure although the real cost of placements varies hugely. This means that the model cannot, at present, take into account possible changes in the complexity of placement needs.

Thirdly, some of the data underlying this model are incomplete. In particular gaining an accurate picture of the number of weeks of care provided by the Council at present (and historically) has been very challenging as has getting accurate figures on the costs of placements across all budgets. In places where data are limited, estimates have been made based on the best available information.

Figure 20. Thurrock children's social care demand and cost forecasting model 2017



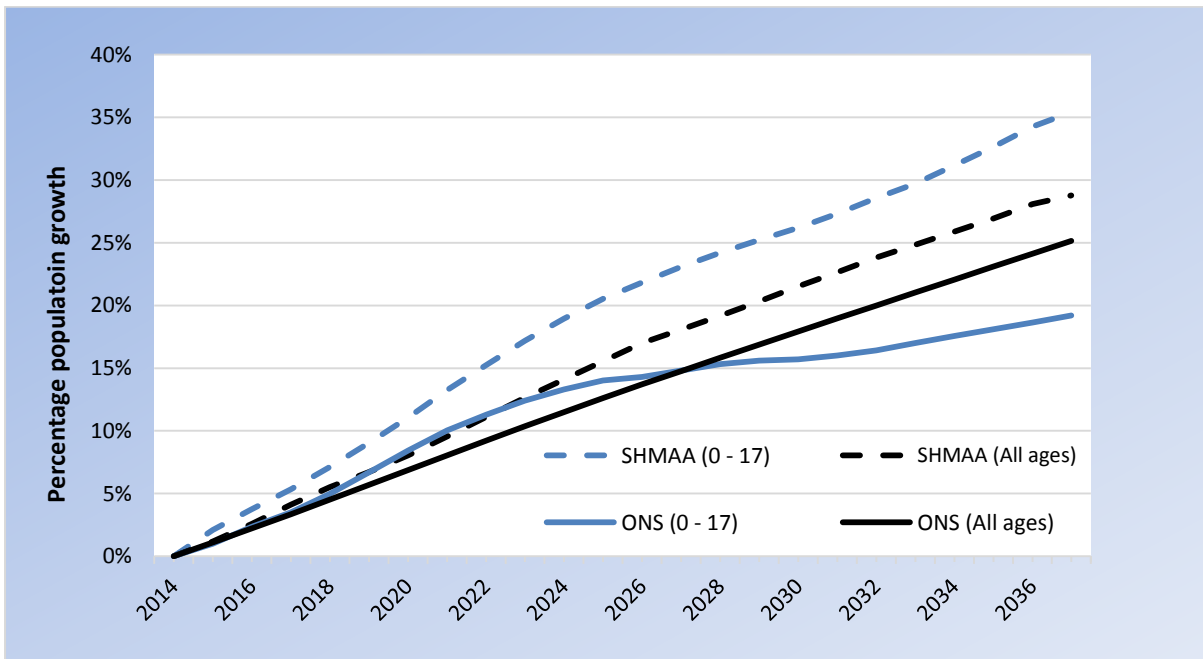
### 1.3.2. The impact of population growth

We have seen that Thurrock’s child population has grown at more than twice the national average rate over the past ten years. Forecasts for the future suggest that this rapid pace of growth is likely to continue. Figure 21 below shows projected population growth in Thurrock over the next 20 years. National estimates from the Office for National Statistics (ONS) are shown alongside local projections created for Thurrock as part of the Strategic Housing Market Assessment (SHMA). The SHMA projections take into account the high levels of job and housing growth expected to take place in Thurrock in the coming years and provide a more accurate forecast.

From the baseline year of 2014, SHMA projections suggest that the child population (0 – 17) will grow by 19 % by 2024 and 35.4% by 2037. By comparison, the child population of England is projected to grow by just 13.3% by 2024 and 19.2% by 2037 (Office for National Statistics, 2014); around half the rate of growth expected in Thurrock over the next 20 years.

*...it seems inevitable that the rapid pace of growth of the child population expected in Thurrock... will continue to put significant pressures on the social care system over the next 10 – 20 years.*

Figure 21. Projected population growth in Thurrock 2014 – 2037



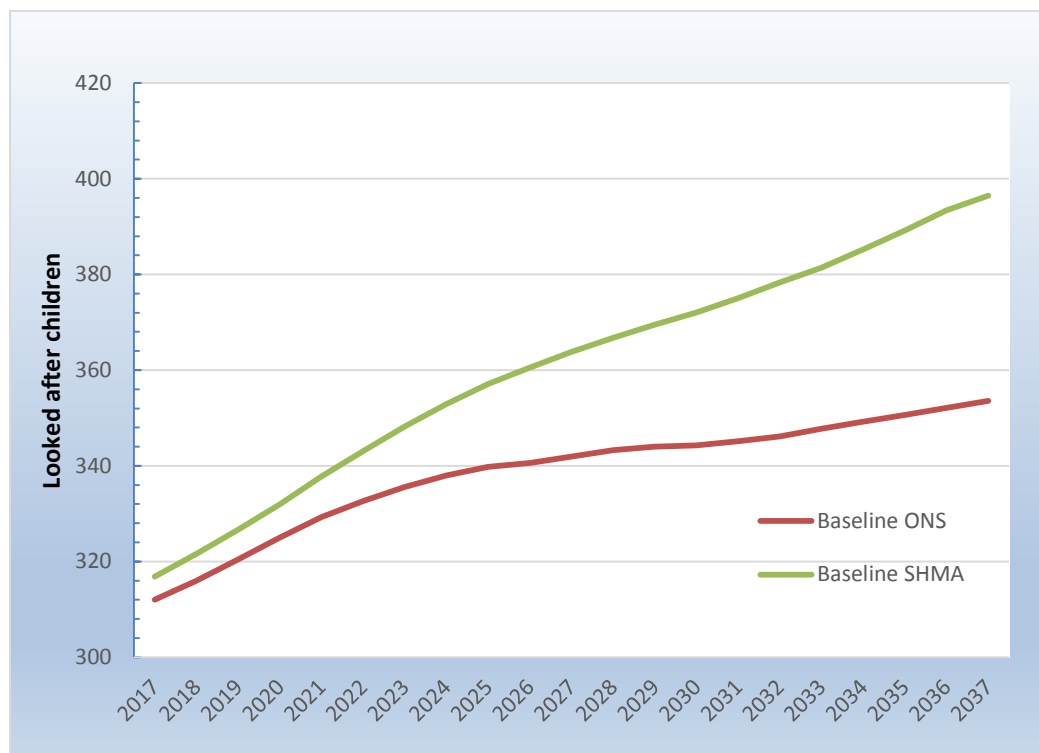
Source: Office for National Statistics (ONS) and Strategic Housing Market Assessment (SHMA)

It seems inevitable that this rapid pace of growth of the child population expected in Thurrock (around twice the national rate) will continue to put significant pressures on the social care system over the next 10 – 20 years. Moreover, this pressure will be much greater for Thurrock than is experienced nationally or in most other comparable areas since population growth is being driven by rapid economic and housing development.

All other things being equal, this rapid population growth will have a significant impact on the numbers of children in the social care system and the cost of providing social care services. Figure 22 and Figure 23 below show the potential impact of population growth on the numbers of Looked After Children in Thurrock and the resulting cost to the Council<sup>2</sup>.

Even based on the (lower) ONS population projections, it is clear that the number of Looked After Children is likely to increase considerably in future. However, the forecasts based on SHMA population projections, suggest an even greater increase. The difference between these two forecasts can be taken as an indication of the impact of economic and housing growth in Thurrock beyond natural population growth. Based on the more realistic SHMA population projections Thurrock is likely to see 17% growth in the number of LAC and growth 15% in LAC-related costs over the next 10 years (2017 – 2027)

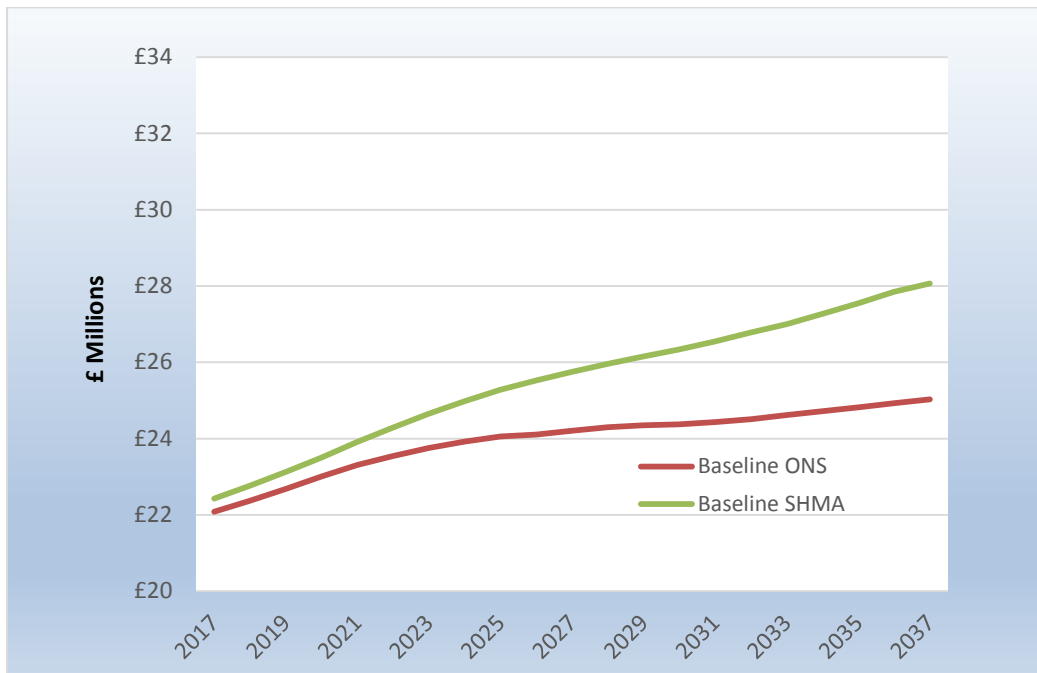
**Figure 22. Forecast impact of population growth on the number of Looked After Children in Thurrock 2017 - 2037**



<sup>2</sup> This model assumes that all other factors stay constant at the most recent available levels (August 2017). See Appendix 1 for more detail).



Figure 23. Forecast impact of population growth the cost of services for Looked After Children in Thurrock 2017 - 2037



### 1.3.3. The impact of changes in LAC rates

It is also possible to consider the possible impact of changes to the rate of Looked After Children in the Thurrock population. The factors affecting this rate are discussed above<sup>3</sup>. These models indicate what will happen if, as has happened over recent years, not only are there more children in the borough but those that live here are also more likely to end up being looked after.

Figure 24 below shows three possible scenarios illustrating the impact on the cost of LAC-related services in future. The 'Population growth only' scenario is the same as that presented in the section above on population growth. It assumes that LAC rates and costs stay the same but that the population grows in line with SHMA population projections. The other two scenarios show the impact of changes in the rate of children in care.

The 'Rising CLA' scenario assumes that LAC rates will continue to grow in line with the growth seen since 2011. The 'Falling CLA' scenario, on the other hand, assumes that over the next 5 years, LAC rates are brought in line with the current national average. Further details are given in Appendix 1.

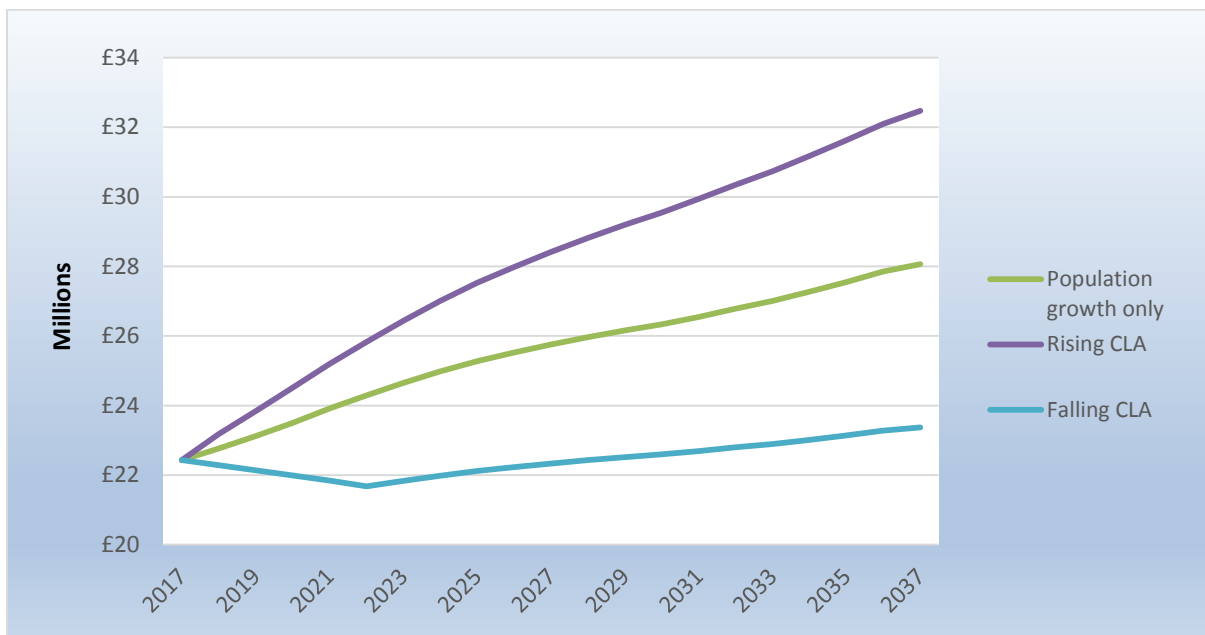
The results show that future costs are very strongly affected by the rate of children coming into care. Relatively small changes in rates can produce large changes in costs. The "Rising CLA scenario" illustrates the most likely course of future costs if trends over the past 5 – 10 years were to continue into the future. It forecasts a 27% increase in activity and cost over the next 10 years (17% due to population growth plus 10% due to increasing LAC rates). On the other hand, the Falling CLA scenario illustrates the potential gains to be made if LAC rates can be reduced to the national average<sup>4</sup>. Action is underway (detailed below in Section 2) to move Thurrock from the upper to the lower trajectory.

*The "rising CLA scenario" illustrates the most likely course of future costs unless significant action is taken to reduce the rates of children becoming looked after. It forecasts a 27% increase in activity and £6 million of extra funding required in 10 years' time.*

<sup>3</sup> Here, the impact of changes in the LAC rate combined with population growth are illustrated without making assumptions about the specific demand and supply-side factors which might affect this rate. Further development of the model in future, would allow specific assumptions to be tested about factors such as deprivation rates and ethnic diversity.

<sup>4</sup> This scenario assumes that the non-UASC rate of LAC is reduced to the current national average (56 per 10,000) over the next 5 years and then stays constant.

Figure 24. Forecast impact of changes in LAC rates and population growth on the cost of services for Looked After Children in Thurrock 2017 - 2037



Other demand-related factors, such as increasing numbers of children with special needs and changes in the ethnic make-up of the population, or deprivation rates are more difficult to quantify and have not, therefore, been included in the model at this stage. Further work could be done to incorporate the potential impact of these factors.

### Potential future costs

If current trends in LAC rates over the past 5 – 10 years continue and if population growth is as expected, the cost of Looked After Children is expected to rise by £4M pounds over the next 5 years. By contrast, a reduction in CLA rates could see costs being reduced by £0.6M

#### Projected changes in LAC costs over the next 10 years

Scenario	3 years	5 years	10 years
<i>Rising CLA</i>	£2.08M	£4.01M	£5.98M
<i>Population growth only</i>	£1.07M	£2.22M	£3.32M
<i>Falling CLA</i>	-£0.44M	-£0.59M	£0.94M

## 2. How can we reduce the number of children in the social care system?

It is clear, then, that the number of children in the social care system is rising in Thurrock, faster than in other areas. Some of the reasons for this have been explored. It is also clear that the numbers in the system are likely to continue to grow in future unless significant action is taken. But what kind of action can be taken to prevent children from having to enter the social care system? This chapter attempts to answer that question.

First, we review the recommendations provided by iMPower following their analysis of Thurrock child social care system last year. Then, we present the results of an in-depth review of the research evidence in order to understand what works in prevention. In preparing this, the authors also met with key service leads across the social care system to understand how existing services operate and gather views on how services could be strengthened. The full results of the literature review are given in Appendix 2.

### 2.1. iMPower recommendations

The consultancy iMPower was commissioned by Thurrock Council in 2016 to identify opportunities to manage demand and cost in children's social services. Their review highlighted five main opportunities to influence demand and cost in Thurrock:

- 1. Ensuring the right demand is entering the system by working with partners**  
This related to their finding that partner organisations such as schools and the police were making large numbers of enquiries and referrals into the Council when, in many cases, no action was required by social workers. Inappropriate referrals were taking up a lot of staff time.
- 2. Develop the prevention and early intervention offer**  
An audit of Looked After Children cases found that in 49% of cases it might have been possible to prevent those children ending up in care if the right early support services were put in place. This highlighted the need for a more effective set of early intervention services.
- 3. Enable more active interventions to enable step down of care**  
It was recommended that social workers' time should be freed up from carrying out large numbers of assessments, and allowing them to spend more time working with families to resolve their problems.
- 4. Reduce the proportion of agency staff;**
- 5. Increase the ratio of in-house foster care provision to reduce placement costs.**

The first three of these recommendations concern reducing the amount of activity in the system, whilst the last two are measures to reduce the cost of providing services.

### 2.2. Recent Developments

Following the review carried out by iMPower a number of developments have taken place in the service to improve sustainability. These include:

**A new Prevention and Support Service:** the new, integrated service brings together a number of previous prevention services including the Early Offer of Help and Troubled Families. This has also been integrated into Brighter Futures (see below).

**Brighter Futures** has been established to integrate Thurrock's early years and preventative services. The PASS service is part of Brighter Futures, which also includes Children Centres and the Healthy Families service (school nursing and health visiting). Efforts to create a more joined-up offer to children and families, with health, education and social care professionals working together, are designed to prevent issues from escalating to the level where social worker intervention is required.

**Reductions in agency staffing** have been pursued. Agency numbers now appear to be in steady decline. Efforts have also been made to recruit more foster carers from the local population, although the availability of in-house foster carers (and, indeed, any foster care placements) continues to be a significant challenge in Thurrock and nationally (see section 1, p14).

**Targeting social work.** A data system called Xantura has been commissioned to provide 'predictive analytics'. The system uses data from a variety of sources to flag up children at high risk, allowing social workers to intervene earlier and more effectively.

**Signs of Safety.** This is a strengths-based approach to child protection work which is being rolled out in Thurrock to improve case work and risk assessment.

### 2.3. What works in early help?

Early help describes interventions with children and families who are not at the stage of having statutory social worker intervention (CiN/CP or LAC). They are, by definition, preventative services designed to address problems at an early stage and prevent them from escalating. They are, therefore, critical to reducing the number of Looked After Children. Our review of evidence found a number of interventions which have been shown to work in this field.

#### 2.2.1. Home Visiting

Home visiting programmes at the ante-natal and early post-natal stage can be effective in facilitating the development of a sensitive and empathetic relationship between the parent and young child which may forestall attachment and other relationship difficulties. There is enough evidence of its effectiveness for it to be recommended in NICE guidance (2017) as a form of early help for families showing possible signs of abuse or neglect.

**Current provision** of home visiting is provided to all families in Thurrock through the Healthy Families service which includes graded levels of intensity according to need. For those assessed as having greater needs, the service provides more intensive visiting from health visitors and a multi-agency response where appropriate, which may include social workers. Family Nurse Partnership, which used to be provided in Thurrock, is no longer commissioned as it was judged not to be cost effective in line with the results of UK trials (Barlow, Davis, McIntosh, Jarrett, & Mockford, 2007) (Robling, et al., 2015). To fill this gap, the newly commissioned Healthy Families Service provides an offer to young parents and more vulnerable families with more intensive support to replace this service.

### 2.2.2. Parenting Programmes

Parenting programmes aim to improve parenting skills and produce better outcomes for children. There is moderate to strong evidence that these can be effective in improving outcomes such as positive parenting behaviours, reduced behavioural problems in children and reducing risks of abuse and neglect. However, reviews of the evidence base also suggest that parenting interventions may be ineffective or insufficient in cases of high need and families with complex, multi-layered problems (Barlow, Johnston, Kendrick, Polnay, & Stewart-Brown, 2006).

**Current provision** includes three commissioned parenting programmes. Full details of the programmes and the evidence underpinning them can be found in Appendix 2. In summary:

- *Strengthening Families Strengthening Communities (SFSC)* is a 12-week group parenting course that covers all aspects of effective parenting, boundary setting, praise and warmth, and working with children's emotions. It uses peer support and includes additional support for the family in their home. In 2016/17, 252 families were referred into this programme but only 128 were able to go through the programme due to capacity constraints. This means some families were waiting for weeks or months before getting a place on the programme.
- *Mellow Mums* is an attachment and relationship based group intervention for mums who have babies and young children. In 2016/17, 21 mothers were referred into this programme and 18 went through the programme, with 10 on a waiting list. This suggests again that capacity is not sufficient to meet the current level of need.
- *Triple P* is a 13-week programme for parents with teenage children showing problematic behaviour. It seeks to avoid those behaviour patterns escalating further by giving parents practical strategies to help them build strong, healthy relationships, and to enable them confidently to manage their children's behaviour. No referrals were made into this programme in the past year. Therefore, although the provider is able to offer this service, it has not been utilised. As the evidence base underpinning this programme is relatively strong (See Appendix 2) the reasons for the lack of uptake of this programme need to be investigated.

### 2.2.3. Troubled Families<sup>5</sup>

This is a national programme which comes with its own funding from central government based on performance. It is intended to change repeating inter-generational patterns of poor parenting, abuse, violence, drug use, anti-social behaviour and crime in the most troubled families in the UK. Troubled families are defined as those that have problems and cause problems to the community around them, putting high costs on the public sector. Specific aims of the programme are to:

- get children back into school;
- reduce youth crime and anti-social behaviour;
- put adults on a path back to work;
- reduce the high costs these families place on the public sector each.

The Thurrock Troubled Families programme has a target to work with 1,240 families over a five-year period (2015 – 2020) and this year is due to work with 370 families. The programme was judged to be good during Ofsted inspection. Nationally, the effectiveness of this way of working is, however,

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<sup>5</sup> Some, though not all, families in the programme have children who are in the CiN/CP category meaning that this programme provides both Early Help and CP/CiN intervention.

highly politically controversial with some evaluations suggesting that it has little impact. Funding for Troubled Families is due to be withdrawn from 2020.

#### **2.2.4. Recommendations on Early Help<sup>6</sup>**

There is moderate to strong evidence that the current early help offer of home visiting and parenting support is effective in preventing children from entering the social care system or preventing their situations from escalating. It is clear that the capacity of these programmes is not sufficient to meet demand and many families have to wait for long periods before getting a place on the programme. It is recommended that capacity should be increased in line with current demand and then kept under review. Meeting current demand would require a 90% increase in capacity.

However, demand for these services depends on the awareness and confidence of the professionals who refer into these programmes. It is possible that more families could benefit from these programmes if they were referred into them. In particular, the lack of uptake of the Triple-P parenting programme needs to be investigated as this is a commissioned and evidence-based programme which is effective in preventing the escalation of behavioural problems in teenagers. It is also recommended that a review of referral practice should consider whether there are families with children on CiN/CP Plans or the families of Looked After Children who could benefit from these programmes. If more families could benefit it may be necessary to expand capacity of these programmes accordingly. Ultimately, these services will reduce pressure on the most high-cost parts of the social care system.

The evidence base underpinning Troubled Families is weaker. This programme is funded by central government, on a pay for performance basis. It is recommended that the methods used to achieve Troubled Families outcomes should be reviewed to consider whether the evidence-base presented above could be put into action to achieve Troubled Families outcomes. It is also important to note that there is a very significant financial risk for the Council related to Troubled Families funding may end in its current form from 2020. It is unclear at present whether it will be replaced with an alternative/similar funding stream.

There is a risk that the withdrawal of Troubled Families funding from 2020 could result in a further overall reduction in the funding for preventative services. This would continue long-term trend which has had the effect of driving up costs in the most expensive part of the system. However, if the funding is replaced in full or in part by a less restricted funding stream, it may be an opportunity to invest in interventions (at early help or CiN/CP stage) which have a stronger evidence base. It is recommended that plans be put in place to ensure that, as far as possible, changes to Troubled

*There is a risk that the withdrawal of Troubled Families funding from 2020 could result in a further reduction in the funding for preventative services. This would continue a long-term trend which has had the effect of driving up costs in the most expensive part of the system.*

<sup>6</sup> There is significant overlap between 'Early Help' services and those appropriate for those at the CiN and CPP level. This section has focussed on those interventions which are primarily focussed on the pre-statutory stage of intervention. The Prevention and Support Service provides a number of services which are targeted more at the CiN/CP stage and these are outlined below (Section 2.4).

Families funding are used as an opportunity to strengthen demand-reducing services, rather than

### Financial impact of recommendations on early offer of help

Increasing the capacity of parenting programmes is likely highly likely to make savings in other parts of the system by preventing cases from being escalated to CiN/CPP or LAC level. Though the amount of savings this would make is hard to estimate, the table below presents the capacity and costs of the existing programme and the recommended programme. Based on the figures below, in order to be cost neutral the expanded programme would need to prevent an additional 3.4 children from becoming looked after in order to be cost-neutral. That means that it would be cost neutral if the programme successfully prevents a child being taken into care for just 1 in 50 families accessing the programme. This makes it highly likely that the proposed expansion of parenting services would not just be cost neutral but cost saving overall.

Table 5. Estimated costs and savings for recommended action on edge-of-care

	Current service	Recommended service	Difference
<b>Capacity</b>	148	283	135
<b>Cost</b>	£260,000	£497,162	£237,162

allowing them to be weakened.

## 2.4. What works for Child in Need and Child Protection Plans?

In cases which progress beyond the Early Help stage, children may be put into the statutory categories of Child in Need (CiN) or (for higher risk cases) be put on a Child Protection Plan (CPP). For children, short-term care is provided by five Family Support Teams, who work with children under 12, and 1 Adolescent team. The principal aim of intervention at this stage is to prevent the children becoming looked after and, ideally, allow the matter to be stepped down.

There are a large number of possible interventions which can be put in place at this stage and it is important that they are tailored to suit the needs and issues of the children and families involved in each case. The summary presented below is organised by issues which can cause children to be designated as CiN or on a CPP. These include: domestic violence/abuse, substance misuse, and multiple issue interventions or 'edge of care' services. However, it is important to note that families often present with multiple issues and need holistic support which is adapted to their individual situations. For example, the Ofsted's report *Learning lessons from serious case reviews 2009–2010* (2010) which looked at the evaluations of 147 Serious Case Reviews where abuse or neglect were factors, found that domestic violence was present in 31% of cases, mental ill health in 23%, parental drug misuse in 19% and parental alcohol misuse in 14% of cases.

### 2.3.1. Domestic violence/abuse

Children can suffer serious long term problems as a result of domestic abuse even if they themselves have not been directly harmed or abused. According to NICE guidance, support should be provided



for both the non-abusing parent and child (NICE, 2014). In Thurrock, there is also provision of a service for perpetrators of domestic violence.

There is moderate evidence to support programmes which support non-abusing parents including: advocacy, skill building, counselling, and group therapy. For interventions to support children, the evidence is strongest for those programmes which include mothers and children, rather than children on their own. These include: mother-child psychotherapy, shelter-based parenting interventions; and parent-child interaction therapy.

**Current provision** of services related to domestic abuse includes two programmes:

- **STEPS (Success Through Effective Parenting Support):** aims to decrease the impact of domestic abuse on parenting. This is an eight-week programme of therapeutic and practical one-to-one support. Following the course, 96% reported feeling safer, and 92% of women reported having a better understanding the impact of abuse and violence on their children. The programme received 135 referrals in 2016/17 and there were significant waiting times (3 – 4 weeks) to get on the programme. The current service appears not to have capacity to meet all demand in a timely way. It is estimated that increasing capacity by 50 – 80% would be necessary to meet the current level of demand.
- **Domestic Violence Perpetrators Programme:** This is an intensive 26-week programme commissioned for just 10 men each year. It aims to change the behaviour of men who have been abusive towards their families. It is targeted at those cases which represented the highest risk to children, usually where children are on a CPP or are CiN. There is moderate evidence showing that this is effective in reducing abusive behaviour in future (Dobash, Dobash, Cavanagh, & Lewis, 1999) and local outcome data shows that 93% of partners report a cessation of abuse after completion of the programme. During interviews with service leads it was highlighted that the current number of places on this programme is not sufficient to meet demand and that many more people would benefit from this. There were 18 referrals to the service in 2016/17. This is beyond the capacity of the current service but it is also possible that social workers are not referring into the service because capacity is known to be an issue. The numbers who would actually benefit from the service are currently unknown.

**Recommendation:** Whilst this has not been identified as a major gap in existing services, there does appear to be scope to strengthen existing services based on the evidence available and it is recommended that an expansion of the capacity of the existing perpetrators scheme should be considered.

### Financial impact of recommendations on domestic violence services

The cost of domestic violence to children's social services has been estimated taking into account the fact that domestic violence has been found to be present in 40% of cases of child abuse (Walby, 2004). On this basis, it has been estimated that each incident of domestic violence costs, on average, £1,183 to social care (including the costs of social worker time and, in some cases, children becoming looked after), and a further £7,230 to the healthcare system. We estimate that implementing these recommendations would result in 163 incidents of domestic violence being prevented and associated cost savings (after the costs of the programme) of £125,926. In addition to the savings which would accrue to social care, a further £1.2M of savings are estimated for the healthcare system.

Table 6. Costs and savings for recommended action on domestic violence services

Programme	Current capacity	Recomm -ended capacity	Incidents of DV averted	Additional Cost	Estimated gross savings to social care	Net savings to social care
STEPS	75	135	144	£37,080	£170,300	£133,220
DV perpetrators	10	20	19	£30,000	£22,707	-£7,293
<b>Total</b>	<b>85</b>	<b>155</b>	<b>163</b>	<b>£67,080</b>	<b>£193,006</b>	<b>£125,926</b>

Sources: Walby (2009) Costs of domestic violence<sup>1</sup> and Dobash (1999)

### 2.3.2. Substance misuse

The evidence review found one programme, Parents Under Pressure (PUP), which addresses substance misuse as a component of children maltreatment. The programme addresses multiple domains of family functioning including parental psychopathology, child behavioural problems and parent-child relationships. A small trial of this programme in Australia found it to be effective in improving parenting, parent-child relationships and child behaviours in the families of parents who were on methadone treatment. An evaluation of the effectiveness and cost-effectiveness of this programme is currently underway in the UK.

Previous service: Previously, a tier-1 (advice and support) substance misuse service was commissioned as part of the Early Offer of Help. This was decommissioned in 2015 following funding reductions. Service leads have identified tier 1 substance misuse support as a gap in existing services.

**Recommendation:** Further work is needed to determine the size, scope and cost of a potential new substance misuse intervention focussed on families where children are at risk of (or already in) the social care system. The public health team should work with social care to consider whether existing child/adult DAAT services could be adapted in line with the evidence base to provide interventions specifically targeted at children at the CiN/ CPP stage.

### 2.3.3. Edge-of care services and multiple-issue interventions

Service leads consistently identified the lack of an 'edge-of-care' service as a major gap in existing provision in Thurrock. An edge-of-care service provides intensive support for families where there is a high risk of the child becoming looked after. In most cases, it is appropriate for such a service to address a range of issues simultaneously. Two reviews of the evidence for edge of care services (Bowyer & Wilkinson, 2013) (Asmussen, Doolan, & Scott, 2012) both identified Multi-Systemic Therapy (MST) and Functional Family Therapy (FFT) as having the strongest evidence base as effective edge-of-care interventions:

- **Multi-systemic therapy (MST)** is a family and community-based treatment programme originally designed for young offenders or young people aged 11-17 at risk of care who were demonstrating anti-social behaviours. The intervention has also been adapted specifically for families where there is child abuse and/or neglect (MST-CAN). Trials from the US have demonstrated that this can be effective in reducing the number of children taken into care by more than half from 30% to 14%. MST-CAN is now being piloted in several sites in the UK. Though no UK evaluations have yet been published, MST has been recommended in recently published NICE guidance on Child Abuse and Neglect (2017).
- **Functional Family Therapy (FFT)** is an intensive family-focused intervention targeted at young people aged 10 – 18 years who are still living at home but have persistent behavioural problems and/or substance misuse. Weekly sessions over a 3-4 month period aim to reduce disruptive communication patterns and encourage positive interactions among the family. Trials from the US have demonstrated that it can be effective in reducing violent crime by 30% and reoffending rates by 21% (Sexton & Turner, 2011). The impact on reducing care proceedings in the UK has yet to be determined. An FFT pilot started in Brighton in 2007 and the first UK randomised controlled trial is currently being conducted by Kings College in partnership with Brighton and Hove Youth Offending Services (Dixon, Lee, Ellison, & Hicks, 2015). Currently, two randomised controlled trials are underway in the UK in Brighton & Hove and Croydon.

Other interventions with an emerging evidence base are:

- **Step Change** combines elements of MST with FFT (Blower, et al., 2017). It was piloted across three London boroughs. Evaluation of Step Change found some improvement in follow-up measures such as offending and engagement in education though the numbers involved were too small for reliable analysis.
- **Short stay residential care for adolescents on the edge of care**  
The UK has traditionally operated a binary model of care: at home or out of home. In other, particularly European countries, short-stay residential care (also known as respite care) is a more established part of children's social care systems. In some cases it can prevent full entry into care by offering respite and space to improve young people's relationships with their families. A number of local authorities in the UK are trialling this approach though further research is needed to evaluate its effectiveness and cost-effectiveness (Dixon, Lee, Ellison, & Hicks, 2015).

**Previous service:** The Family Intervention Project (FIP) was an intensive programme for families with multiple and complex issues. Work was completed with a key worker allocated to each family, working with them for between nine and 18 months. Though no controlled trials have been

identified, both local and national evaluations of FIP services were very positive. The national programme, for example, found that serious conduct problems with children dropped by one third (from 59% to 40%).

When it operated, the service cost £300,000 per year and supported 40 families per year (a cost of £7,500) per family. The service operated a waiting list, with an average waiting time of 30 days, indicating that there was more demand than the service could comfortably accommodate. This service was decommissioned following the withdrawal of CCG funding in 2015.

### **Recommendation**

There is a clear gap in existing services in providing support to families where there is a known risk of children being taken into care. Such services will have a direct impact on the number of children becoming looked after. It is recommended that a service be designed and implemented for Thurrock based on the evidence summarised above (see also Appendix 2). The evidence base for preventing children being taken into care appears to be strongest for MST and FFT so it is recommended one of these should form the basis of an edge-of-care service. In order to prevent children being taken into care it is important that an edge of care service is able to respond quickly. Delays caused by waiting lists or assessment are likely to significantly reduce its effectiveness and cost-effectiveness.

Given the emerging nature of the evidence base in this field (particularly in the UK context) it is strongly recommended that a robust evaluation plan be developed (by children's social care in collaboration with public health) to ensure that the effectiveness and the cost-effectiveness of any new service can be demonstrated and that opportunities to learn from this are captured as fully as possible.

### Financial impact of recommendations on an edge-of-care service

Implementing an MST-based edge-of-care service is likely to make savings through reducing the number of children being taken into care. A cost-effectiveness study of MST (Cary, Butler, Baruch, Hickey, & Byford, 2013) found that the intervention cost £2,285 per participant to implement. As of September 2017 there were 1,355 children in Thurrock classified as either CiN (1,074) or CPP (281). If 10% of them were suitable to receive the MST intervention, the total cost of the intervention would be in the region of £309,000.

Based on the estimated annual cost of a looked after child to the Council of £70,792, the service would only have to prevent an average of 4.4 children per year entering care to be cost-neutral. This would represent a 3.2% success rate for the service; that is, the service would only need to be successful in preventing 3.2% of the children it worked with from entering care each year in order to pay for itself. If we assume, in line with trials, that the intervention successfully prevents 16% of those in the programme for entering care, the net savings (see below) are estimated to be £1.2M per year, £650,000 of which would be directly cashable as reduced placement costs.

Table 7. Estimated costs and savings for recommended action on edge-of-care

No of eligible families	Cost per case	Total cost of service	Number of LAC prevented	Gross savings	Net savings	Cashable net savings
135.5	£ 2,285	£ 309,618	21.7	£ 1,534,771	£ 1,225,153	£ 649,331

## 2.5. What works for Looked After Children?

Even once children have been taken into care, it is possible to take action which will shorten their stay or prevent other children in the family becoming looked after. Our work has focused on two important ways in which this can be done and which have been identified as gaps in the current system.

First we consider 'reunification': the process of children returning to their families after a period of being in care. This was chosen as a focus because, as noted above (Figure 19, p27) there appears to have been a large and rapid decline in the proportion of children returning home to their families after a period of being looked after in Thurrock. iMPOWER also highlighted a cultural issue in Thurrock, where the journey of children through the system is seen as one-directional rather than opportunities to return children to their families being considered at every stage. Reunification work was also identified as a potential gap in existing services by some service managers and is an important way in which activity can be reduced in the most expensive part of the system.

A second issue explored in this section is preventing repeated occurrences of children being taken into care from the same family. This covers evidence relating to women who have repeated children removed from their care at birth. Again, this has been identified by service managers as a potential gap in existing services.

### 2.4.1. Reunification

Returning home is not always in the best interests of children in care (Wilkins & Farmer, 2015) (Biehal, Sinclair, & Wade, 2015) and the child's welfare should be paramount in any decision to return a looked after child to their family. Nevertheless, there is evidence that certain practices and specific interventions can increase the likelihood of safe and effective reunification taking place. This includes:

#### *Appropriate timing and thorough assessment*

Reunification is less likely to be successful after a prolonged period in care (over 2-3 years) (Thoburn, Robinson, & Anderson, 2012). However, it has also been found that reunification is less likely to be successful if the child returns after a short stay in care (less than 3-6 months), perhaps because this may not allow sufficient time for change to occur in the family. This suggests that there may be an important window period between 6 months and 2 years in which reunification is most likely to be successful.

Assessing the suitability of a child and their family for reunification is a complex process. One study (Farmer, Sturgess, O'Neill, & Wijedasa, 2012) found that more thorough assessment was associated with greater stability for children returning home. In spite of this, 43% of children in their study returned home without a thorough assessment.

#### *On-going work with parents and families of LAC*

In most cases, if reunification is to be considered a possibility, significant changes have to occur in the lives of the parents or wider families of Looked After Children (Wade, Biehal, Farrelly, & Sinclair, 2010). At present there appears to be little systematic work with families who have had children removed; this was identified as a gap in existing services by some service leads. The evidence review supports on-going work with families after children have been removed as a way of promoting reunification. In particular the evidence supports:

- *Tailored support*: Matching services to underlying needs or problems, which may include mental health, housing, family counselling or substance abuse, has consistently been shown to improve family reunification (Choi & Ryan, 2007). The consensus is that programmes are also more likely to be effective if they are intensive and tailored to meet the needs of each member of the family (Ward, Brown, & Hyde-Dryden, 2014).
- *Timing and duration*: Support needs to commence as soon as possible after children are removed from the family, and should be proactive rather than reactive (Hyde-Dryden, et al., 2015). In order for reunification to be successful, interventions need to be delivered for long enough to bring about sustained changes in behaviour and the family situation.
- *Strong caseworker engagement* with the families whilst children are in care, increases the likelihood of reunification (Cheng, 2010).
- *Substance misuse support* for parents with substance misuse issues, support may help children to return home from care more quickly (Harwin, Alrouh, M, & Tunnard, 2014).
- *Parenting support*: There is some evidence from the US that parent mentoring programmes can be effective in promoting reunification (Enano, Friesthler, Perez-Johnson, & Lovato-Hermann, 2016).
- *Child emotional and behavioural support*: addressing emotional wellbeing of Looked After Children through Child and Adolescent Mental Health Services can be helpful for Looked After Children may be helpful in preventing re-entry into care (Thoburn, Robinson, & Anderson, 2012).
- *Ongoing monitoring and support post reunification*: Statutory guidance is clear that a child should continue to be supported and will often be treated as a child in need or under a Child Protection Plan once they return home. However, evidence reviews have found that interventions tend to end abruptly with no arrangements for long-term support or monitoring of children's circumstances (Hyde-Dryden, et al., 2015). Ongoing assessment of the family's needs is necessary as the full extent of many difficulties may not become apparent until some time into the return home.

**Recommendation on reunification:** Further work is needed to understand why the rates of children returning home after a period of being looked after appear to have fallen very significantly in recent years. There appears to be a gap in current services in working intensively with families who have had children removed. It is recommended that this should be considered within the design of a new edge-of-care service which could work intensively with families not only to prevent the removal of children but immediately following removal in order to promote reunification. This has the potential to reduce the length of LAC placements and thereby reduce the number of children in care. Extending the remit of other relevant services (e.g. drug and alcohol or domestic violence services) to work with families who have had children removed from their care should also be considered.

### **Financial impact of recommendations on reunifications**

More detailed work is needed to understand trends in reunification in Thurrock in order to design a service which fits the needs in Thurrock. However, it is clear that increasing reunification could have a significant impact on costs by reducing the length of time that children remain in care.

Our analysis found that the average length of stay for children in care in Thurrock in any particular year is 35 weeks. This includes many children who stay for the full year (52 weeks) and some who stay for shorter periods. We estimate that reducing this average by just 1 week (to 34 weeks) would save £0.65M each year. Reducing the average to 32 weeks (an 8.6% reduction) would reduce costs by £1.93M per year, £1M of which would be reduced placement costs.

### **2.4.2. Repeated care proceedings**

Recent research from the University of Lancaster has shown, for the first time, how common it is for mothers to have multiple children removed at birth (Broadhurst, et al., 2015). It was found that 24% of women who have a child removed at birth go on to have a second children removed from their care. Moreover, the likelihood of this happening is greatly increased for younger mothers. For women aged 16 – 17, when their first child is removed, there is a 32% chance of this being repeated. It also found that 40% of mothers who have multiple children removed at birth had themselves experienced being in care and substance misuse is a common reason for repeated care proceedings. In these cases only around 10% of children are ever reunited with their mothers compared to around 40% for the general population of Looked After Children. It is estimated that, at any one time in Thurrock's social care system, there are 10 – 15 women who have had multiple babies removed. Though the numbers are relatively small, these are both tragic and highly resource-intensive cases.

Our literature review found that there is a lack of robust evidence about what works to prevent repeated removals of children. However, an innovative programme called PAUSE has been piloted in a number of areas with central government funding. A national evaluation of the programme (McCracken, et al., 2017) found that it appeared to be effective in preventing women from going on to have further pregnancies and further removals of children. The programme worked by providing intensive support over an 18 months period to children who have had children removed at birth. Support was given by a dedicated practitioner though multi-agency support to address issues such as domestic violence, substance misuse and insecure housing was crucial to making this work. A cost-benefit analysis also found that this work saved large sums in social care costs after the initial 18 month intervention period. For a programme delivering Pause to 125 women, net savings (i.e. taking into account the cost of delivering the intervention) after 18 months were estimated at between £1.2 and £2.1 million.



**Recommendation on preventing repeated care proceedings:** A dedicated programme along the lines of PAUSE should be established for Thurrock. Given the relatively low number of women who are likely to require such a service, consideration should be given to working with neighbouring councils to commission this across a larger geographical area. Given that the evidence on this programme is emerging and that no controlled trials have been done, a robust evaluation plan should be put in place to determine effectiveness and cost-effectiveness of the programme locally.

**Financial impact of recommendations on repeated care proceedings**

Based on a cost-benefit analysis of Pause pilot programmes (McCracken, et al., 2017), we can estimate the cost-savings which might be possible in Thurrock. The cost of implementing the intervention was estimated at £20,202 per woman supported over the 18 months intervention period. We estimate, conservatively, that 15 women per year in Thurrock might be eligible for support from the scheme. This would mean the cost over 18 months would be £303,030. For this price, we would expect 2.55 – 4.35 further pregnancies to be prevented. Taking into account the estimated local costs of care, we would expect the programme to be cost-neutral in the second year of operation and thereafter it would save between £128,520 and £307,945 per year, of which £68,116 to £163,211 would be directly cashable as reduced placement costs.

### 3. Key findings and conclusions

#### 3.1. Key findings

In this report we addressed a number of questions:

*Is the number of children in the social care system rising faster in Thurrock than elsewhere?*

Yes. The numbers have been rising steadily in recent years, particularly the number of Looked After Children. This increase has been greater than in other, similar areas. Over the past 12 – 18 months, however, LAC rates do appear to have levelled off or even started to decline. Much of this has been due to reductions in the numbers of Unaccompanied Asylum Seeking Children (UASC) though modest declines in the numbers of non-UASC looked after children have also been seen. It remains to be seen whether this is the beginning of a long-term change in the direction of trends.

*Why are the numbers increasing in Thurrock?*

Some of the increases in recent years have been due to more children being in need of support from social care (demand factors). In particular, the number of children living in Thurrock has increased and there has been a higher number of Unaccompanied Asylum Seeking Children entering the area in recent years. Over the last ten years, the child population in Thurrock has grown by 13.3% more than twice the national rate (6%) and Thurrock has had a much higher number of Unaccompanied Asylum Seeking Children entering the system than other comparable areas. At its peak in 2016, 21% of Thurrock LAC population was made up of UASC compared to a national rate of 6%.

It also seems likely, however, that the social care system has become more likely to intervene (supply-side factors). Some of this may be due to changes in national policy and guidance. However, the decline of investment in preventative services is also likely to have played a part; some children end up being taken into care when early and effective intervention might have prevented it. This is tragic for the children and their families involved and results in large, avoidable costs for the Local Authority.

*How many children are likely to be in the social care system in future and how much will this cost?*

There are huge potential costs if the trends of recent years were to continue unchecked. Based on local population projections and assuming that the trends of the past 5 – 10 continue, we estimate that the number of Looked After Children in Thurrock is likely to rise by around 27% to ~400, over the next ten years. That equates to extra costs of £4M per year in five years' time and nearly £6M per year in ten years' time.

Unless radical action is taken to upgrade demand-reducing services, the cost of children's social care could become increasingly unsustainable. Work is already underway to make this change.

Projected changes in LAC costs over the next 10 years			
Scenario	3 years	5 years	10 years
<i>Rising CLA</i>	£2.08M	£4.01M	£5.98M
<i>Population growth only</i>	£1.07	£2.22	£3.32
<i>Falling CLA</i>	-£0.44M	-£0.59M	£0.94M

*Unless radical action is taken to upgrade demand-reducing services, the cost of children's social care will become increasingly unsustainable. Work is already underway to make this change.*

### *How can the system be made more sustainable?*

There are effective ways of preventing children from needing social care support. There are also interventions which can prevent their cases from escalating once they are in the system. Unfortunately, investment in preventative services has declined in recent years. This has had the effect of increasing costs in the most expensive part of the system (Looked After Children) and probably means that some children end up being taken into care when it might have been avoided. Making the system sustainable will require a significant rebalancing of investment towards prevention.

We estimate that around 70% of all social care spending is linked to the care of Looked After Children and that the majority of this (53%) of this is made up of placement costs (i.e. the cost of foster care, children's homes or other types of placement). Achieving financial sustainability will only be possible if these costs are reduced through a combination of preventing children from becoming looked after, reducing the amount of time that they stay looked after, and reducing the amount that is paid for placements.

## **3.2. Detailed Recommendations**

Based on our analysis, we make the following three strategic recommendations for managing the pressures on the children's social care system in Thurrock:

### *1. Make a long-term strategic commitment to invest in prevention*

To reduce the number of children in the social care system, a high-level strategic commitment must be made to re-balance investment towards preventative activities. In recent years investment in preventative services has been eroded whilst spending on high cost care placements has increased. By rebalancing investment towards preventative services, we can prevent children from ending up in care unnecessarily and, over time, relieve financial pressures on the social care system.

The change must be seen against the background of continuing cost pressures. It is likely that investing in preventative services will initially slow the growth in costs but may eventually lead to overall cost reductions. However, we have demonstrated that the cost of doing nothing is likely to be much higher than the costs of investing in preventative services.

### *2. Invest in the most effective preventative services*

Making a strategic commitment to invest in prevention will only be effective if that investment is made in the right areas. Based on our review of evidence we recommend:

- **Early help:** Making efforts to expand the number of families benefiting from early help services by increasing capacity, strengthening referral systems and expanding inclusion criteria;
- **Children in Need & Child Protection Plans:** Investing in a new 'edge of care' service to work intensively with children at greatest risk of coming into care; expanding the capacity of existing domestic violence programmes; more targeted drug and alcohol outreach to families of Children in Need or on a Child Protection Plan
- **Looked After Children:** Working systematically with families who have had children removed to increase the chances of Looked After Children being reunited with their families; providing intensive support to mothers (especially young mothers) who have had babies removed from their care to prevent this re-occurring in future.

Table 8. Detailed recommendations for increased investment in preventative services

Stage in the system	Recommended action	Expected Impact
<b>Early Help</b>	<p><b>Expand the capacity of existing parenting programmes</b></p> <p>An expansion of capacity by around 90% is needed to meet existing demand and eliminate waiting lists.</p> <p>Keep capacity under review to ensure that it is meeting demand from other parts of the social care system.</p>	<p>These services will prevent escalation to CiN/CP/LAC stage or enable de-escalation for families already at those stages. Reducing waiting times is likely to make them more effective by ensuring that help truly is given early in the process. It will also give social workers more confidence to refer into these services and may, therefore, increase demand further.</p>
	<p><b>Review referral into parenting programmes</b></p> <p>Review practice of referral into early help parenting programmes to ensure that all families who could benefit from these services (at any stage of the social care process) are appropriately referred. In particular, investigate the lack of referrals into Triple-P parenting programmes.</p>	<p>Better use of existing services (especially Triple-P) will prevent escalation to CiN/CP/LAC stage or enable de-escalation for families already at those stages.</p>
	<p><b>Consider expanding inclusion criteria</b></p> <p>Consider expanding the availability of some early help services to families of CiN/CP children and families who have had children removed. Capacity may need to be expanded accordingly.</p>	<p>Prevent escalation to LAC and promote children returning home to their families.</p>
	<p><b>Ensure end of TF funding is used to strengthen prevention</b></p> <p>Plan for changes to Troubled Families funding to ensure that this does not result in further disinvestment in prevention. Future changes to the service should be based on the best available evidence and designed to prevent children from becoming looked after.</p>	<p>Ensure that the balance of investment is moving towards prevention rather than away from it, reducing costs in more expensive parts of the system.</p>
<b>Child in Need &amp; Child Protection Plan</b>	<p><b>Establish an “edge of care” service</b></p> <p>Establish a new “edge of care” service to work intensively with children who are at risk of becoming looked after.</p> <p>Design this service based on Functional Family Therapy or Multi-Systemic Therapy which have the strongest evidence base.</p> <p>Put in place a robust evaluation plan to determine cost-effectiveness.</p>	<p>Prevent children in the social care system (CIN and CPP) from becoming looked after.</p>

	<p><b>Expand existing domestic violence programmes</b> Expand the two existing programmes (for victims and perpetrators) to meet demand. This would commissioning an additional 60 places for victims and an additional 10 places for perpetrators.</p>	<p>Reduce risk to parents and children who are victims of domestic violence. Reduce the impact of domestic violence on children and prevent escalation of their cases within the social care system.</p>
	<p><b>Targeted drug and alcohol outreach to families of Children in Need or on a Child Protection Plan</b></p>	<p>Prevent escalation and reduce the duration of social care intervention by dealing with underlying substance misuse</p>
<p><b><i>Looked after children</i></b></p>	<p><b>Invest in services which allow Looked After Children to return home</b> Work systematically with families of children who have been taken into care to resolve problems and, where possible, to allow them to the children to return home.  Consider including this within the remit of the edge-of-care service.  Design of this service should begin with an in-depth analysis of why rates of children returning home to their families appear to have declined significantly in recent years.</p>	<p>Increase the number of Looked After Children able to return home to their families and reduce the amount of time they spend in care and reduce costs significantly.</p>
	<p><b>Prevent mothers from having multiple babies taken into care</b> Commission the Pause programme to provide intensive support to mothers who have had a baby removed.  Put in place robust evaluation of the programme to ensure effectiveness and cost-effectiveness.</p>	<p>Reduce the number of mothers who have multiple babies removed from their care and reduce the number of children taken into care.</p>

### 3. Improve information on activity and spending

Reducing the number of children in the system and controlling costs can only be achieved if reliable activity and financial information are available, allowing us to understand current patterns of activity and spending. For the purposes of this report, a new way of forecasting future activity and spending has been developed. This kind of forecasting can help to make good strategic decisions and financial plans for the future. The model used here is relatively simple and its accuracy could be improved with more work in future. Moreover, a number of weaknesses in existing data systems have been identified during the course of this report, which make effective planning and cost control difficult.

**Table 9. Detailed recommendations for improving information on activity and spending**

Recommendation	Details	Expected impact	Responsible
<b>Monitor trends in key cost drivers</b>	Key cost drivers identified in this report are: <ol style="list-style-type: none"> <li>1. The numbers of weeks of care provided by the Council over the course of a year;</li> <li>2. The average length of stay of children in care;</li> <li>3. The average cost of placements of different kinds.</li> </ol>	Monitoring trends in key cost drivers will help to control costs and evaluate the effectiveness of preventative strategies	Performance, quality and business intelligence team
<b>Link data on activity and spend</b>	Currently, data on activity and spending are kept separately. Work needs to be done to link these data systems and regularly analyse the data together	Improved understanding of the costs of different types of social care activity allowing more efficient ways of working to be devised and costs driven down.	Performance, quality and business intelligence team
<b>Carry out a financial deep dive on Looked After Children</b>	A deep dive is required to get a more accurate understanding of all the costs associated with Looked After Children including the costs of different types of placement, the costs of staff time and travel expenses etc.	A better understanding of all the costs associated with Looked After Children will allow costs to be controlled more effectively in this crucial area.	Finance
<b>Investigate the decline in the number of children returning to their families after a period of being looked after</b>	This may be an important factor increasing the number of children in care and, therefore costs. Up-to-date data is required to understand the most recent trends. Further data analysis and case-note audit may be required to understand the reasons for these changes	The results of this analysis should be used to increase the likelihood of LAC returning to their families.	Performance, quality and business intelligence team
<b>Develop and update the forecasting model</b>	There are several ways in which the model could be developed to be more accurate including: adding	The model can inform strategic planning as well as helping to	Public health and children's social care

	more detailed and accurate financial information on placement and other social care costs; modelling the impact of changes in deprivation rates and numbers of children with Special Educational Needs and Disabilities	predict and evaluate the effectiveness of prevention strategies.	
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## **Appendix 1. Technical details of the Thurrock Public Health Team Forecasting model**

### **Approach to modelling future demand for children's social care**

The forecasts of future demand presented in Section 1.3 were developed using system dynamic modelling techniques. This approach uses a mathematical model to represent the forces which influence activity and cost in the children's social care system. Specialist software (*Vensim*) was used to develop these forecasts. The model included a simplified version of the factors which influence the number of Looked After Children (LAC) in Thurrock. The model is represented graphically below in Figure 26.

The rationale for this model includes the assumption that the size of the child population in Thurrock is a key driver of the number of children LAC. The exception to this assumption is the number of Unaccompanied Asylum Seeking Children (UASC) in the LAC population. The number of UASC is assumed to be independent of the size of the local population. UASC numbers are influenced by the numbers arriving in Thurrock and the agreement to distribute UASC across the region. We modelled the size of the child population in future based on two population forecasts, the standard sub-national forecasts produced by the Office for National Statistics and the Thurrock-specific forecasts produced as part of the Strategic Housing Market Assessment (SHMA). The SHMA forecasts take into account the projected economic and housing growth and are likely to be a more accurate estimate of future population.

The total weeks of care provided by the Council in a year is influenced not only by the number of LAC but also by how they remain in care, whilst annual placement costs are a function of the number of weeks of care provided and the average cost of placements. Both average placement length and the average placement cost were estimated based on real social data from the 2016-17 financial year.

Non-placement costs were estimated from real social care financial data (2016-17) by subtracting placement costs from the total estimated spend on Looked After Children. Our model assumes that non-placement costs represent a fixed proportion (47%) of the total spend on LAC and that they vary in line with placement costs.

### **Forecast scenarios**

The results of any model are only as accurate as the assumptions which underlie it. Our modelling technique allowed us to simulate the impact of changes in key assumptions by running multiple scenarios and comparing the results. The model results are only as accurate as the assumptions (or inputs) underlying it. The forecasts presented here included four scenarios with different assumptions made for the inputs underlying each model. Details are given in the Table 10 below.

Table 10. Assumptions made in model inputs for forecasting models

Model inputs	Model			
	Baseline ONS	Population growth only	Rising LAC	Falling LAC
<b>Child population</b>	ONS mid-year	SHMA	SHMA	SHMA
<b>Non-UASC rate</b>	constant (66)	constant (66)	Rising logarithmic trend based on actual rates from 2011 – 2017 (see Figure 25)	Falls to national non-UASC rate (56) over 5 years then stays constant
<b>Number of UASC</b>	constant (38)	constant (38)	constant (38)	constant(38)
<b>Average length of stay</b>	constant (35 weeks)	constant (35 weeks)	constant (35 weeks)	constant (35 weeks)
<b>Average placement cost per week</b>	constant (£1,072)	constant (£1,072)	constant (£1,072)	constant (£1,072)
<b>non-placement LAC costs</b>	47% of total LAC spend	47% of total LAC spend	47% of total LAC spend	Constant at 2017 levels (£10.54M)

Figure 25. Non-UASC LAC rate, projected trend for Thurrock 2011 – 2037

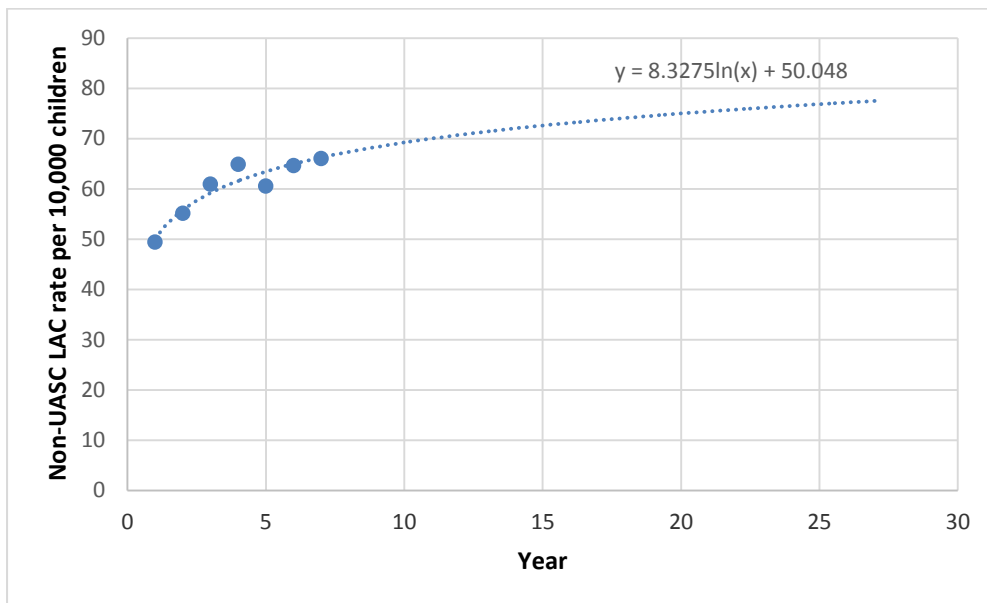
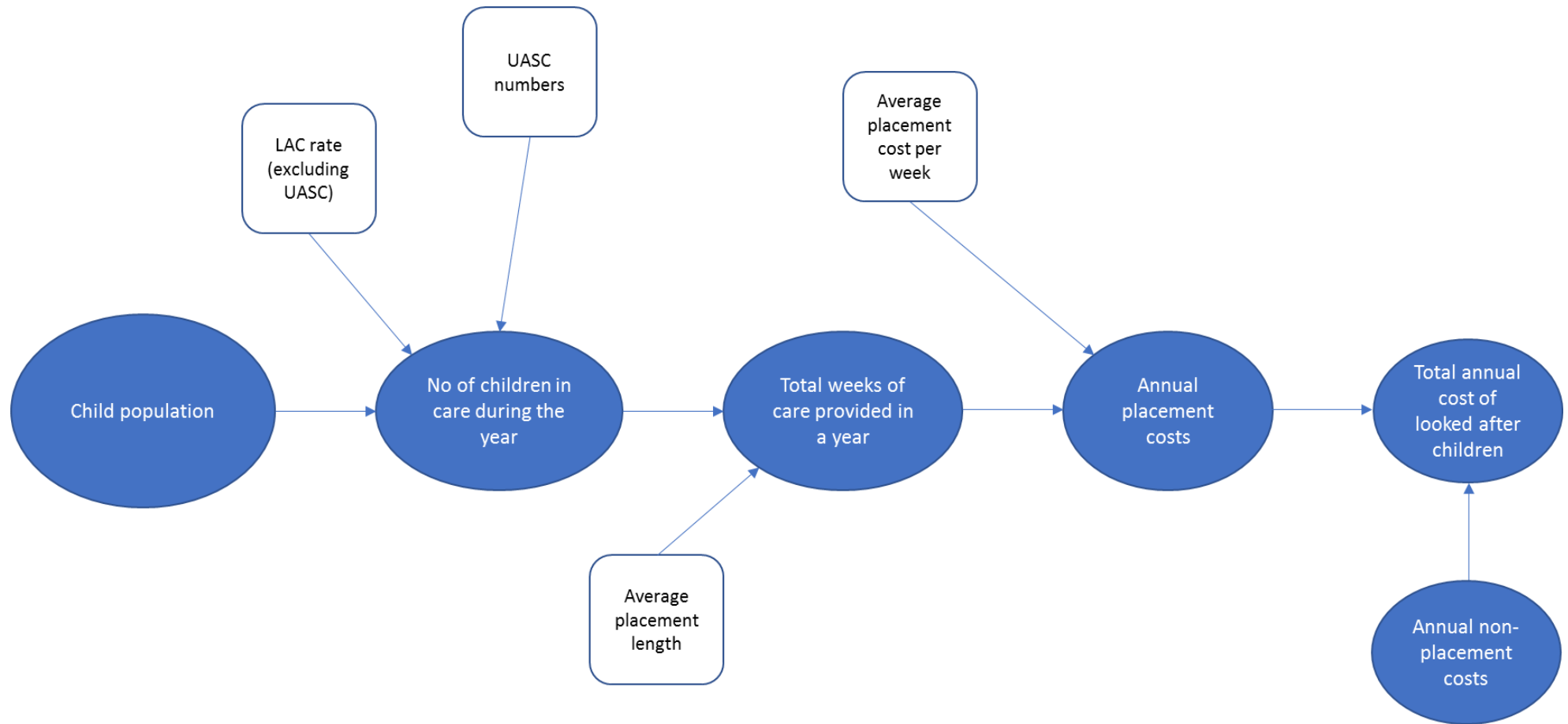


Figure 26. Thurrock children's social care demand and cost forecasting model 2017



## Appendix 2. Literature review on what works in prevention and early intervention

Elozona Umeh, Senior Public Health Programme Manager  
Annelies Willerton, Public Health Graduate Trainee

The literature supporting this review was searched using the Aubrey Keep Library Service. The search resulted in a range of articles which formed the major part of this review. Grey literature was also used to retrieve articles after an extensive search using the following sites;

- Early Intervention Foundation
- Research in Social Care Practice
- Community of Care Online
- Association of Directors of Children's Service

This section of this Annual Public Health report reviews what works in preventing children from accessing statutory children's care services as well as interventions that aid early identification and intervention. It is important to distinguish between prevention – stopping the problem happening in the first place; early intervention – getting in at the first signs of risk or trouble; treatment – responding once what has gone wrong has gone wrong. In Thurrock, there is a range of service to prevent risks, intervene early as well as respond to identified risky situations. A service mapping of the Thurrock Early Offer of Help Service was conducted. The below provides an insight to the current and formerly commissioned services within early help.

### Service Mapping of Thurrock Early Help Services

A variety of evidence suggests early help or integration of services as part of ways to improve statutory response to families. There is an early help service known as the Early Offer of Help which is currently being delivered in Thurrock by a range of providers. A needs analysis was undertaken to identify the key factors present in Child in Need (CIN) and Child Protection (CP) cases and the services that were evidenced to have an impact in addressing these. In over half the cases childhood neglect was present and the underlying factors in many of these cases were substance misuse, poor parenting, domestic violence and sexual violence.

As a result the local authority in partnership with the Thurrock Clinical Commissioning Group (CCG) jointly funded and commissioned a range of services aimed at providing support at an earlier stage to reduce the risk of needs escalating and to improve outcomes for those most in need of support. In recognition of the impact on outcomes for children and financially for both organisations the following services were jointly commissioned in 2013 under the Early Offer of Help

- Domestic Abuse support services (a perpetrators program and a victim support program)
- Sexual Violence support service
- Substance Misuse support service
- Parenting program
- Family Intervention Program

However, in 2016 the CCG funding element was discontinued. An impact assessment and a Return on Investment(ROI) of the early help commissioned services was conducted. The exercise recommended that the CCG continue its £450,000 funding for Early Offer of Help as this will prevent excessive increased demand and future costs. As a result of this reduction in funding the Family Intervention Program and the Substance Misuse Programme were discontinued.

The table below attempts to map the services commissioned within the Early offer of Help banner, supported by outcomes achieved and evidence of effectiveness of these services is presented in the table below.



Service	Provider	Service Description	Outcome	Evidence of Effectiveness
Parenting Programmes	Coram	<p><b>Mellow Mums</b> - Mellow Mums, part of the Mellow Parenting and family programmes, is an attachment and relationship based group intervention for mums who have babies and young children. This programme uses a combination of reflective and practical techniques that allow parents to address their personal challenges as well as the challenges they face with their children. Parents also reflect on their experience of being parented and how this affects their relations with their children. This is delivered over 14 weeks with both mum and baby/child with significant attachment issues. This programme now forms part of the Prevention and Support Service.</p>	<p>During the three years of delivery samples have been taken on two occasions to review the success rate of interventions at Social Care level. The sample size covered approximately 10% of the overall case load over the three year period.</p>	<p>Mellow Parenting evidence rating is 2 . Mellow Parenting has formative evidence of improving child and parent outcomes from a single study involving pre/post intervention comparisons of the mothers' behaviour. It has been effective in;</p> <ul style="list-style-type: none"> <li>• Reduced likelihood of children remaining on the child protection register</li> <li>• Improving parenting skills (coded observation)</li> </ul>
		<p><b>Strengthening Families Strengthening Communities</b> - This service is an inclusive evidence-based parenting programme, designed to promote protective factors which are associated with good parenting and better outcomes for children. The service in Thurrock is a 12 week group parenting course that covers all aspects of effective parenting, boundary setting, praise and warmth and working with children's emotions. It uses peer support with distinct modules covered each week. It also includes face-face brief intervention with additional support for the family in their home. This programme now forms part of the Prevention and Support Service.</p>	<p>The outcomes of this programme were maintained one year on from the end of the programme.</p>	<p>The effectiveness of SFSC has been demonstrated by a variety of studies. A meta-analysis of 55 studies concluded that SFSC causes positive changes in the small to medium range for child behaviour problem, parent well-being and parenting skills; effect sizes increased with the intensity level of the programme with overall effect sizes (Cohen's d) ranging between 0.35 and 0.48 for between groups.</p>

		<p><b>Triple P</b> - Triple P give parent’s simple and practical strategies to help them build strong, healthy relationships to enable them confidently manage their children’s behaviour and prevent problems developing. This is a 13 week programme which is utilised by parents with teenage children where there are particular behavioural patterns and seeks to avoid those escalating further in adolescence. It works over a 13 week programme. This programme now forms part of the Prevention and Support Service.</p>		<p>The evidence base for Triple P includes scientific papers that have contributed to the theory and development of essential procedures involved in forming part of the Triple P system of parenting interventions. This includes research related to the efficacy, effectiveness and dissemination of intervention programs, epidemiological studies, correlational studies, service-based research, and evaluation of professional training, large-scale population trials, and meta-analyses. It also includes observational studies of family interaction and independent program evaluations . Two large trials of Triple-P offered at all levels are among the few studies to have demonstrated impact of a universal and targeted approach combined. Barth suggests that the evidence-based Triple P approach offers a general framework that could be used to guide the future evolution of parenting programs</p>
<p>Programme to Support Victims and Survivors</p>	<p>Changing Pathways</p>	<p><b>Success Through Effective Parenting Support</b> - – This programme offers an 8 week therapeutic and practical support 1-2-1 response covering service user-led group programme. The key focus of the STEPS programme is to raise awareness and decrease the impact on parenting of domestic abuse. The service in Thurrock is working to build a better understanding of all victims of domestic abuse, how this may have an impact on children and fast emotional recovery victims may need. In doing this, women who attend the programme gain support from both the facilitators and each other, and are empowered to address the issues affecting them and their children. As well as exploring the emotional impact of abuse on them and their children, the programme also provides an opportunity to develop/build on positive parenting after domestic</p>	<p>430 women have accessed the 8 week ‘STEPS’ programme and 1360 sessions have been delivered for the drop-in service over the three year period that the contracts have currently run. The outcome of this programme indicated higher percentage of women understanding the impact of abuse and violence on their children and feeling safe.</p>	

		abuse. This programme now forms part of the Prevention and Support Service.		
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	<p>Essex Community Rehabilitation Company (previously DVIP)</p>	<p><b>Domestic Violence Perpetrators Programme</b> – This programme in Thurrock is an intensive 26 week programme (2.5 hours per week) and only commissioned for 10 men each year. It aims to help this cohort, who have been abusive towards their families, partners or ex-partners, change their behaviour and improve in their relationships. In Thurrock, the service delivers an intensive challenge and support peer programme which seeks to understand perpetrators childhood experiences and how they formed the attitudes that led to abusive patterns of behaviour. One of the key focuses is to address these behaviours and attitudes through providing understanding of power and control and its impact on partners and children, and exploring these via the group facilitators and peer challenge. All referrals to this service have been within Social Care, generally with children on a Child Protection Plan and sometimes on a child in need plan. For this reason it was intentionally targeted at those cases which represented the highest risk to children. Family intervention helps vulnerable families who may be facing issues such as:</p> <ul style="list-style-type: none"> <li>• poor physical and mental health;</li> <li>• domestic violence;</li> <li>• substance misuse;</li> <li>• a lack of basic and life skills;</li> <li>• Behavioural problems.</li> </ul> <p>This programme now forms part of the Prevention and Support Service with a change of providers from January 2018</p>	<p>For the outcome of this programme, 93% of partners reported a cessation of abuse after completing the programme. Additional 93% of partners reported feeling safer where as 73% of partners reported the perpetrator had an improved relationship with children. Finally 83% of partners reported the changes had been sustained post intervention. This indicates a potential need to offer follow up support after closure to ensure that changes are sustained in the view of Social Care (this is not completely in line with the 83% of partners reporting sustained changes.</p>	<p>A cohort of men convicted and sentenced by the criminal courts was allocated to a DVPP programme. The impact of both types of sentence on women’s experiences of abuse and violence was measured and compared. The findings of the research included that there was a positive impact – men who had attended the DVPP recently were much less likely to continue abusive behaviour than men who had not (Dobash et al, 1999).</p>
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Family Intervention Project (FIP)	Catch 22	<p><b>FIP</b> - The Thurrock service delivered an intensive programme for families with multiple and complex issues including: substance misuse, crime and anti-social behaviour, domestic abuse and violence, teenage pregnancy, children not in school, no paid employment, housing issues, debt, inadequate parenting and others. Work is usually completed with a key worker allocated to a family working with them for between 9 and 18 months, with 12 months an average intervention time. The keyworker will seek to work in all areas, signposting where appropriate, and co-ordinate the family to ensure children are kept safe and remain in the family home. <b>(This service has been decommissioned following reduction in funding from the CCG)</b></p>	<p>The programme has been effective and has received a positive outcome since it was implemented. For example 60% of parents gained employment after signing up to the programme, 23% completely moved off of benefits, 75% or more decrease in crime and anti-social behaviour whereas 59% of children has no school exclusions</p>	<p>An evaluation of family intervention projects (FIPs) has shown that this programme have reduced crime and antisocial behaviour. The research, commissioned by the government, found that the more time family intervention teams worked with families the greater the chance of a successful outcome. Overall they found that 79% of parents completing the courses showed improvements in mental well-being while three quarters of all parents reported reductions in either parenting laxness or over-reactivity. Serious conduct problems in their children dropped by a third from 59% to 40%.</p>
Substance Misuse P		<p><b>Substance Misuse</b> – This service was based on a hybrid service which encompasses elements from Changing Trax, Options 2 and Hidden harm programme. The service involves delivery of a two levels of support – early intervention and an intensive support for families affected by substance misuse and where children at significant risk of becoming looked after. <b>(This service has been decommissioned following reduction in funding from the CCG)</b></p>		

Sexual Violence Support Programme	SERICC	<p><b>Sexual Violence Support Programme</b> - The service in Thurrock provides support to:</p> <ul style="list-style-type: none"> <li>- Women with children on the edge of care where sexual violence is or has significantly impacted on the welfare and wellbeing of the child / children.</li> <li>- Women whose children who are looked after, who have been referred as a result of a child protection conference where the intervention has been recommended before consideration is given to their children being returned. <b>(This programme forms part of the Prevention and Support Service).</b></li> </ul>		
Troubled Families Programme	Thurrock Council (in-house provision)	<p><b>Troubled Families</b> - This programme is a targeted intervention for families with multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse. The programme identifies a 'troubled family' and assigns a key worker. <b>This programme forms part of the Prevention and Support Team.</b></p>	<p>Troubled Families programme has had two phases of programme deliver.</p> <p>Thurrock TF target numbers for Phase I was to recruit 360 families on the programme between 2012 –2015. Thurrock met this target. Phase e II which started in 2015 runs until 2020. Thurrock is required to work with 1240 families which is broken down below;</p> <ul style="list-style-type: none"> <li>• Year 1 – 197 families were supported</li> <li>• Year 2 – 370 families were supported</li> <li>• Year 3 – 331 families were supported</li> <li>• Year 4 &amp; 5 not yet known but will be broken up to cover the remaining</li> </ul>	<p>An evaluation of the programme was carried out in 2015 with a suite of evaluations at different stages . It is worth noting that funding from this service forms a huge part of the PASS service and is likely to be suspended after 2020. An implementation plan for post 2020 has been submitted to the DCLG for consideration. (Still waiting on Teresa Goulding for more information on outcomes etc</p>

			number to reach full target.	
Multi-Agency Safeguarding Hub	Thurrock Council (in-house provision)	MASH was created to enhance information sharing across all organisations involved in safeguarding the welfare of children in Thurrock - encompassing statutory, non-statutory and third sector sources.	<p>A summary of MASH outcomes;</p> <ul style="list-style-type: none"> <li>• MASH enquiries have decreased since the previous year</li> <li>• Police and Schools are biggest enquiry groups</li> <li>• 2016/17 saw more cases rated as Red than the previous year (i.e. increased severity)</li> <li>• 2016/17 saw a large increase in proportion of cases that were past their due date (is this a sign of increased demand on the system?)</li> <li>• 2016/17 saw an increase in the proportion of enquiries for non-White British children, e.g. White Other and African groups.</li> </ul>	A Report by the Home Office on Multi-Agency Safeguarding Hubs underpins the setup of this offer. Thurrock model has been acknowledged by Ofsted as working well.

Home Visiting	North East London Foundation Trust (NELFT)	<p>This includes universal and targeted offer through Health Visiting and School Nursing programs for children aged 0 – 19 years.</p> <p><b>Health Visiting</b> – This is a universal offer to children and families led by Health Visitors (HV) and supported by teams of mixed professionals with multiple skills. The service in Thurrock work across a number of stakeholders, settings and organisations to lead delivery of the Healthy Child Programme 0-5 (HCP), a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity. The model of delivery is termed 4-5-6 model which comprises of 4 levels of delivery, five mandated contact points (it involves key contact points families are expected to be offered an encounter with a Health Visitor) and six high impact areas. Safeguarding children cuts across this model to ensure risks are identified and outcomes are improved.</p> <p><b>The School Health Service</b> – the core offer for school nursing include health promotion and prevention by multi-agency group with. This is done across four levels with contacts with all school children’s at Key stage 1, 2 and 3. Health assessments are carried out and risks identified. This service also provides defined support for children with additional and complex health needs as well as needs identified through the Joint Strategic Needs Assessment (JSNA).</p> <p>The offer here also includes some offer for Young and</p>	<p>The Healthy Families Service is expected to contribute to the following overarching outcomes for children as well as contribute to the closing the gap in inequalities within Thurrock</p> <ul style="list-style-type: none"> <li>• Children and Young People are ready for Education and Learning</li> <li>• Children and Young People are in Good Physical Health</li> <li>• Children and Young People are able to make Healthy Lifestyle Choices</li> <li>• Children, Young People and their Parents have Good Emotional Mental Health and Wellbeing</li> <li>• Children and Young People Live Safely</li> <li>• Improved Parental Aspirations and Achievements</li> </ul>	<p>This service is underpinned by the Healthy Child Programme Pregnancy - 5 years old is an evidence based policy that underpins the home visiting service. Evidence base for this policy has been recently updated - Rapid review to support evidence for the Healthy Child Programme 0 - 5 published in 2015. The Healthy Child Programme 5 – 19 underpins the School Health Service</p>
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		Vulnerable parents, healthy eating for infants and mothers including parenting programme to support positive parenting skills.		
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## What Works for Early Intervention

Early help involves support provided ‘as soon as a problem emerges’<sup>7</sup>. The evidence reviewed on the effectiveness of early interventions to prevent abuse and neglect of children and young people was predominantly from outside the UK, and focused more on home visiting programmes and parenting programmes.

### *Home Visiting*

Home visiting programmes at the ante-natal and early post-natal stage can be effective in facilitating the development of a sensitive and empathic relationship between the parent and young child which may forestall attachment and other relationship difficulties.

The NICE guidance on Child Neglect and Abuse (NG 76; 2017) suggests that home visiting programmes should be considered as a form of early help for families showing possible signs of abuse or neglect. This should be for a minimum duration of 6 months, for parents or carers at risk (or those with previously confirmed instances) of abusing or neglecting their children.

The recommendations required that home visiting programmes should include:

- support to develop positive parent-child relationships, including helping parents to understand children’s behaviour more positively, modelling positive parenting behaviours; observing and giving feedback on parent-child interactions
- Helping parents to develop problem-solving skills
- Support for parents with substance misuse and mental health difficulties
- Support for parents to access relevant services,

Although evidence around home visiting is well established, it is important to note that further research is still called for on effective components of a home visiting programme for preventing child abuse and neglect in the UK. The majority of the evidence base is from the US, with mixed findings of effectiveness as well as poor reporting of intervention details, making it difficult to ascertain the key components of a successful home visiting programme.

Two home visiting interventions have been conducted in the UK<sup>8 9</sup>. In one of the studies, pregnant women receiving home visits were assessed as having a higher level of maternal sensitivity and infant cooperativeness compared to those receiving standard care, but no differences were identified in any other measures, possibly due to a lack of statistical power. There was also no difference in the outcome of being placed under child protection or into care – in fact, the intervention arm observed a slight increase in the number of cases of abuse, which the authors attributed to surveillance bias.

The other randomised controlled trial was conducted on a larger scale with a larger sample size of 1645 first-time teenage mothers in order to test the effectiveness of the US Family Nurse Partnership (FNP) programme as an intensive preventive home visiting service. Again potentially as a result of surveillance bias, those receiving the FNP intervention were significantly more likely to have a safeguarding event noted in GP records (AOR 1.85, 95% CI 1.02 to 2.85, p=0.005). Conversely, GP health records were used as opposed to data from children’s social care, and there were high levels of missing data in both intervention and control groups in relation to this outcome. No significant differences were found between groups in regards to parent-reported abuse and neglect or

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<sup>7</sup> Working Together to Safeguard Children, 2013

<sup>8</sup> Barlow J, Davis H, McIntosh E, Jarret P, Mockford C, Stewart-Brown S (2007) The role of home visiting in improving parenting and health in families at risk of abuse and neglect: Results of a multicentre randomised controlled trial and economic evaluation. Arch Dis Child 92: 229-33.

<sup>9</sup> Robling M, Bekkers M-J, Bell K et al. (2015) Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. The Lancet 387 (10014): 146-55.

maternal-child interaction outcomes. The authors suggested that benefit for child development outcomes would largely arise in children after the age of 2 years and called for a longer-term follow up to accurately determine the effectiveness of a home visiting intervention on these outcomes.

In the UK, an RCT<sup>10</sup> of the Family Nurse Partnership programme, on the one hand found the programme to be successful in engaging with disadvantaged families and reaching vulnerable groups of young mothers. On the other hand, measures of effectiveness found no significant impact on neither the primary outcomes measure nor outcomes by key sub-groups (age, NEET, problems with basic life skills, area deprivation) or by variation in programme implementation. A wide range of secondary outcomes assessed also did not show significant benefits for this programme. As a result, Thurrock Council decommissioned this service and re-designed an offer for families to include a wider age range and population groups.

Other evidence based home visiting offer include; The Healthy Child Programme (HCP) which is the key universal public health offer for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, promoting screening and immunisations. A rapid review of evidence to update the Healthy Child Programme 0 – 5 in 2015 aimed synthesise relevant systematic review about ‘what works’ in key areas: such as parental mental health; smoking, alcohol/drug misuse; intimate partner violence; preparation and support for childbirth and the transition to parenthood; attachment; parenting support; unintentional injury in the home; safety from abuse and neglect. Evidence from the rapid review supported the design of the Thurrock Healthy Families Service.

### *Parenting Programmes*

A range of parenting programmes have been documented to effectively support parenting in building positive parenting skills and sensitively required to improve children’s wellbeing. The Parenting Early Intervention Programme provided government funding to all England local authorities from 2008-2011 to test the effectiveness of several parenting programmes that have previously demonstrated trial efficacy in improving parenting skills and resultant improvements in children’s behavioural difficulties<sup>11</sup>. The process tested four parenting programmes (Triple P, Incredible Years, Strengthening Families Programme 10-14 and Strengthening Families, Strengthening Communities) and found all four were effective in improving outcomes for parents and children (in improving parenting skills, parent well-being and reducing children’s behaviour difficulties) across the range of demographic backgrounds, including SEN). Improvement in these areas was maintained one year on. However, outcomes in relation to risk of abuse or neglect were not measured. In Thurrock, Triple P and Strengthening Families Strengthening Communities are currently being commissioned within the Prevention and Support Service as part of earlyt intervention to prevent children accessing statutory services.

An Australian study<sup>12</sup> found that participants in 2 variants of the Triple-P Parenting Program did show significant improvements across all measured indicators of risk potential for abuse and neglect, which were also sustained at the 6-month follow up. This study targeted parents who were experiencing anger management problems in relation to their child. The enhanced programme version contained additional content targeted at risk factors for abuse and neglect, and participating parents showed a significantly greater reduction compared to the standard programme in child abuse potential (measured via Child Abuse Potential Inventory scores, and unrealistic expectations scores, as measured by the Parent Opinion Questionnaire).

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<sup>10</sup> Robling, M et al, 2015, **Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): A pragmatic randomised controlled trial**, The Lancet , Volume 387 , Issue 10014 , 146 - 155

<sup>11</sup> Lindsay G, Strand S, Cullen MA et al. (2011) Parenting Early Intervention Programme Evaluation. Department for Education

<sup>12</sup> Sanders MR, Pidgeon AM, Gravestock F et al. (2004) Does parental attributional retraining and anger management enhance the effects of the Triple P-Positive Parenting Program with parents at risk of child maltreatment? Behavior Therapy 35: 513-35

Whalley and colleagues<sup>13</sup> conducted a mixed-methods evaluation of Pathways Triple P, an NSPCC service tailored specifically to families where there are specific concerns about child neglect. This intervention was specifically delivered in the home on an individual basis for parents of children aged between 2 and 12 years old, who were not yet at the threshold for child protection interventions. Parents reported a reduction in severe emotional and behavioural child difficulties following the programme in addition to severe parenting difficulties. Improvements were noted in understanding of child's needs, parenting capability, parental commitment to child, greater parental sensitivity and helping to meet child's developmental needs. These outcomes were described in greater detail in the semi-structured interviews, where the relationship with the programme practitioner was described as the key facilitator to these outcomes (in particular the practitioner's communication style, approach, experience, flexibility and supportive encouragement).

It is important to note that, despite not being on a Child Protection Plan, children on entry to the programme were reported as still having very high levels of need, and almost half of the children still had clinical levels of need by the end of the programme, indicating that that further support may be required. A similar conclusion that parenting intervention may be ineffective or insufficient in cases of high need and families with complex, multi-layered problems has been reached during a recent literature review<sup>14</sup> as well as earlier evidence reviews<sup>1516</sup>

## Children in Need and Children in Protection Plans – Supportive Interventions

A child should be taken to be in need if:

- He/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
  - His/her health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services;
  - He/she is disabled.
- (Section 17(10), Children Act 1989)

Some parenting programmes have been found to be effective in preventing children from being taken into care. Effective programmes and interventions with children and families at the edge of care (this stage describes various stages before or as a child becomes looked after).

Two systematic reviews have identified interventions aimed at improving parent sensitivity and secure child attachment which have shown to be effective in children under the age of five (NICE 2015; Barlow 2016). Video feedback programmes and parent-child psychotherapy in particular have been recommended for parents of preschool-age children on the edge of care with, or at risk of, attachment difficulties. NICE (2015)<sup>17</sup> recommends an alternative such as parental sensitivity and behaviour training for parent unwilling to take part in video feedback programmes. This should

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<sup>13</sup> Whalley P (2015) *Child neglect and Pathways Triple P: an evaluation of an NSPCC service offered to parents where initial concerns of neglect have been noted*. London: NSPCC.

<sup>14</sup> Schrader-McMillan A and Barlow J (2017) *Improving the effectiveness of the child protection system - A review of the literature*. University of Oxford.

• <sup>15</sup> Barlow J, Johnston I, Kendrick D, Polnay L, Stewart-Brown S (2006) *Individual and group-based parenting programmes for the treatment of physical child abuse and neglect*. *Cochrane Database of Systematic Reviews* (3) CD005463. DOI: 10.1002/14651858.CD005463.pub2.

<sup>16</sup> Ward H, Brown R and Hyde-Dryden G (2014) *Assessing Parental Capacity to Change when Children are on the Edge of Care: An Overview of Current Research Evidence*. London: Department for Education

<sup>17</sup> NICE Guidinace, *Child Abuse and Neglect, NG 2017*; <https://www.nice.org.uk/guidance/ng76>

consist of a parent-only session followed by 5-15 weekly or fortnightly parent-child sessions over a 6-month period, to include the following:

- Coaching the parents in behavioural management (for children 18 months- 5 years) and limit setting
- Reinforcing sensitive responsiveness
- Ways to improve parenting quality
- Homework to practise applying new skills

NICE also recommend a multi-agency review for parents who decline the above interventions or made little improvement before going ahead with further interventions.

A recent review by Schrader-McMillan and Barlow (2017)<sup>18</sup> has warned however that the evidence for the above interventions in cases of identified child maltreatment is generally based on limited research of low quality.

### *Interventions to support Physical abuse*

**Parent-child interaction therapy** - Parent-child interaction therapy (PCIT) is an individualised intervention developed for parents and children aged 3-7 years with externalising behavioural problems. It aims to improve the quality of the parent-child relationship by helping parents to understand how their behaviour affects their child and by teaching behaviour management strategies that focus on positive reinforcement rather than power assertion.

While there is no evidence of its application in the UK, there is evidence of its effectiveness among Australian families at a high risk of, or already engaged in, maltreatment<sup>19</sup>. However, the difficulties in assessing the effectiveness of such interventions with families where a child has been physically abused should be acknowledged. The measured effect of the intervention could be imprecise as a result of a reliance on parent self-reporting and measuring risk factors associated with abuse such as parental behaviour and attitudes, as opposed to direct, objective measures of physical maltreatment.

The majority of the supporting evidence has relied on risk factors associated with child maltreatment as primary outcomes. Despite this, an earlier US RCT did show an intervention effect on abuse recurrence rates - after a 2 year follow-up, considerably fewer parents receiving PCIT had a re-report for physical abuse (19%) compared to those who received standard care (49%).

**Multi-systemic therapy** - Multi-systemic therapy (MST) is a family and community-based treatment programme originally designed for young offenders or young people aged 11-17 at risk of care who are demonstrating anti-social behaviours<sup>20</sup>.

The intervention has recently been adapted specifically for families where there is evidence of child abuse and/or neglect (MST-CAN) as an intensive, multi-faceted intervention to address the multi-determined nature of child physical abuse. It has been evaluated in a US randomized effectiveness

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<sup>18</sup> Schrader-McMillan, A., & Barlow, J. (2017). Improving the effectiveness of the child protection system - A review of the literature. Oxford: University of Oxford.

<sup>19</sup> Thomas, R., & Zimmer-Gembeck, M. J. (2012). Parent-child interaction therapy: An evidence-based treatment for child maltreatment. SAGE. <http://dx.doi.org/10.1177/1077559512459555>

<sup>20</sup> <http://www.mstuk.org/>

trial, where 86 families followed by Child Protective Services due to physical abuse were randomly assigned to receive MST-CAN or Enhanced Outpatient Treatment (EOT), which was the standard service normally offered with enhanced engagement and parent training.

Intention-to-treat analyses showed 16 months after programme entry, MST-CAN was significantly more effective than EOT improving risk factors closely associated with maltreatment from both youth and parent perspectives, and led to fewer out-of-home placements (14 versus 30%). Perhaps surprisingly, there were no significant differences between the groups regarding maltreatment outcomes (the youth experiencing another abuse was 4.5% in MST-CAN group compared to 11.9% in the EOT group). MST-CAN is now being piloted in several sites in the UK; however an evaluation is yet to be undertaken or published. Despite this, it is an intervention that will be recommending in the upcoming (currently out for consultation) NICE 2017 guidance on Child Abuse and Neglect for parents with children aged 10-17 if the parent has abused or neglected their child. It should involve the whole family and include a 24/7 on-call support service to help families to manage crises.

### ***Gaps in the evidence***

The draft NICE (2017) guidance on Child Neglect and Abuse recommends effective interventions to address abuse and neglect of children and young people. The guidance also states that the majority of evidence used to make recommendations was from outside the UK, as many UK interventions or approaches have not yet been evaluated using high-quality research designs hence posing a gap in evidence for effective interventions within the UK. The guidance also calls for more evidence to assess the potential effectiveness and cost-effectiveness of home visiting in higher risk families where abuse or neglect is occurring or has occurred. Home visiting is a tool often used for monitoring families as part of a Child Protection Plan, but little is known about what practices within this setting help families to change and address problematic behaviours.

### ***Interventions to support child sexual abuse***

Evidence suggest that plans for children who have been sexually abused need to take account of the overall needs of the child rather than focusing on the sexual abuse alone, and need to consider a variety treatment approaches to suit the individual needs. The draft NICE (2017) guidelines specifically emphasise, for girls aged between 6 and 14 who have been sexually abused and are showing symptoms of emotional or behavioural disturbance, professionals should discuss with the individual as to whether individual focused psychoanalytic therapy or group psychotherapeutic and psycho-educational sessions would suit her best.

***Cognitive behavioural therapy*** - Cognitive behavioural therapy (CBT) currently has the strongest evidence base for benefitting sexually abused children. A systematic review by Macdonald et al<sup>21</sup> assessed the efficacy of cognitive-behavioural approaches in addressing the immediate and longer-term adverse consequences of sexual abuse in children and young people. Across the ten included trials, results suggested that trauma-focussed CBT may have a positive impact on outcomes including depression, post-traumatic stress disorder, anxiety and child behaviour problems, but most results were not statistically significant. However, half of the studies included asymptomatic children which

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<sup>21</sup> Macdonald ,G, et al. (2012) Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database Systematic Reviews* Issue 16:5.

may limit the ability to detect an intervention effect, as it is difficult to observe improvement in better-functioning individuals. The validity or applicability should still be questioned due to the generally poor reporting by the studies which were predominantly conducted in the US.

**Letting the Future in** - A psychodynamic, attachment-based therapeutic approach called 'Letting the Future In' is an example programme developed by the NSPCC and due to be recommended by NICE (2017), stating that such a programme should:

- emphasise the importance of the therapeutic relationship between the child and therapist
- offer support tailored to the child's needs, drawing on a range of approaches including counselling, socio-educative and creative approaches (such as drama or art)
- include individual work with the child (up to 20 sessions, extending to 30 as needed)
- involve parallel work with non-abusing parents or carers (up to 8 sessions)

The evaluation for this intervention<sup>22</sup> included qualitative case studies and the largest ever RCT of a therapeutic intervention for child sexual abuse, with 242 children aged 6-16 years. Children were randomised to either an immediate intervention group or six-month waiting list group.

The proportion of children with clinical levels of symptoms or significant difficulties between assessment on referral, and 6 month follow up reduced significantly from 73% to 46% in the intervention group, while there was no significant reduction in the control group. It is important to note this was only for older children (over 8 years) and young people. No change was observed in the younger children (33% of the participants) who were unable to complete the self-report measures, emphasising the importance of considering the child's age and developmental stage when choosing an intervention.

#### *Interventions to support Substance abuse*

Along with domestic abuse and mental health problems parental substance misuse features in a large number of cases open to children's social care. It is clear that parental substance misuse can have an impact on child health and development from birth through to when they are adults. The potential for parenting capacity to be undermined and children's health and development harmed by parental substance misuse is considerable, particularly when other risk factors such as domestic abuse and mental health difficulties are present (Cleaver et al, 2011; Horgan, 2011; Barnard, 1999)<sup>23,24</sup>. There is a serious risk that parents will neglect their children in these circumstances hence evidence suggested intervention below;

**Parents Under Pressure** - Child maltreatment tends to occur as a result of a complex interplay between drug use, maternal psychopathology, parenting practices, family environment and socioeconomic factors such as unemployment and poverty, as opposed to parental drug use specifically as a single risk factor. In recognition of this, an intensive, home based intervention named 'Parents Under Pressure' (PUP) was developed by Australian researchers to address multiple domains of family functioning including parental psychopathology, child behaviour problems, parent-child relationship difficulties, and social-contextual factors<sup>25</sup>. The programme was designed

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<sup>22</sup> Carpenter J, Jessiman T, Patsios D et al. (2016) Letting the Future In: a therapeutic intervention for children affected by sexual abuse and their carers – an evaluation of impact and implementation. <https://www.basw.co.uk/resource/?id=5045>

<sup>23</sup> Cleaver, H; Unell, I and Aldgate, J (2011), *Children's needs, parenting capacity: The impact of parental mental illness, learning disability, problem alcohol and drug use and domestic violence on children's safety and development* (2nd edition), Department for Education

<sup>24</sup> Horgan, J (2011) *Parental substance misuse: Addressing its impact on children*

National Advisory Committee on Drugs

<sup>25</sup> Dawe, S. and Harnett, P. H. (2007) 'Improving family functioning in methadone maintained families:

for high risk families where a parent is receiving methadone maintenance treatment. The Australian randomised-controlled trial compared the 20-week intervention to both a 'usual care' group and another receiving a 'brief intervention' (two-session parenting education) service. Only parents who participated in the PUP intervention showed a significant decrease in child abuse potential (measured by the child abuse potential inventory), harsh parenting and parenting stress.

Despite this, 36% of the PUP group showed continued high-risk status over the course of the study, suggesting that not all parents are responsive to intervention and highlighting the need to examine each individual family's response (change in parenting capacity) to a parenting intervention.

The programme is currently being evaluated in a UK-based randomised controlled trial for families with a child under two and a half years old by the NSPCC and University of Warwick in regards to its effectiveness, cost-effectiveness and acceptability to service users.

### *Interventions to support domestic abuse*

Children can suffer serious long term problems as a result of domestic abuse even if they themselves have not been directly harmed or abused. According to NICE guidance support should be provided for both the non-abusing parent and child<sup>26</sup>. Services should be tailored to the level of risk and specific needs of people experiencing domestic violence or abuse.

### *Support for the non-abusing parent*

There is moderate evidence to support the following forms of support:

- Advocacy services (to inform, guide and help victims access a range of services and supports)
- Skill building (teaching, training, experiential or group learning)
- Counselling interventions (based on brief educational, cognitive behavioural and motivational interviewing approaches) to improve a range of outcomes - PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level and/or readiness to change.
- Intensive therapeutic interventions such as group therapy may also be effective for many of the above outcomes in some cases may reduce likelihood of future IPV or re-abuse

The majority or all of the studies included in the evidence review conducted for the guidance<sup>27</sup> reported improvements in a number of the outcomes above that were measured.

### *Support for the child*

The above review indicates the evidence is currently stronger for single component therapeutic interventions that are aimed at both mother and child, compared to child only. Intervention approaches include:

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results from a randomised controlled trial.' *Journal of Substance Abuse Treatment* 32, 381-390.

<sup>26</sup> NICE (2014) PH50: Domestic violence and abuse: multi-agency working

<sup>27</sup> <https://www.nice.org.uk/guidance/ph50/resources/review-of-interventions-to-identify-prevent-reduce-and-respond-to-domestic-violence2>



- mother-child psychotherapy
- shelter-based parenting intervention combined with play sessions for children
- parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques)
- experiential, activity-based and interactive therapy intervention.

Outcomes that potentially improve as a result include child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children.

Psycho-educational interventions (addressing skills such as: stress and conflict management, coping and relationship skills, understandings of violence, etc.) may also be effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence, but the evidence is weakened by methodological weaknesses, such as small sample sizes, lack of detail on intervention.

There is also moderate evidence (i.e. most studies contain some methodological weaknesses) of effectiveness of multi-component interventions that:

- focus on advocacy, such as community-based service planning, nurse case management, and non-parental childcare for disadvantaged families, helping to reduce trauma symptoms and stress, and improving child behaviours such as aggression)
- include both therapy and advocacy
- focus on therapy and parenting

The review acknowledged that there is still a lack of evidence for general population interventions for children, and for community based educational interventions that offer more broad prevention.

#### *Other Interventions*

**Short stay residential care for adolescents on the edge of care** - An evidence scope conducted by Dixon et al<sup>28</sup> found support for a restructuring of the care system where short-stay residential care is an option within a continuum of child and family support, rather than simply a last resort. The authors suggested this option could be effective in preventing full entry into care by offering respite and improving young people's relationships with their families. It also suggests where care is considered to still be the most appropriate option, allow the opportunity for a more planned and smoother transition to care, which may in turn promote future reunification.

The combination of direct work with young people and support for their families may better meet the needs of some older adolescents and those with more challenging behaviours.

**Functional Family Therapy** - Along with Multi-Systemic Therapy, Functional Family Therapy (FFT) is an intensive family-focused intervention originating from the US that is previously government funded in the UK. It targets young people aged 10-18 years who are still living at home but have persistent behavioural and/or substance misuse problems. It includes a focus on and assessment of those risks and protective factors that impact on children and young peoples as well as their environment. The weekly sessions over a 3-4 month period aim to reduce disruptive communication patterns and encourage positive interactions among the family.

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<sup>28</sup> Dixon, J. et al. (2015) *Supporting Adolescents on the Edge of Care: The role of short term stays in residential care*. London: Action for Children

An FFT pilot started in Brighton in 2007 and with the first UK randomised controlled trial is being conducted by Kings College in partnership with Brighton and Hove Youth Offending Services. Other randomised controlled trials have equally started in parts of the UK for e.g. in Croydon Council in partnership with Queen's University, Belfast.

***Integrated or multi-dimensional programmes*** - The need to offer a more integrated package of support in order to better meet the complex needs of children and their families has recently been acknowledged (Ward 2014).

With funding from the Department for Education (DfE) Innovation Programme, a project called 'Step Change' was created by Action for Children to bring together Multi-systemic Therapy (MST), Functional Family Therapy (FFT) and Treatment Foster Care Oregon (TFCO) within 1 overall programme, operating across 3 London boroughs with a single referral pathway to provide adolescents and families with access to the most appropriate intervention from the three on offer. However, TFCO was removed early due to concerns about the involved costs and resources as well as the lack of evidence of its effectiveness in the UK. The evaluation found some improvement in follow-up measures (risk taking behaviours including offending; increasing engagement in education, employment and training; improving relationships between young people and families to avoid family breakdown; reduction in need for care or custody), although these were not completed in sufficient numbers to provide a reliable analysis<sup>29</sup>.

Factors that appeared to improve outcomes emerged from the qualitative data with families and workers, including the consistency, frequency and accessibility of the therapy, the meaningful relationship formed with therapists and their perceived impartiality. While the project showed some initial signs of success, the organisations involved decided to close the project after the DfE funding finished, but did recommend that setting up joint commissioning arrangements (between health and social care) would help to maximise the chances of sustainable implementation.

In summary, the evidence base for effective interventions in the UK is generally lacking in robustness but innovative interventions are currently being piloted and evaluated, with findings to be published in the near future. As emphasised by NICE (2017), it is important to take the age and developmental stage of the child into account when selecting an intervention. Furthermore, it should be recognised that even if an intervention is noted as effective by the literature or guidance, it may not suit a particular person, family, and therefore where possible it is encouraged to give children, young people and families a choice of proposed interventions.

## **Reunification**

Foster care is an intervention for children and young people experiencing abuse and or neglect in their home environment. The most common outcome for children leaving care is returning home to their parents or relative. However, evidence suggest that about half of children who come into care because of abuse or neglect suffer further abuse children if they return home, with up to half of those returning into care as a result. Gypen et al.'s (2017) systematic review reviewed 32 studies looking at multiple outcomes with the finding that outcomes were poor for these children across education, employment, housing, health, substance abuse and criminal involvement compared to their peers from the general population. Having a steady home base and getting a foothold in

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<sup>29</sup> Blower S, Dixon J, Ellison S et al. (2017) Step Change: an evaluation. Department for Education. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/585194/Step\\_Change\\_an\\_evaluation.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585194/Step_Change_an_evaluation.pdf)

education is shown to be important in outcomes for children growing up in foster care. Having a steady mentor who gives support when needed is a protecting factor<sup>30</sup>.

A briefing published by the NSPCC 'Returning children home from care: learning from case reviews' identified a number of ways to improve practice for reunification, which are reflected in current legislation and guidance<sup>31</sup> to include the following:

- Thorough assessments
- Clear conditions for return of child
- Preparation for and staged return of the child
- Sharing information and working with professionals in other agencies
- Good monitoring of the child before, during and after the return

### *Thorough Assessments*

A thorough and careful assessment is needed to inform the decision as to whether Looked After Children should return to their family. In a follow-up of 3,872 children looked after by seven local authorities, Wade et al<sup>32</sup> observed that well planned reunifications were associated with more stable reunifications, in particular those which were based on evidence of sustained change in parenting capacity and included provision of support services. Farmer et al<sup>33</sup> also noted greater stability for children returning home as a result of a more thorough assessment, but that 43% of children still returned home without a thorough assessment.

A recent review of the evidence on reunification<sup>34</sup> concluded that an assessment and care plan for reunification should include the following information:

- The types and number of family stressors/difficulties
- An agreement with parents about what needs to change before the child can return home i.e. the problems that led to care and require addressing
- A set of clear targets for parents to meet which are centred on what needs to change prior to reunification and over what timescales, including the consequences if these conditions are not met/risks are not removed
- Interventions and services to address known issues
- Contingency plans i.e. an alternative care placement if return home from care/accommodation is not possible
- Extent of family engagement, in particular compliance with conditions set out in the plan
- Family readiness/parental motivation (e.g. are the parents ambivalent about their child returning home)
- Reason for return home from care/accommodation
- When reunification should commence
- Preparation for reunification and support prior to return home from care
- Support and services post reunification
- Processes for monitoring and reviews following reunification

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<sup>30</sup> Gypen, L., Vanderfaellie, J., De Maeyar, S., Belenger, L. and Van Hoken, F. (2017) Outcomes of children who grew up in foster care: Systematic-review. **Children and Youth Services Review**, Vol 76, May 2017, 74-83.

<sup>31</sup> NSPCC Information Service, October 2015, Returning Home from care – Learning from case reviews.

<sup>32</sup> Wade J, Biehal N, Farrelly N and Sinclair I (2010) Research Brief: Maltreated Children in the Looked After System: A Comparison of Outcomes For Those Who Go Home and Those Who Do Not. London: DCFS/DoH.

<sup>33</sup> Farmer, E., et al (2011) Achieving Successful Returns from Care: What Makes Reunification Work?, London, BAAF.

<sup>34</sup> Hyde-Dryden G, Gibb J, Lea J et al. (2015) Research report: Improving practice in respect of children who return home from care. National Children's Bureau

It is recommended that reunification plans for children in Thurrock consider the above assessment guide.

#### *Gradual timing of reunification*

Studies have found that a gradual, staged return home can increase chances of reunification and lead to a more durable home placement, as it allows time for well managed planning and proper consultation<sup>35</sup>.

A review by Thoburn et al<sup>36</sup> found that reunification is less likely to be successful if the child returns after a short stay in care (less than 3-6 months), suggesting that a short timeframe may not allow sufficient change in the family environment or behaviour to take place. Equally, reunification is less likely to be successful after a prolonged period in care (over 2-3 years) where the child may have settled into a long-term permanent placement, experienced repeated placement disruption, or had minimal contact with their birth parents, impacting on their emotional and behavioural development which may be difficult for the birth parents to manage.

#### *Caseworker engagement and family involvement*

A longitudinal analysis of long-term foster care in the US found that relatively strong caseworker engagement with the family increased the likelihood of reunification<sup>37</sup>. This suggests that that family reunification may be helped by promoting parents' active, positive engagement in the child welfare process.

Research conducted in the UK also concurs that a plan for reunification should also be inclusive of the views of the involved children and families (Hyde-Dryden et al., 2015). Wade et al. (2010) found this factor to be associated with a reunification continuing at six months.

The NSPCC Reunification Practice Framework was developed, implemented and evaluated as a result of collaborative working between the NSPCC, 14 local authorities and the Universities of Loughborough and Bristol, with the ultimate aim of improving outcomes for children in relation to return home from care. It is based on both a detailed literature review of the evidence reunification as well as the experiences of local authorities, and is designed to support practitioners and managers to apply professional judgement to the decision of reunification and how to ensure its success.

In agreement with the research by Biehal et al (2015) returning home will not provide the best outcome in all cases and therefore the Framework recommends that robust assessments of risk of abuse and neglect are necessary to decide whether or not reunification would be the best option based on parental capacity to change among other factors. Most importantly, the child's own interests should be at the centre of all decision-making. Furthermore, as already mentioned, ongoing support, monitoring and review is needed for children and young people who do return home.

An evaluation of the introduction of the Practice Framework in 3 local authorities was conducted by the University of Bristol<sup>38</sup>. Questionnaires and interviews were conducted with practitioners and managers before and after the introduction of the Framework. Prior to its implementation,

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<sup>35</sup> Biehal N, Sinclair I and Wade J (2015) Reunifying abused or neglected children: Decision-making and outcomes. *Child Abuse & Neglect*, 49, pp.107-118.

<sup>36</sup> Thoburn J, Robinson J and Anderson B (2012) SCIE Research Briefing 42: Returning children home from public care.

<sup>37</sup> Cheng, T.C. (2010) 'Factors associated with reunification: a longitudinal analysis of long-term foster care', *Children and Youth Services Review*, vol 32, no 10, pp 1311–1316

<sup>38</sup> Farmer E and Patsios D (2016) Evaluation Report on Implementing the Reunification Practice Framework.

<https://www.nspcc.org.uk/globalassets/documents/evaluation-of-services/implementing-reunification-practice-framework-evaluation-report.pdf>

managers expressed awareness of issues in current reunification practice in their authorities, such as lack of timely assessments, inconsistent practice, lack of access to services and lack of data on outcomes. Practitioners reported that they found the Framework to be useful for all key tasks involved in reunification, and more practitioners felt more confident in conducting an assessment of a parent's capacity to change as a result of the Framework use. There was also an increase in the proportion of managers who established and used data to improve reunification practice to monitor returns home.

## **What works in promoting good outcomes for LAC and YP?**

Good care planning and case management/tracking is fundamental to improved outcomes – this includes regular contact for the child or young person with a trusted key worker (usually a social worker) and effective co-working with other key professionals and carers. Recent research highlights the ongoing need for better quality decision making by social workers, and champions a blurring of the lines between the care system and community-based care to ensure that YP in particular can return home after brief spells in care (via adolescent support teams or other services such as treatment foster care)

Matching services to the underlying needs or problems, which may include mental health, housing, family counselling or substance abuse, have consistently been proven to improve family reunification in US studies<sup>39</sup>.

A UK literature review has emphasised that support from services needs to commence as soon as possible, and should be proactive rather than reactive (Hyde-Dryden et al 2015). Concern has previously been expressed that supporting services tend to be of a short duration; in order for reunification to be successful, interventions need to be delivered for a sufficient duration in order to bring about sustained changes in behaviour/the family situation.

Currently, UK research is limited in regards to the types of interventions or services that work well to support families to enable children to return home from care, but there are ongoing studies being conducted. Below is a discussion of what already exists in the literature.

Effective substance misuse support services may help children to return home from care more quickly than those receiving usual services. An evaluation of the Family Drug and Alcohol Court (FDAC) pilot found that families who experienced the court-based family intervention had higher rates of cessation of parental substance misuse and consequently were more likely to be reunited with their children in comparison to families who received the usual care proceedings (35% vs 19%). Most importantly, neglect and abuse in the year following reunification was significantly lower than the comparison group<sup>40</sup>.

Substance-involved parents also tend to exhibit negative parenting practices and therefore evidence-based parenting interventions are likely to be an important additional service to improve chances of reunification<sup>41</sup>.

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<sup>39</sup> Choi, S. and Ryan, J.P. (2007) 'Co-occurring problems for substance abusing mothers in child welfare: matching services to improve family reunification', *Children and Youth Services Review*, vol 29, no 11, pp 1395–1410.

<sup>40</sup> Harwin J, Alrouh B, Ryan M, Tunnard J (2014) Changing Lifestyles, Keeping Children Safe: an evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings

<sup>41</sup> D'Andrade, A and Nguyen, H (2014) The relationship between parents' use of specific services, treatment problems, and reunification with children placed in foster care. *Journal of Public Child Welfare* 8(1).

The Strengthening Families Program (SFP) for substance-abusing families was created in the US to focus on three targeted areas: parenting skills training, child skills training, and family bonding/attachment with the aim of preventing child maltreatment. Interestingly, the analysis found that programme participation led to higher rates of reunification compared to matched families who did not receive the intervention, despite recovery from addiction not being the focus or requirement for programme participation<sup>42</sup>. This evidence suggests that for some families, parenting interventions which improve parental capacity may be sufficient to promote reunification.

The consensus from evidence reviews is that the programmes are more likely to be effective if they are intensive and multi-faceted, tailored to meet the needs of each member of the family (Ward et al. 2014).

### *Parent mentoring*

Findings from a recent preliminary US study have suggested that a parent mentor programme may help to increase the likelihood of reunification<sup>43</sup>. 98 parents involved in the US child welfare system were invited to participate in 'Parents in Partnership' (PIP), where parents who have successfully navigated the system provide support, information and mentorship to parents whose children are still in care. Of the 73 parents where reunification outcomes were measured, parents who attended the PIP orientation were 5.6 times more likely to be reunified. It is important to note no further data were regarded regarding programme participation, and the orientation attendance reflects the minimal level of involvement in the PIP programme. It is difficult to attribute the higher reunification rate solely to the intervention, as parents who are more motivated to reunify with their children may therefore have been more motivated to attend the PIP programme.

While the findings are in agreement with other US studies that have found promise for parent mentoring in the reunification process (Berrick 2011; Leake 2012), randomised controlled trials and larger sample sizes are needed in future research to determine effectiveness, and the application in a UK context would be welcomed.

### *Child emotional and behavioural support*

As a result of abuse or neglect, Looked After Children and young people may exhibit difficult behaviours. Support from emotional well-being services such as CAMHS or its local equivalent should therefore be offered to address the underlying emotional wellbeing and/or mental health issues, and should continue for as long as needed after the child returns home (NSPCC).

A research briefing from the Social Care Institute for Excellence suggested that while it is not clear if emotional and behavioural support services are associated with reunification, they may be helpful in preventing reentry into care (Thoburn et al. 2012).

### *Ongoing monitoring and support post-reunification*

Statutory guidance is clear that a child should continue to be supported and will often be treated as a child in need or under a Child Protection Plan once they return home. However, evidence reviews have found that interventions tend to end abruptly with no arrangements for long-term support or

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<sup>42</sup> Brook J, McDonald TP and Yan Y (2012) An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review*, 34(4), pp.691-695.

<sup>43</sup> Enano, S., Freisthler, B., Perez-Johnson, D., & Lovato-Hermann, K. Evaluating Parents in Partnership: A preliminary study of a child welfare intervention designed to increase rates of reunification. Accepted for publication September 2016, *Journal of Social Service Research*. doi: 10.1080/01488376.2016.1253634

monitoring of children's circumstances (Hyde-Dryden 2015). Ongoing assessment of the family's needs is necessary as the full extent of many difficulties may not become apparent until sometime into the return home<sup>44</sup>.

In a prospective study with a two-year follow-up of 180 children returned to their parent(s) in six local authorities in England, involvement of another agency or professional in monitoring children was a key factor that contributed to return stability<sup>45</sup>.

The reason this is particularly important for Looked After Children has been highlighted in a study by Biehal et al (2015). This study compared decision-making for 149 maltreated children in seven English authorities (68 reunified, 81 who remained in care) as well as outcomes six months and four years after the return home or decision to remain in care. The two key predictors of reunification were assessments that parental problems had improved and that assessed risks to safety of the child were not unacceptably high. However, one-third of children were returned home despite persisting concerns about unchanged or even worsened family circumstances. Consequently, 35% re-entered care within six months and 63% re-entered at some point during the four-year follow-up period, often due to recurring abuse or neglect. At the final follow-up, positive outcomes were more likely to be experienced by children remaining in care as opposed to those who had returned home, even once children's characteristics and histories were taken into account. Neglected children who had been reunified experienced particularly poor outcomes, regardless of whether reunification was stable or unstable. The authors concluded that due to the high rate of care re-entry and reoccurrence of abuse or neglect, appropriate monitoring and support should be provided after the return to ensure children's safety and well-being.

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<sup>44</sup> Wilkins, M. and Farmer, E. (2015) *Reunification: An Evidence-Informed Framework for Return Home Practice*. Bristol: University of Bristol.

<sup>45</sup> Farmer, E. and Wijedesa, D. (2012) The Reunification of Looked After Children with their Parents: What Contributes to Stability? *British Journal of Social Work* 44 (2). p.348-366.

