MERSEYSIDE Violence Reduction Partnership

PROCESS EVALUATION: WIRRAL WHOLE FAMILY, HIGH INTENSITY THERAPEUTIC PROGRAMME 2021-22

Susan Cowell, Eden E Beggs, Adam T Garland (July 2022)

MERSEYSIDE VIOLENCE REDUCTION PARTNERSHIP https://www.merseysidevrp.com/

Process Evaluation of Whole Family High Intensity Therapeutic Programme, Wirral, September 2021-March 2022

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Abstract

This evaluation illustrates how the Whole Family High Intensity Therapeutic Programme implemented in Wirral, funded by the Home Office via Merseyside Violence Reduction Partnership between September 2021 and March 2022, has had a significant impact for all individuals closed thus far (224/507). Quantitative data demonstrates significant improvement in needs, behaviours, wellbeing and mental health for children, young people, and adults, supporting positive changes in reduced risk and improved protective factors. Qualitative data collected with participants and from observations/interactions of stakeholders with families following their access to the programme is presented.

Conclusions: Further case closure data should be collected, and commitment made by multi-agency partners to review data again over time (e.g. 12 months, 18 months, 2 years, 3 years) to see whether the positive effects achieved in the short term are maintained long-term. Further investment and upscaling of this programme is likely to reduce strain on crisis intervention services in both the short and long-term, whilst improving access and reducing stigma of accessing more timely, early therapeutic support for families.

Recommendations: This should be considered as a joint commissioning opportunity by Supporting Families teams, Child Mental Health Commissioners, Adult Mental Health Commissioners, Children's Social Services and Early Help, Public Health and Merseyside Violence Reduction Partnership. It should also be strategically connected to the new Integrated Care Partnerships and hospital trust NHS Prevention Pledge.[1] It is clear from this evaluation that implementation of a community-based whole family therapeutic programme requires system commitment.

Executive Summary

Key Findings – Importance

Public Health data for Wirral shows that it performs worse than the national average on aspects like alcohol specific hospital admissions for under 18s, rates of parents in treatment for drug misuse problems, number of looked after children and self-harm hospital admissions for 10–24-year-olds. To combat the growing systemic issues associated with violence and experiences of children and young people, underpinned by factors including alcohol, substance misuse, mental health and domestic abuse on the Wirral, the Home Office funded a project working with the local authority Early Help service to provide community-based support for families. This responded to Wirral families' feedback provided about Early Help services. The focus was on preventative, therapeutic support to help early signs of adversity and struggle. It intended to have positive impacts on violence reduction, improvements in mental health, wellbeing, and resilience, with research suggesting more comprehensive impact on co-morbid health outcomes associated with trauma and adversity for todays and subsequent generations living in Wirral.

[1] https://www.champspublichealth.com/subregions-hospitals-commit-to-preventing-ill-health-by-adopting-nhs-prevention-pledge/

Key findings- Relevance/Design

Throughout the duration of the programme (September 2021-March 2022), 324 families were supported. 50% of these families were open to children's social care and 50% were referred by community partners. Stakeholder and staff surveys reviewing the Whole Family High Intensity Therapeutic Programme showed a clear need for a service which provides easy referral pathways to a community-based clinical triage process, which identifies the most suitable trauma-focused therapeutic support, free of waitlists, within a wraparound service for whole families. Starting with the referral coming in from social workers or from community partners, the psychological triage team gathered information and provided access to appropriate interventions in collaboration with the family. A tiered system for the interventions was used: tier 1 was a minimum of 10 weeks of high intensity therapy; tier 2 was access to psychosocial activities and psychoeducation; tier 3 was more extended social activities for adults and children to strengthen their relationships. Each family was assigned a Family Wellbeing Engagement Worker (FWEW) as part of the wraparound service to support the family and encourage engagement. Six key outcome measures were agreed with the Home Office with significant and outstanding improvements evidenced across all:

1. Reduce vulnerabilities by increasing or developing protective factors, for example trusted relationships with adults (family members of safe community members/volunteers) and/or develop positive peer networks
2. Improve social, emotional, and educational wellbeing (most referrals were made based on this criteria)
3. Improve behaviour management and emotional control for child/ren, young person
4. Reduce acts of violence/ aggression through retaliation and/or aggressive behaviour
5. Identify opportunities to improve school or employment attendance/performance for any family members including the target child/ren or young persons in the home
6. Reduce opportunities for victimisation of bullying, criminal or antisocial behaviour

Additional psychometric outcome measurement tools were used prior to and after interventions were assessed by the triage team. Generalised Anxiety Disorder (GAD7) and Patient Health Questionnaire (PHQ9) decreased on average, while Childrens Global Assessment Scale (CGAS) and Chrysali6 (designed for use in the project) increased, all of which demonstrate significant or outstanding impact for families.[2]

Key findings- Feasibility

The data quality is integral to this process of understanding feasibility. Social Services Liquid Logic system was embedded within the lead community delivery provider to manage referrals. Data was extracted regularly throughout the programme from Liquid Logic through PowerBI, which indicated that each family was offered on average three interventions. Most reporting challenges were highlighted as relating to speed of project set-up to meet the funders' timeframe. Liquid Logic streamlined the processes in line with social care and Home Office directives and offers opportunity for longitudinal outcomes studies. However, integration with health data systems would improve ability to measure impact on wider demand on services as well as the impact on families. The risks and mitigations were considered throughout the process to ensure the best interventions were offered throughout and families were fully supported with the intensity they required. Cost-effectiveness is demonstrated using economies of scale with evidence of initial higher expected cost per family than was delivered in practice.

[2] See section 4.1 of full evaluation for outcome data.

This evaluation supports the case that using a public health approach to address behavioural indicators early as an invest-to-save model would likely have a significant impact on wider health and social outcomes for the Wirral population. The current data indicates that the project has significantly improved psychological wellbeing and decreased antisocial behaviours, including violence and aggression. Stakeholder, staff, and participant feedback demonstrated an unmitigated need for this intervention, with most stating this is a gap in service and not offered elsewhere. The current data has been supported and substantiated through previous studies, reiterating that this style of intervention as an early help model and wraparound therapeutic intervention, can be effective.[3] Some case closures are ongoing for this programme at time of evaluation, but short-term outcomes for families are already statistically significant. Overall, there is a need to track whether changes are sustained long-term, which is possible to undertake using the current data collection and reporting mechanisms, along with ongoing partnership relationships between Wirral Early Help teams and the main community delivery provider, where the triage team are based.

Key findings- Scalability

The Wirral Whole Family High Intensity Therapeutic Programme is unique in its design and processes, combining clinical and community approaches for a fully collaborative wraparound intervention for individuals and families to reduce violence and mental health problems. Outcomes are not limited to a likely reduction in violence, but as this is a programme which supports recovery from trauma and adversity and builds resilience, research suggests that by providing a therapeutic buffer, this approach is likely to also have long-term effects on a reduction in co-morbid diseases and wider health inequalities. The evaluation recognises the importance of a central, trauma-skilled community delivery provider with a sustainable business model, to enable to continuation of relationships and support for families beyond their direct involvement in programme interventions. Accessibility and location of services is crucial to the impact this approach can have, alongside the key roles outlined in the design and implementation section of this evaluation. With the right guidance, delivery providers, longer-term commitment from the right strategic leads and appropriate resources, this programme has the potential to make significant impact and consideration should be made as to how it can be rolled-out across the region to further evaluate the potential impact.

[3] See section 5.4 of full evaluation, in particular references: Carr, (2009); Fish, (2003); Mottaghipour and Bickerton (2005); Olson et al., (2021); Solantaus, Toikka, Alasuutari, Beardslee and Paavonen, (2012); Suter and Bruns, (2009); Vedel, Larsen & Aamand, 2020

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1. Background

The government Serious Violence Strategy highlighted the national need to tackle escalating violent crime, especially that which involves children and young people up to the age of 25 years, using a Public Health Approach (HM Government, 2018). Merseyside was subsequently selected as one of the 18 areas across England and Wales to receive additional Home Office funding in 2019 to create Violence Reduction Units, now known as the Violence Reduction Partnership (MVRP) within Merseyside.

Alongside Violence Reduction Units, the Home Office established the Youth Endowment Fund (YEF) in March 2019 with a £200m endowment and ten-year mandate. The YEF's mission is the same as VRUs: to prevent children and young people becoming involved in violence. However, YEF have a national focus on evaluation and research, finding out what works and building a movement to put this knowledge into practice. This has resulted in the YEF toolkit.

In May 2021, the Home Office announced additional funding for Violence Reduction Units (VRUs) to encourage delivery of some of the more developed evidence-based approaches to preventing youth violence, as demonstrated on the YEF Toolkit. One of these approaches was high intensity therapeutic interventions (Cognitive Behavioural Therapy (CBT), Multi-Systemic Family Therapy (MST) and/or Social Skills Training). The turnaround for this funding was incredibly quick (two weeks to collaborate, write and submit application for a minimum of £500,000 to be spent by 31 March 2022) and left VRUs with limited scope to fully consult and tender for provision. Therefore, MVRP approached Local Authority (LA) Early Help teams for expressions of interest, requiring 'mobilisation readiness', amongst other more specific criteria, to have a chance of families benefiting from this funding. Following this process, the Home Office granted funding to one programme of high intensity therapeutic intervention in the Wirral LA area of Merseyside and was given funding to establish the programme from July 2022-March 2023.

On 1 April 2022, the Government announced a further £130m to bolster our efforts to tackle serious violence in 2022/23, including £64m for VRUs. VRUs will receive a multi-year grant agreement, covering 22/23, 23/24 and 24/25 financial years.

As part of a range of approaches to develop, promote and sustain a whole system public health approach to violence prevention, MVRP seek to better understand the need, existing evidence, scope, and potential sustainability for Whole Family High Intensity Therapeutic Programme. This approach aims to work with families with children aged 0-25 years to reduce vulnerabilities to known risk factors of experiencing violence, which may also result from childhood adversity or trauma. MVRP are exploring this preventative, therapeutic approach, which addresses early signs (physical, emotional, or behavioural) of adversity, which could potentially affect a child's development, relationships, education, their engagement with their environment and their ability to thrive in society, as they grow up.

1.1 Evaluation Method

In May 2021, the Home Office invited the 18 Violence Reduction Units to tender for funding to deliver 'High Intensity Therapeutic Interventions'. MVRP supported a successful application from the Community Matters Partnership in Wirral. This report will inform continued development of MVRP and their contribution to mental health and wellbeing of children, young people, and their families across Merseyside. It will retrospectively evaluate the Whole Family High Intensity Therapeutic Programme in Wirral.

Along with the use of more traditional quantitative data being collected like the GAD-7, PHQ-9 and CGAS, the collection of qualitative data was also employed. This offered a distinct advantage when paired along with the quantitative data as the more generalised assessments

were able to track progress while the less structured idiographic conversations were used to identify how and why the changes occurred. Moreover, as suggested by Green (2015) the ideographic approach was more person centred and inclusive especially as many people did not define their problems by the specific parameters of the quantitative assessment questions, while others may have struggled with the language in these questions.

Using a mixed-methods approach, this evaluation also gathered evidence using:

- Stakeholder interviews (n = 32)
- Staff surveys (n = 12)
- Family Outcome Data
- Project Oversight Evaluation Focus Group (n = 5)
- Review of Home Office monthly monitoring (incl. risk register), which includes insights from fortnightly Provider Forum
- Review of Home Office Interim and Final Monitoring reports

The results of this evaluation should be used to develop:

- A logic-model
- A pilot study with more in-depth outcomes and process evaluation
- A tender for extension and expansion of delivery

2. Introduction

2.1 Importance

Based on the data and insight presented in this section, children, young people, and families in the most deprived areas of Wirral face significant challenges to accessing early support, reducing their risk of experiencing a range of social, emotional, and health-related risk factors. Two overarching themes which are prevalent in the participant referral information for the Whole Family High Intensity Therapeutic Programme and in health outcomes data, and which correlate with known risk factors for violence, are mental health and alcohol and substance misuse (Office of Health Improvement & Disparities (OHID), Public Health Analysis Unit (PHAU), Local Knowledge & Intelligence Service (LKIS) (2018-2021); (TIIG (2021-2022); Wirral Intelligence Service, n.d.).

Both data and insight indicate that child and adolescent mental health services are in high demand, but that access to services is perceived to be poor, with thresholds too high to enable prevention or early intervention.

"Been waiting on a CAMHs list forever and getting nowhere with things getting worse"
– Programme Participant

"The wait for CAMHS was ridiculous but I am so glad that Crea8ing Community was available as I prefer this service to CAMHS as it is a wraparound service for the family."
- Stakeholder

2.1.1 'Why Community Matters' Insight Report

In 2019, Wirral Community Matters Partnership commissioned an insight report which engaged over 450 children, young people, parents, carers, guardians, and professionals. The aim of the project was to better understand what an effective and sustainable Early Help model should be for families and communities. This insight was used to inform the design of the Whole Family High Intensity Therapeutic Programme. Here is how it responded to some of the key findings:

Table 1

Community Matters Insight on Challenges Identified by the Community	**Community Matters Recommendations**	**Whole Family HI Therapeutic Programme Response**
Mental Health – wide range of unmet mental health needs (from anxiety and low mood to severe mental illness) which children and families felt current services did not have capacity to meet. Families said that services react to crisis, not preventing a problem from escalating. Many felt that their issues weren't "bad enough" and that services did not listen, reflect, and understand the underlying problem. *"Don't give me time-restrictions, tick boxes or waiting lists."* - Adult	More accessible, low-cost mental health support across the life-course.	Offered a free service with no waiting list for all family members, no matter what their age. There were no thresholds to access the programme, and the focus was to take referrals at early signs of struggle rather than reacting to crisis. All aspects of the programme were designed to be trauma-focussed to enable recovery and the processing of adversity and trauma, reducing risk of escalation to crisis.
Social Isolation – escalation of problems or opportunities for informal support due to a lack of meaningful connection to others. Many families said that they wanted support closer to home, preventing need for travel costs and transport. *"We need places to come together, to meet new people and learn new skills."* – Child/young person	Create experiences that whole families can take part in and the conditions to help build meaningful relationships	Offered activities for the whole family (via extended relationships part of the programme), as well as access to community-based coffee mornings and group sessions to bring people *"who make you feel like you belong, who ground you and with whom you share a common understanding and experience of daily life"* together (Lucy, local parent, writing in Community Matters Insight Report). Programme managers stressed the importance that the offer was flexible as to where therapy could take place (Focus Group). The position of the

		main community centre in an area of high deprivation, but with good transport links and provision in the budget to support any transport costs to families was seen as imperative.
Managing Change – additional support needed during times of significant change to address problems before they escalate. They wanted well-promoted, well-connected services so that they do not have to keep repeating their story. *"Help our parents look after themselves, so that they can look after us."* – Child/young person	Families want clearer information, peer-support groups and trusted people who can offer practical and emotional support	Offered Family Wellbeing Engagement Workers who were from the community with lived/common experiences. They coached families using an empowerment approach to feel confident to access support, removing any practical barriers to access. This included using a strengths-based approach to reduce the fear and shame families said they felt around "needing Early Help". The offer of a central clinical triage team intended that there be less of a burden on the family to navigate what was on offer, and the assurance of information sharing to reduce the need to have to repeat their story to multiple professionals.
Supporting Children with Additional Needs – more inclusive, whole family experiences *"Take on board the reality of my situation without being over-whelmed or referring me on."* - Adult	Offer opportunities for families to have fun together. Especially before a formal diagnosis, families want the opportunity to interact with others going through similar experiences and to gather knowledge and information.	Offered extended relationships activities as well as access to psycho-social support courses which were delivered within the community, accessible for the whole family, and delivered in a non-stigmatising way which allows for positive group interaction. The expectation was that many families referred would have children with learning or behavioural difficulties (as per the intended outcome measures). This was also due to international research findings around the effects of childhood adverse experiences on learning and behavioural difficulties (Burke-Harris, 2018).

2.1.2 Existing Local Response – Futures in Mind (FIM)

A range of strategies are being supported to address emotional health and wellbeing of children and young people via the Future in Mind (FIM) Strategic Partnership, including: online mental health support for children and young people (Kooth.com), support in school (Health Services in Schools), in-school counselling (Action for Children), and crisis support for drug and alcohol misuse for children and young people (Response). There is no provision in the current response strategy for whole family support around this issue, nor is there reference to links existing between adult and child/adolescent mental health services.

FIM is a government approach published in 2015, which aims to improve the emotional health and wellbeing of children and young people. It specifically calls for action on the following five themes:

1. Promoting resilience, prevention, and early intervention
2. Improving access to effective support – a system without tiers
3. Care for the most vulnerable
4. Accountability and transparency
5. Developing the workforce

In Wirral's local response to this approach, the below headline evidence-base is available (Wirral Intelligence Service, n.d.):

- Children and young people (0-24 years) represent 27.6% of the total Wirral population
- Compared with England, Wirral has:
  - Worse – rates of teenage mothers
  - Worse – Good level of development at end of reception
  - Worse – rates of Learning disabilities at secondary age
  - Worse – rates of hyperkinetic disorders, including attention deficit hyperactivity disorder (ADHD)
  - Worse - rates of school-age children with additional social, emotional, and mental health needs (this has increased between 2011/12 and 2019/20 for under 18s)
  - Worse – Alcohol-specific hospital admissions for under 18s
  - Worse – self-harm hospital admissions for 10-24-year-olds (of note, this is significantly above national levels, but there has been a steady reduction since 2010)
  - Worse – numbers of looked after children (99.2/100,000 in Wirral compared with 60.3/100,000 nationally)
  - Worse – rates of parents in treatment for drug misuse problems
  - Worse – levels of child poverty
  - Worse – numbers of lone parent families
  - Similar – rates of hospital admissions for accidental/deliberate injuries in children aged 0-4 years
  - Similar – rates of obesity in children (aged 4-5 years)
  - Similar – rates of low life satisfaction for children aged 15
  - Similar – rates of GCSEs achieved
  - Similar – rates of NEETs (although Wirral is slightly higher)
  - Better – rates of first-time entrants to Youth Justice System (10-17 years)
  - Better – rates of bullying (by a slight margin)

- Of note, Wirral FIM acknowledge that there is a knowledge gap in rates of pre-diagnosable emotional problems and prevalence of mid-moderate mental health problems locally.
- Findings from the 2019 School staff Survey for the FIM Steering Group (of which most respondents, 78.5%, were from mainstream Primary Schools):
    - 68% of respondents expressed dissatisfaction with the effectiveness of young people's access to therapeutic support in CAMHS. However, 65% of respondents stated they were satisfied with the Advice Line provided by CAMHS.
    - School perceived the most important issues affecting mental health and wellbeing of their pupils to be "Exam/School Pressure/Issues", "Self-esteem/Self-confidence/Self-image", "Behavioural outbursts / Anger management" and "parental physical/mental health".
    - 42 of 65 schools reported buying-in additional mental health services to supplement their mainstream offer.

2.1.2a How do these findings relate to the evidence-base for what we know about mental health problems in children and young people?

Research into the effects of childhood mental illness show:

- Just 25% of children who need treatment receive it
- 50% of those with lifetime mental illness (excluding dementia) will experience symptoms by the age of 14. Furthermore, 75% of those with lifetime mental illness will experience symptoms by the age of 24
- Maternal depression is associated with a 5-fold increase in risk of mental health problems for the child
- Boys aged 11-15 are 1.3 x more likely to have a mental illness compared to girls aged 11-15 years
- 60% of looked after children have some form of emotional or mental health problem

2.1.3 Trauma and Injury Intelligence Group (TIIG) Data

The TIIG was established at the Public Health institute in Liverpool John Moores University to develop an injury surveillance system to routinely collect deliberate and unintentional injury data. MVRP have commissioned TIIG since 2019 to enable the continuous monitoring of serious violence-related injuries and offences for Merseyside residents. This section of the report will focus on Wirral and define the need for early intervention and prevention based on emergency services data.

2.1.3aEmergency Department Admissions

Presented here are Hospital Episode Statistics (HES) prepared by Office of Health Improvement & Disparities (OHID), Public Health Analysis Unit (PHAU), Local Knowledge & Intelligence Service (LKIS) and provided to TIIG.

From Merseyside Hospital Admissions data for violence (including sexual violence) between April 2018 to March 2021, the following picture of admissions where violence is included in a diagnosis field for Wirral patients can be extrapolated (OHID, PHAU, LKIS, (2018-19 to 2020-21)). This data will focus on demographic characteristics of sex, age, and deprivation.

2.1.3b Overall Admission Numbers

- From the time between 2019 and 2021 655 people were admitted to hospital with the diagnosis code of violence.
- Men were more likely to be admitted to hospital than women: 71% of all hospital admissions in this period were men.

- The age group with the highest hospital admissions was 20-29 years (28%), closely followed by 30-39-year-olds (25%). 0-9-year-olds represented 2% of all admissions and 11% were aged 10-19.
- There is a strong correlation between high deprivation and admissions to hospital for Wirral patients: 65% of patients admitted to hospital were from the most deprived areas of Wirral (IMD quantile 1). 3% were from the least deprived areas of Wirral (IMD quantile 5).

2.1.3c Admissions related to Alcohol

This is where the cause of admission to hospital included violence in a diagnosis field, but there was also alcohol-specific (wholly attributable) ICD10 code in any diagnosis field. Headlines include:

- Men were more likely than women to be admitted for violence related causes where alcohol was involved. 29% of all male patients admitted had cause codes of violence and alcohol, whereas 26% of women admitted had the same two cause codes.
- The age groups with the highest proportion of hospital admissions where both violence and alcohol were coded as causal factors were 50-59 and 60-69 both at 50%. Of the total hospital admissions for 0-9-year-olds, none had diagnosis fields for violence and alcohol, whereas for both 10-19-year-olds and 20-29-year-olds 14% admitted to hospital had violence and alcohol as diagnosis fields. For 30-39-year-olds and 40-49-year-olds, 31% and 43% respectively had diagnosis fields of violence and alcohol.
- There is a correlation between deprivation and admissions to hospital with violence and alcohol diagnosis fields completed (27% of patients from areas of Wirral which are IMD quantile 1 (most deprived) had violence and alcohol fields complete).

2.1.3d Admissions related to Substance Misuse

This is where the cause of admission to hospital included violence as a cause code, but there is also a substance-misuse related ICD10 code in any diagnosis field. Headlines include:

- Women were more likely than men to be admitted for violence related causes where substance-misuse was involved: 71% of women admitted had cause codes of violence and substance-misuse, whereas 65% of all male patients admitted had the same two cause codes).
- The age group with the highest proportion of hospital admissions were both violence and substance-misuse were coded as possible causal factors was 50-59 years (79%), closely followed by 40-49-year-olds (78%). 0% of 0-9-year-olds, 43% of 10-19-year-olds and 61% 20-29-year-olds admitted to hospital had violence and substance-misuse diagnosis fields completed. While 30-39 (72%), 60-69 (75%) and 70-79-year-olds (67%) had admission codes of both violence and substance misuse.
- The correlation with deprivation is even stronger than alcohol-related diagnosis for admissions to hospital with violence and substance-misuse diagnosis fields complete (70% of patients from areas of Wirral which are in IMD quantile 1 (most deprived) had violence and substance-misuse fields complete).

2.1.3e Admissions related to Mental Health

This is where the cause of admission to hospital included violence as a cause code, but also had a mental health related ICD10 code in any diagnosis field. Headlines include:

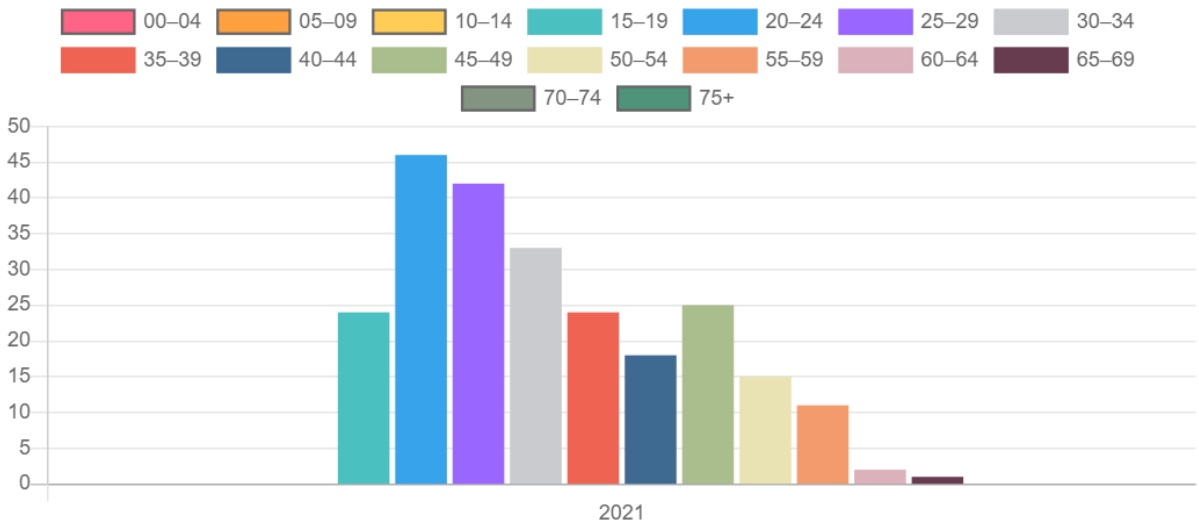
- Women were more likely to be admitted to hospital for violence related causes where mental health was involved than men: 39% of women admitted had violence and mental health diagnosis fields completed, whereas 38% of men admitted had the same two fields recorded.
- Ages 20-29 and 30-39 were the peak age groups for hospital admissions for both violence and mental health, both being 70 individuals (39% and 44% respectively). However, proportionally more 50-59-year-olds were admitted with these diagnostic fields (50%). 0-9-year-olds did not have any hospital admissions due diagnosis fields of both mental health and violence. For 10-19-year-olds 21% of violence admissions were related to mental health, while it was 50% for 50–59-year-olds.
- The correlation between deprivation and admissions to hospital where violence and mental health diagnosis fields are complete shows that more deprived areas of the Wirral had higher admission rates due to both violence and mental health than less deprived areas (43% for IMD 1, 35% IMD 2 and 33% for IMD 3).

2.1.3f 2021 – Alcohol and Violence-related Attendance

From TIIG Merseyside Emergency Department Attendance data, the following represents trends in Wirral residents *attending** any Emergency Department between 1 January 2021 and 31 December 2021 for violence-related injuries. This is where the patient disclosed that they had consumed alcohol:

- Men from Wirral were more than twice as likely to attend Emergency Departments than women (69% were male).
- The peak age group for attendance was 20-29 years (36%), with over half (52%) of attendances from this age group being 20-24-year-olds. The next age group with the most attendances was 40-49 years (18% of total attendances for violence where alcohol was disclosed as having been consumed). See Figure 1.
- The majority are self-referrals (82%) to emergency departments
- The majority were discharged with no follow-up (58%)
- Most violence-related attendances involved a ‘combination of body parts’ as the assault weapon recorded by emergency departments (35%) followed by ‘fist’ (24%). Sharp/bladed objects, bottles, glass, knives were recorded as having been used for 12% of violence-related attendances (specifically knife-related injuries represented 4% of violence-related attendances).

Figure 1



Source: TIIG, Violence Reduction Partnership Hub, Data Hub Charts, Emergency Department Attendances, 01/01/2021 – 31/12/2021, Grouped by Age for Wirral LA residence where 'Alcohol Consumed' = 'yes'

**Please note that this is Emergency Department Attendances, rather than admissions data.*

2.1.4 ADDER – Place-based Accelerator 2021-2023

Wirral is a recipient area for government 'place-based accelerator' funding (£2.8 million over two years 2021-2023) to reduce significant issues in drug-related deaths, drug-related offending, and the prevalence of drug use. This project is called ADDER (Addiction, Diversion, Disruption, Enforcement, Recovery) and brings together local partners in law enforcement, criminal justice, public health, children and young people, health, housing, employment, and specialist drug treatment to deliver a whole system response to drug misuse and drug-related crime. Wirral was selected for this project based on crime, health, and criminal justice indicators. Admissions to hospital for alcohol-related conditions in Wirral is significantly higher than the England average (Public Health England, C21, (2020-2021)). The rate of deaths from drug misuse in Wirral (10.1 per 100,000) were double the England average (5 per 100,000) (Public Health England, C19d, (2020)). Detail of proposed interventions in ADDER programme can be found here. Of these interventions, the following are noteworthy in relation to their potential to interact with the Whole Family High Intensity Therapeutic Programme:

- Recruitment of post in Wirral Ways to Recovery focused on drug using families with children who are engaged with the criminal justice system.
- Recruitment of post to work with families of those associated with substance misuse. This is a whole family approach and will also see the development of a website and strengthening of the provision of a 24-hour helpline.

This accelerator funding was not available to the Whole Family High Intensity Therapeutic Programme managers and commissioners at the time of its inception. However, it would be beneficial to the Whole Family High Intensity Therapeutic Programme to be aware of and connected with those delivering and coordinating a whole family approach supported by the accelerator funding.

2.1.5 Domestic Abuse

The Children's Commissioner's Office (CCO) produced an estimate of the prevalence rates of children living in households experiencing Domestic Abuse (DA). There is no available or consistent data on prevalence of this issue and so it important to note that this data uses statistical modelling to present an estimate and is therefore experimental (Clarke, 2019). The data used initially was from the 2014 Adult Psychiatric Morbidity survey (APMS) and looked at whether an adult has ever experienced DA and whether an adult had experienced DA within the last year (Clarke, 2019). The CCO has projected that 7.39% of children (4,990 0-17-year-olds) in Wirral experienced domestic abuse in the last year.

Data collected as part of the Whole Family High Intensity Therapeutic Programme over the seven-months of delivery revealed that 58% of families referred to the programme disclosed experiences of domestic abuse. Alongside the aforementioned factors of living in households where members abuse substances, domestic abuse (specifically violence against the mother) is one of the seven categories recognised Adverse Childhood Experiences (ACEs) in the original Felitti et al. (1998) study. Also known as Intimate Partner Violence (IPV), McDonald et al. (2016) cite several research studies linking exposure to IPV with physical, mental health and behavioural problems, experience across the life-course. Graham-Bermann et al. (2009) conclude in their study that children's ability to adjust is influences by "parent functioning". The whole family approach therefore has the potential to play a significant role in family recovery and re-building of resilience and adjustment skills for those children who have experienced or witnessed domestic abuse.

2.1.6 Research: Mental Health, Substance Misuse and Violence

Research has found that along with victimisation of IPV, mental health including anxiety, depression and PTSD were all linked with perpetration of IPV (Spencer et al., 2019). Similarly, it was found that drinking, drug use and serious mental health struggles are common amongst perpetrators of IPV, and they are at higher risk of having unmet mental health care needs (Lipsky, Caetano and Roy-Byrne, 2010). Meanwhile Ganson, O'Connor and Nagata (2021) found physical violence perpetration to be higher in students who have experienced poor mental health, self-harm, and substance use within the previous 12 months. Domestic violence has been linked with child psychopathology (McCloskey, Figueredo and Koss, 1995) and mental health, indicating it is an area that needs to be targeted as it may have bidirectional effect. Substance misuse was linked to mental health, with those struggling with substance misuse disorders having previous psychiatric disorders diagnosed (Weaver et al., 2003). Population surveys have indicated that over half of those who struggle with mental health will also have an issue with substance misuse (Kelly and Daley, 2013; Ross and Peselow, 2012). However, it should be noted there are preconceptions about substance misuse being linked to mental health problems (Adams, 2008). The links between mental health, substance misuse, aggression and violence perpetration are well established, with Vagi et al. (2014) encouraging interventions to reduce violence, particularly dating violence, to be focused on reducing risk factors for the vulnerable and those who have Adverse Childhood Experiences. The links between mental health, substance abuse and violence need to be considered carefully, as the stigma around the belief that all individuals with mental health problems will be violent can be damaging (Arboleda-Flórez, Holley and Crisanti, 1998).

2.1.7 Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) refers to abuse, trauma or household disturbances witnessed as a child, originating from Felitti et al., (1998) who identified the importance of breaking cycles of ACE's. Felitti et al., (1998) found ACEs had a significant impact upon shortened life expectancy, due to increased risk of impulsive behaviours, such as violence or anti-social activity. This highlights a need for early intervention to prevent ACE's negative impacts, in turn reducing risk taking behaviours and violence. An immediate public need has arisen, with a necessity of early identification of ACE's (Oral et al., 2016), for the betterment of support across community, social and health care. It is important to note that ACEs are not a predetermining factor for further adverse experiences, nor should they be used to target interventions to individuals. ACEs information is included in this evaluation to demonstrate population-level correlations between adversity in childhood and the potential of increased vulnerability to outcomes demonstrated in the programme criteria for the Whole Family High Intensity Therapeutic Programme. This section also serves to illustrate the interconnectedness of adverse experiences in childhood which may increase a population's vulnerability to negative health and social outcomes, along with the potential for intergenerational transmission of adverse experiences.

2.1.7a ACEs and Mental Health

Building from Felitti et al. (1998) original study, evidence has found that increased ACEs are linked to mental health problems later in life (Sheffler, Stanley and Sachs-Ericsson (2020). De Venter Demyttenaere and Bruffaerts (2013) found emotional, physical, and sexual abuse are important factors in developing depression, while family violence and sexual child abuse were linked to anxiety disorders. Meanwhile, findings also suggest that the impact ACEs have on depression in adolescents occur regardless of gender (Schilling, Aseltine and Gore, 2007). Similarly, when using an advanced ACEs questionnaire which includes being smacked as a child, there was a link between the ACEs score, frequency of suicide attempts and depressive affect amongst drinking and drug users (Merrick et al., 2017). Moreover, Fuller-Thompson et al. (2016) found parental domestic abuse, childhood sexual abuse and childhood physical abuse all to be linked with suicide attempts in adults.

2.1.7b ACEs and Substance Misuse

Along with mental health problems, a link between ACEs and substance misuse has been established (De Venter, Demyttenaere, & Bruffaerts, 2013). Wu, Schairer, Dellor and Grella (2010) found amongst people who have substance use disorder and mental health problems, 65.9% had experienced childhood abuse and neglect, 49.3% had experienced physical abuse and 48% had experienced sexual abuse as children, with ACEs being more prevalent in a substance use disorder population than in the general population (Leza, Siria, Lopez-Goni and Fernandez-Montalvo, 2021). It is also suggested that there is a dose-response relation between the number of ACEs an individual has and the use of illicit drugs (Gonçalves et al., 2016). Furthering this, Fuller-Tomson, Roane and Brennenstuhl (2016) identified that the 3 types of ACEs; sexual abuse, physical abuse, and exposure to parental IPV were all associated with increased drug and alcohol misuse in adult life. There may also be a link between ACEs and illicit drug use throughout adolescence, early adulthood and even into parenthood (Dube et al., 2003; Karamanos, Harding and Lacey, 2022).

The reasoning for ACEs being so interconnected with substance misuse may be due to brain changes because of prolonged pre-puberty stressors. Enoch (2011) identified links between early life stress and changes to the centres of the brain involved in the development of addictions. Moreover, stress has been linked to changes in the hypothalamic-pituitary-adrenal (HPA) axis of the brain, having an impact on drug reinforcement, with evidence implying stress impacts on drug use at all stages of drug misuse (Kreek et al., 2005; Moustafa et al., 2021).

Along with drug use, evidence has found ACEs to be increasingly associated with binge drinking (Loudermilk et al., 2018), heavy drinking (Crouch et al., 2017), alcohol misuse and having a partner who also misuses alcohol (Dube et al., 2002).

2.1.7c ACEs and Violence

Jaffe et al. (2013) identified that mothers who had experienced history of abuse had children who were more likely to experience similar neglect or abuse compared to mothers who had not experienced abuse. Moreover, those who maintained the cycle of abuse reported higher levels of mental health struggles, social relationship problems and domestic abuse relationships. Furthering these claims, Eriksson & Mazerolle (2014) found witnessing Father to Mother IPV and bi-directional IPV predicted male perpetration of IPV. Furthermore, Karakurt, Keiley and Posada (2013) identified attachment insecurity to be linked to the likelihood of victimisation of dating aggression. Evidence has also identified that an individual's emotional regulation difficulties may impact the relationship between childhood maltreatment or witnessing IPV and IPV within their relationship as an adult (Oliveros & Coleman, 2019).

Beyond IPV, exposure to violence as either a witness or victim has been linked to childhood delinquency (Tsang, 2017). Moreover, witnessing violence, physical assaults and neglect were also linked to later adult criminality (Howel et al., 2017). Duke et al., (2010) found each type of ACE to be associated with a variety of adolescent violence like bullying, weapon-carrying, and dating violence as well as more self-directed violence like self-mutilation, suicidal ideation, and attempts.

2.1.7d Breaking the Cycle: Evidence-based Approaches

The evidence implying a relationship between ACEs, mental health, substance misuse and violence demonstrate that work must be done to reduce the impact of ACEs to improve public health. Bettering the bonds and attachments within family units has been found to result in an inverse relationship between antisocial traits, including violence with maternal and paternal care (Schoor et al., 2020). Research has shown that parenting styles of warmth and consistency along with maintaining safe, stable, and nurturing relationships are linked with reduced intergenerational antisociality, maltreatment and trauma (Thornberry et al., 2003; Schofield, Lee and Merrick, 2013, Gee et al., 2021). These findings demonstrate the role that education of family relationships and parenting styles can play in halting the trauma cycles.

Along with education, providing social support for mothers who themselves have experienced domestic abuse or ACEs has been found effective, particularly if the children are young (Tracy, Salo and Appleton, 2018; Bartlett and Easterbrooks, 2015). Evidence has found that improving protective factors for adolescents can reduce the likelihood of substance misuse. Protective factors such as engaging in organised activities, having trusted adults in school, in the community and at home, having a strong bond with parents and parents being understanding of children’s needs or problems (Afifi et al., 2022). Moreover, interpersonal relationships as well as more expressive arts has helped to improve self-esteem, stress management and mitigates the impact of the ACEs exposure (Pliske, 2020). More conventional therapy has been found to be equally effective on people with ACEs compared to those without ACEs (Edinger et al., 2020). Therefore, early help models addressing the need for social support, education of parental techniques and therapies could be beneficial not only to the parents but also implicitly beneficial to the children through helping to reduce trauma cycles.

2.2 Aim of the project

The whole family therapeutic programme in Wirral did not specify a hypothesis due to the short-term nature of the funding for this programme. Rather it identified six key outcome criteria against which impact could be measured in the short term. However, the programme was developed using the existing evidence-base for the impact of Cognitive Behavioural Therapy (CBT) and CBT-informed approaches on reducing behavioural difficulties associated with violence and violent crime (Gaffney et al., 2021).

2.2.1 Project Outcome Criteria

Six project criteria for referral against which outcomes can be measures from pre-/post-intervention were designed, in-line with Home Office requirements for reducing risk of violence. These were:

1. Reduce vulnerabilities by increasing or developing protective factors, for example trusted relationships with adults (family members of safe community members/volunteers) and/or develop positive peer networks
2. Improve social, emotional, and educational wellbeing (most referrals were made based on this criteria)
3. Improve behaviour management and emotional control for child/ren, young person
4. Reduce acts of violence/ aggression through retaliation and/or aggressive behaviour
5. Identify opportunities to improve school or employment attendance/performance for any family members including the target child/ren or young persons in the home
6. Reduce opportunities for victimisation of bullying, criminal or antisocial behaviour

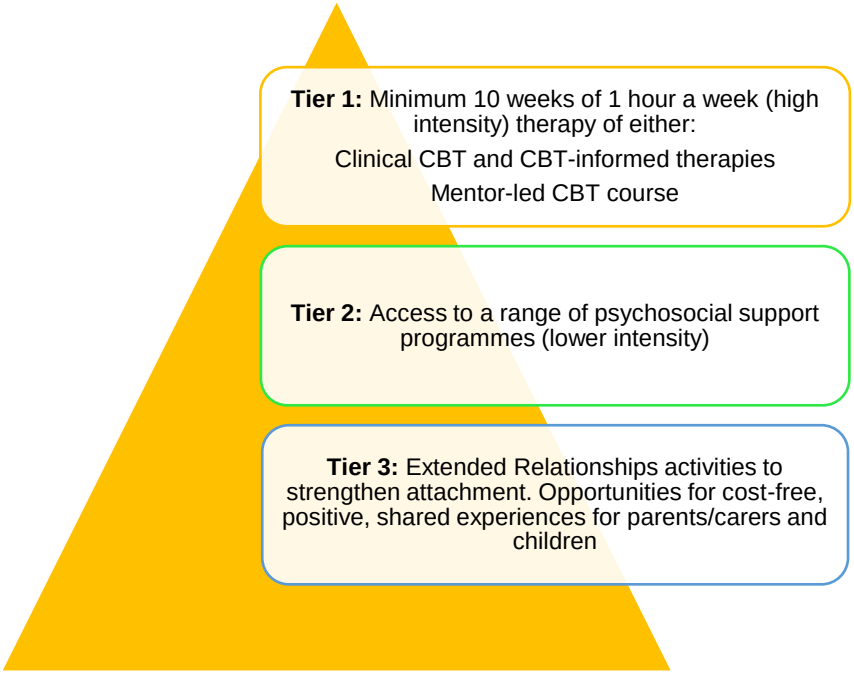
3. Delivery

3.1 Relevance

3.1.1 Design and Implementation

A Logic Model was developed as part of the initial funding proposal and can be seen in Figure 3. In summary, the current approach has been to locate services within a community setting using well-accessed community providers with a track record for offering culturally competent, trauma-informed services with trauma-skilled workforces to offer a tiered therapeutic approach. Three tiers of support were established (see Figure 2).

Figure 2



Underpinning all tiers of the programme was:

- A **clinical triage team** based at Crea8ing Community and overseen by a senior clinical psychologist
- **Family Wellbeing Engagement Workers** (FWEW) employed by Crea8ing Community
- **Use of Liquid Logic Early Help Management System** embedded in Crea8ing Community with access for the project administrator and clinical triage teams

Staff roles across the programme included:

- Programme Manager (Wirral LA) x 0.3 FTE average
- Programme Co-Ordinator (Crea8ing Community) x 1 FTE
- Programme Administrator (Crea8ing Community) x 1.5 FTE
- FWEWs (Crea8ing Community) x 6 FTE
- Data Support (Wirral LA) x 0.1 FTE
- Finance support (Wirral LA) x 0.1 FTE
- Assistant Psychologist Triage (Crea8ing Community) x 3 FTE

- Senior Clinical Psychologist - Oversight of triage and supervision (Seachange) x 0.8 FTE
- Parent-led CBT, pre-therapy, therapy, and clinical team oversight (BlueSphere) x 1 FTE
- Qualified and registered therapists (Heswall Hills) x 30
- Mentor-led CBT project staff (Open Door) x 3 FTE

In addition, the programme provided funding to community delivery providers to increase staffing provision to enable them to increase their offer of:

- Access to youth centre provision (Shaftesbury)
- Access to child-parent relationship building, fun activities:
    - Journeymen
    - Glo
- Additional hours for Fender Primary Play Therapist to increase caseload to include pupils from other primary schools to extend the promising model of practice.[4]

3.2 Focused parenting courses – ACEs recovery

To reduce the impact of ACEs, the programme worked with a trauma focused, person-centred community interest group (Crea8ing Community), focused on breaking negative generational trauma cycles and empowering individuals to try and then maintain more positive life choices. The need for education of parenting techniques was addressed through a variety of courses around ACEs, addressing child mental health and positive discipline to create a more positive family environment. The therapeutic need was addressed through high intensity therapies, including CBT, EMDR and systemic family therapy, along with other support like holistic coaching and mindfulness. Meanwhile, the need for more social focused support was addressed through social meetups, and the use of FWEWs to provide a wraparound 1:1 support for families should they want it. All services were offered with a trauma-informed focus, with trauma-informed practice being instrumental in understanding a young person's antisocial development and psychological maladjustment (DeLisi et al., 2020), especially for vulnerable groups (like refugees) (Shi, Stey & Tatebe, 2021).

3.3 Dose

The programme started receiving referrals in mid-September 2021 and stopped taking referrals in March 2022. Over the course of these seven months:

- A total of 507 individuals across 324 families were referred.
- The average number of interventions each family received was 3.
- High Intensity (min. 10 weeks x 1 hour per week) Clinical Therapy was delivered to:
    - 157 unique children
    - 39 unique adults (over 18, so includes some young people)
    - Parent-led CBT was deemed appropriate for 7 families
- High Intensity (10 weeks x 1 hour per week) Mentor -led CBT was delivered to:
    - 77 unique children
    - 14 adults (Colours programme)

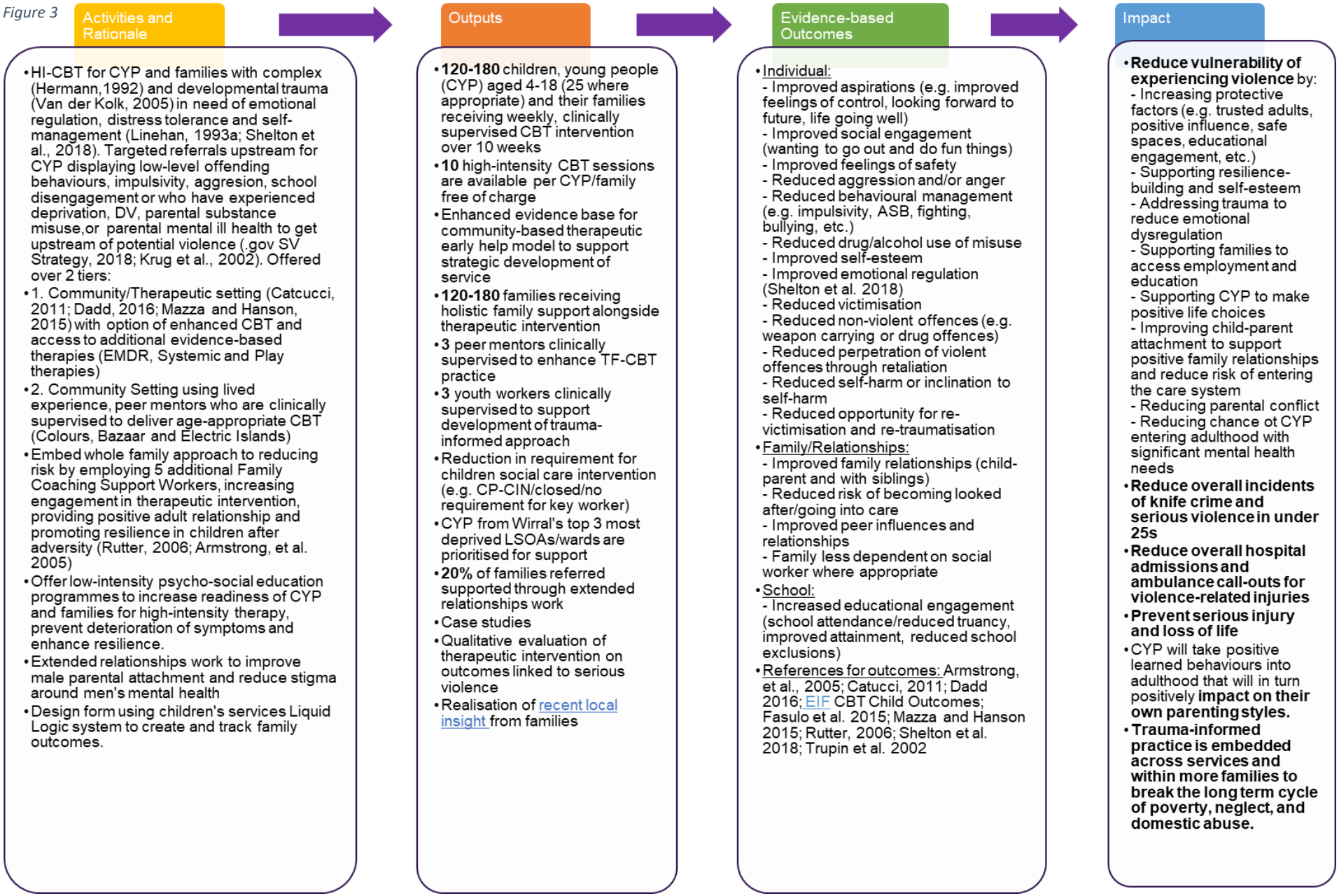
[4] Whole School ACEs and Trauma approach led by Fender Primary is currently being evaluated separately by Chester University. This intervention was added in the autumn 2021, as agreed with the Home Office, as a means of addressing contextual educational factors to improve outcomes for a few targeted children and young people. Initial reflections from the Programme Coordinator indicates that this is a much-needed approach across more primary and secondary schools. However, in some instances, referrals from schools were deemed by practitioners to be part of an exit plan for removing children from mainstream education. In these instances, it is expected that use of this approach will not yield positive outcomes for children.

- In order of the most accessed psycho-social support programmes (including those accessed as 'secondary', supportive interventions to higher intensity therapy):
    - **10-week ACEs programme**, accessed by **107** parents/carers
    - **Strengthening Families programme**, accessed by **79** parents/carers
    - **Meerkat and me programme**, accessed by **78** families
    - **Mind over Natter**, accessed by **67** parents/carers
    - **Youth Connect 5**, accessed by **50** families
    - **DV Recovering,** accessed by **22** parents/carers
    - **Better in Schools**, accessed by **22** families
    - **ACEs awareness**, accessed by **18** parents/carers
    - **Chance for Change**, accessed by **14** young people
    - **Fender Primary, trauma-focussed school integration programme**, accessed by **4** families
- The following programmes were accessed to improve family engagement in therapeutic interventions:
    - Journeymen, accessed by **21** families
    - Glo (portrait photography), accessed by **54** families
    - Pilgrim Street, accessed by **39** new children and young people
    - Shaftesbury Youth Club, accessed by **57** new children and young people

3.4 Reach

- 48% of referrals were aged 10-15 years
- 50% of families were open to social care at point of referral.
- 41% of children referred were SEND (Special Educational Needs and Disabilities) or had EHCP (Education and Health Care Plan).
- Where data exists (for 111 children), 53% of children had less than 90% school attendance.
- Over half of referrals were for families living in the ward areas of Liscard, Birkenhead and Tranmere, Bidston and St James Leasowe and Moreton East. These wards also represent areas with the highest deprivation (IMD 2019).
- 79% of families disclosed a history of trauma
- 50% of families disclosed experiences of domestic abuse
- 24% disclosed alcohol/drug misuse

Figure 3


Activities and Rationale
• HI-CBT for CYP and families with complex (Hermann,1992) and developmental trauma (Van der Kolk, 2005) in need of emotional regulation, distress tolerance and self-management (Linehan, 1993a; Shelton et al., 2018). Targeted referrals upstream for CYP displaying low-level offending behaviours, impulsivity, aggresion, school disengagement or who have experienced deprivation, DV, parental substance misuse,or parental mental ill health to get upstream of potential violence (.gov SV Strategy, 2018; Krug et al., 2002). Offered over 2 tiers:
• 1. Community/Therapeutic setting (Catcucci, 2011; Dadd, 2016; Mazza and Hanson, 2015) with option of enhanced CBT and access to additional evidence-based therapies (EMDR, Systemic and Play therapies)
• 2. Community Setting using lived experience, peer mentors who are clinically supervised to deliver age-appropriate CBT (Colours, Bazaar and Electric Islands)
• Embed whole family approach to reducing risk by employing 5 additional Family Coaching Support Workers, increasing engagement in therapeutic intervention, providing positive adult relationship and promoting resilience in children after adversity (Rutter, 2006; Armstrong, et al. 2005)
• Offer low-intensity psycho-social education programmes to increase readiness of CYP and families for high-intensity therapy, prevent deterioration of symptoms and enhance resilience.
• Extended relationships work to improve male parental attachment and reduce stigma around men's mental health
• Design form using children's services Liquid Logic system to create and track family outcomes.
Outputs
• 120-180 children, young people (CYP) aged 4-18 (25 where appropriate) and their families receiving weekly, clinically supervised CBT intervention over 10 weeks
• 10 high-intensity CBT sessions are available per CYP/family free of charge
• Enhanced evidence base for community-based therapeutic early help model to support strategic development of service
• 120-180 families receiving holistic family support alongside therapeutic intervention
• 3 peer mentors clinically supervised to enhance TF-CBT practice
• 3 youth workers clinically supervised to support development of trauma-informed approach
• Reduction in requirement for children social care intervention (e.g. CP-CIN/closed/no requirement for key worker)
• CYP from Wirral's top 3 most deprived LSOAs/wards are prioritised for support
• 20% of families referred supported through extended relationships work
• Case studies
• Qualitative evaluation of therapeutic intervention on outcomes linked to serious violence
• Realisation of recent local insight from families
Evidence-based Outcomes
• Individual:
- Improved aspirations (e.g. improved feelings of control, looking forward to future, life going well)
- Improved social engagement (wanting to go out and do fun things)
- Improved feelings of safety
- Reduced aggression and/or anger
- Reduced behavioural management (e.g. impulsivity, ASB, fighting, bullying, etc.)
- Reduced drug/alcohol use of misuse
- Improved self-esteem
- Improved emotional regulation (Shelton et al. 2018)
- Reduced victimisation
- Reduced non-violent offences (e.g. weapon carrying or drug offences)
- Reduced perpetration of violent offences through retaliation
- Reduced self-harm or inclination to self-harm
- Reduced opportunity for re-victimisation and re-traumatisation
• Family/Relationships:
- Improved family relationships (child-parent and with siblings)
- Reduced risk of becoming looked after/going into care
- Improved peer influences and relationships
- Family less dependent on social worker where appropriate
• School:
- Increased educational engagement (school attendance/reduced truancy, improved attainment, reduced school exclusions)
• References for outcomes: Armstrong, et al., 2005; Catucci, 2011; Dadd 2016; EIF CBT Child Outcomes; Fasulo et al. 2015; Mazza and Hanson 2015; Rutter, 2006; Shelton et al. 2018; Trupin et al. 2002
Impact
• Reduce vulnerability of experiencing violence by:
- Increasing protective factors (e.g. trusted adults, positive influence, safe spaces, educational engagement, etc.)
- Supporting resilience-building and self-esteem
- Addressing trauma to reduce emotional dysregulation
- Supporting families to access employment and education
- Supporting CYP to make positive life choices
- Improving child-parent attachment to support positive family relationships and reduce risk of entering the care system
- Reducing parental conflict
- Reducing chance ot CYP entering adulthood with significant mental health needs
• Reduce overall incidents of knife crime and serious violence in under 25s
• Reduce overall hospital admissions and ambulance call-outs for violence-related injuries
• Prevent serious injury and loss of life
• CYP will take positive learned behaviours into adulthood that will in turn positively impact on their own parenting styles.
• Trauma-informed practice is embedded across services and within more families to break the long term cycle of poverty, neglect, and domestic abuse.

3.5 The Process

3.5.1Summary

The ethos of the project was to reduce violence and criminalisation through providing support for the whole family unit. The clinical triage process for the project was unique in how the contact was made within 24 hours of referral and a turnaround target of 3 days. The triage process offered a non-judgemental safe space for families to feel like they can open-up about their experiences and trauma. This was approached using a conversational style to make each individual feel comfortable and acknowledged. Assessments were conducted using the GAD-7, PHQ-9, CGAS and the projects own Chrysali6 (see section 4.1.1 Outcomes Data for more detail). During the triage, a collaborative approach between the triage team and the family was used to set up the most applicable and useful support for the family. Following triage, families have access to the wraparound service of a Family Wellbeing Engagement Worker (FWEW) who would help to empower the family and remove any practical barriers of accessing the interventions. Once the interventions were completed a closing conversation with the triage team was conducted to repeat the same assessments to evaluate the efficacy of support. This closing conversation also gained qualitative inputs for constructive feedback, along with helping the family to reflect on the progress they have made.

3.5.2 Referral

Referrals were received through a variety of pathways, social care, community, and self-referral. Initially the project outlined a ratio of 75:25 social care to community referrals with around 120 families intended to be put through the project. However, due to demand from referrers the ratio was updated to 50:50 and there would not be a cap on the number of families referred in. Each referrer would gain consent from the family to refer to the project and then would fill in the referral form together.

The community referral form contained demographic and contact details of the family and the referrer (see Appendix D – E-Form for Community Referral Pathway). Furthermore, the form identified the needs of the family in context of the six project criteria along with establishing any previous help. Four additional questions were asked to identify any previous trauma, domestic abuse, substance misuse or additional needs. Due to the open-ended nature of these questions, many referrers often added a lot of information, particularly for the domestic abuse and previous trauma questions. This information was then used during the triage to focus the conversation, but also to ensure families are comfortable and are not pressured to re-disclose information which may cause further distress. The additional needs question also helped to establish whether reasonable adjustments needed to be made during triage or for the interventions. Community, self-referral, and social care all had the same referral form, however, social care utilised liquid logic to complete the form. All referrals were then copied and put onto everyone's profile on Liquid Logic to collate data.

All referrals are triaged for appropriate intensity of support, depending on developmental stage or cognitive ability (Fonagy et al. 2002). All lower-level psycho-social interventions target behaviours and cognitions to improve mental and physical health, supporting the non-unitary aspects which constitute CBT (Castagna et al. 2020). This triage stage determines which families would benefit most from family therapy or therapeutic interventions and a plan is agreed with the family.

3.5.3 Contact

As part of an agreed timeframe, the clinical triage team aimed to make initial contact with a family within 24 hours. Firstly, with a call then a follow up text if they did not respond to the call. The triage team then attempted to continue contact for the following 3 days, if this was unsuccessful the next step was to contact the referrer, requesting they prompted the family to

engage with the triage team or confirm the contact details. While this timeframe remained consistent, due to receiving referrals from a variety of pathways the triage team were adaptable to the best way to contact families. For instance, one family was already engaging with Crea8ing Community and felt anxious over the phone, a pre-arranged face-to-face triage in a familiar setting was preferable.

3.5.4 Triage

Throughout the triage, the clinical team at Crea8ing Community maintained flexibility to the person being triaged, utilising a person-centred approach whereby they can guide the conversation. This was intended not only to help the individual to feel in charge of the conversation but also if they felt uncomfortable or distressed talking about a certain topic, the topic was not forced. This helped to promote a pre-therapy safe space whereby they could talk through things that they may not have managed to talk about previously in a non-judgemental atmosphere.

The clinical triage team occasionally used prompts when appropriate to funnel the conversation to ensure they ascertained enough information to set up support. From each triage, the aim was to gain information on the individual's experience, the mental health of the family, any ACEs the family may have experienced, along with assessing against the GAD, PHQ, CGAS and Chrysali6 tools (detailed in 4.1.1 Outcomes Data). The clinical team attempted to keep the triage on a conversational level to ensure everyone felt listened to and acknowledged, rather than feeling like they were being assessed. While some families were comfortable talking through the assessment tools, with others they attempted to integrate the use of GAD, PHQ, CGAS and Chrysali6 into the conversation to maintain a more personal approach. The triage team ascertained where the individual/family rate themselves in terms of the six project criteria and if there have been any improvements, to home in on areas in greater need of support or focus.

3.5.5 Intervention

The interventions offered included high intensity therapy, psychoeducation, and social interventions. A full wrap around service was offered whereby each family was assigned to a life coaching trained FWEW. Their role was to engage with the family and provide the source of contact throughout the programme, the frequency and content of the FWEW support was reflective of the family need's.

3.5.6 FWEW feedback

As part of the wrap around approach, people were able to seek support even after the triage. The FWEW through their contact with the family would establish when the family were ready to engage in therapeutic interventions if initially, they were not suitable. The open loop of communication allowed families to get back in touch with triage when they were ready to progress or try a previously offered or mentioned intervention, with the FWEW advocating for them. Some required an additional check-in triage call to check that this was the next appropriate step for their intervention, whereas others who attended courses and remained in contact with their FWEW's were easier to ensure they had the appropriate support and intervention.

3.5.7 Close

Following the interventions and support process there was a closing conversation to establish how effective the support has been. At this point the GAD, PHQ, CGAS and Chrysali6 were repeated to compare the pre intervention and post intervention assessments. Similarly, the clinical triage team compared the level of change on the six project criteria because of the interventions. As part of the person-centred approach, they focused on the families experience

with their interventions and wrap around support, identifying the good aspects along with any improvements that can be made.

View referral process graphic (Figure 5).

3.5.8 How did families engage with the process?

From first contact, families shared their experiences and mental health, to determine what interventions were suitable for them and other individual family members. The ethos of the project was to make families aware that the clinical triage and FWEWs were there to help facilitate positive changes for themselves and their family, whether big or small, and notice the positives if they struggle to do so. The initial triage had a conversational structure to make the process feel less clinical and more like a personalised chat. It was a safe space to kickstart pre-therapy priming work, where they had someone to listen attentively to their experiences and needs. Assistant psychologists identified that individuals engaged better when they felt listened to and understood, without the immediate offer of solutions or interventions. So once a conversation had occurred with assessments interwoven throughout, then interventions were catered to suit the family or each individual and then proposed to the family. Individuals seemed to engage more when they made a conscious choice of which interventions, they wanted to be involved with, as this was used to empower them to make proactive steps to engage.

3.6 Governance

Figure 4 outlines the governance structure for the Whole Family High Intensity Therapeutic Programme. All partners were invited to the fortnightly provider forum as part of the governance plan, with MVRP in constant communication with Wirral LA and Crea8ing Community throughout the programme. MVRP was responsible for reporting to the Home Office with information shared at Provider Forum and via access to PowerBI.

Figure 4

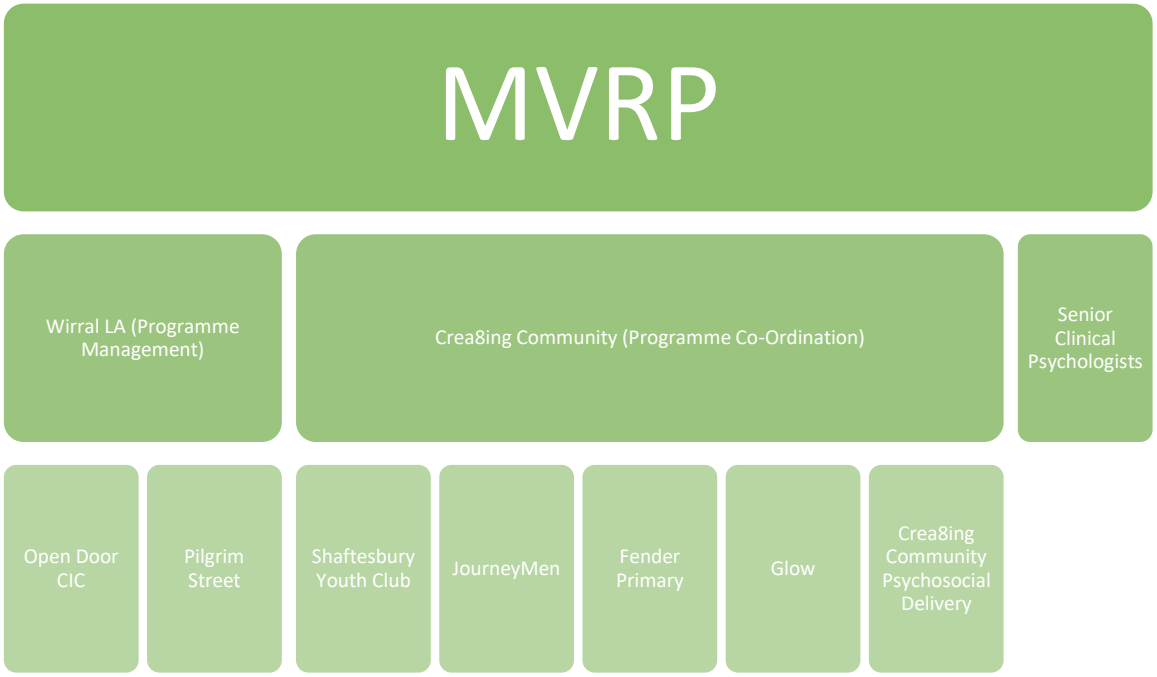
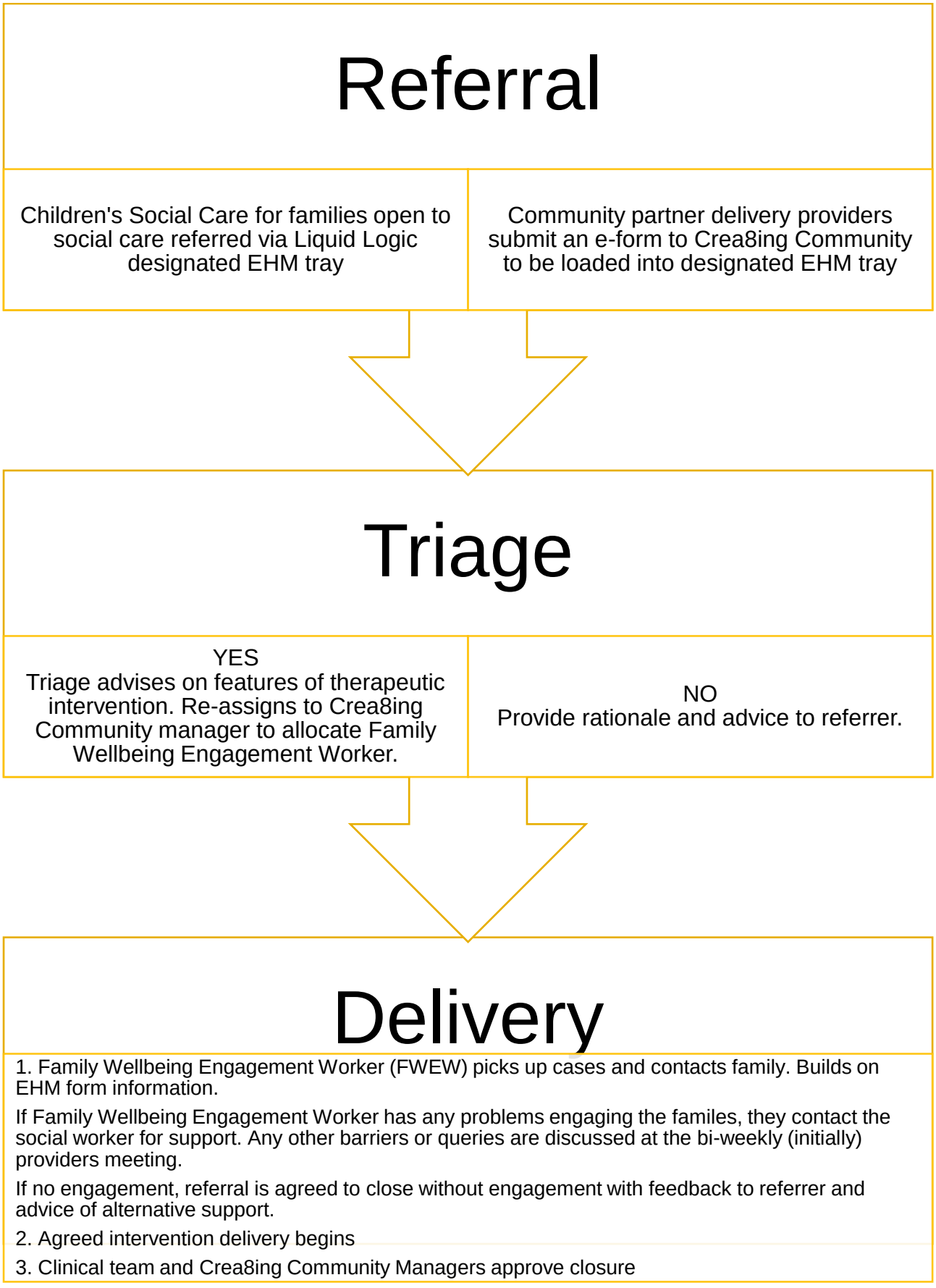


Figure 5


Referral
Children's Social Care for families open to social care referred via Liquid Logic designated EHM tray
Community partner delivery providers submit an e-form to Crea8ing Community to be loaded into designated EHM tray
Triage
YES
Triage advises on features of therapeutic intervention. Re-assigns to Crea8ing Community manager to allocate Family Wellbeing Engagement Worker.
NO
Provide rationale and advice to referrer.
Delivery
1. Family Wellbeing Engagement Worker (FWEW) picks up cases and contacts family. Builds on EHM form information.
If Family Wellbeing Engagement Worker has any problems engaging the familes, they contact the social worker for support. Any other barriers or queries are discussed at the bi-weekly (initially) providers meeting.
If no engagement, referral is agreed to close without engagement with feedback to referrer and advice of alternative support.
2. Agreed intervention delivery begins
3. Clinical team and Crea8ing Community Managers approve closure

The evidence-base suggested that on average, CBT-focused interventions should last for 15 weeks (mean number of sessions 17.3) with about 3 hours (mean of 2.8 hours) per week of support (Riise et al., 2021). Research suggests that the more contact per week there is, the greater the impact. However, it was felt by the programme coordinators and clinical supervisors that this may be too intense for an early intervention programme, and that more research was needed into the appropriate dose for this targeted, primary/secondary approach. The available research for CBT-based interventions presents findings for targeted tertiary cohorts. The decision for the duration of the programme was to offer a flexible approach based on individual need, but to make the CBT-informed therapies a minimum of 10 weeks for 1 hour per week. In a very small number of cases, the therapist deemed it necessary to extend this to 15 weeks.

3.7 The 'Uniqueness'

The uniqueness of the approach was that support was available to every family member concurrently, not just the child or young person for whom the referral was intended. The evidence-base for systemic interventions which include family-based approaches such as parenting support training or parent implemented behaviour programmes is well-documented (Carr, 2019). This evidence was used alongside a meta-analysis of interventions which outlined how CBT to reduce externalising behaviour includes a combination of parent behaviour therapy and child behaviour therapy, as well as opportunities to include teacher training (Riise et al. (2021)). In 49% of studies included in the Riise et al. (2021) review, parents were the target of treatment. In a further 41%, parents and children were the joint targets of treatment. This review found that studies with a high level of parental involvement were associated with the greatest reduction in externalising behaviours and so interventions should therefore concentrate on involving the whole family.

Based on feedback from stakeholders *(n= 32)*, there may be some duplication in some of the psycho-social support available, but the key elements stakeholders identified as unique were:

- No waiting lists (identified as especially important with the current length of existing CAMHS waiting lists)
- Service for children and adults together as "*a wrap-around service for the family"*
- Access to psychological triage and a range of therapeutic options which suit the specific needs of the family (e.g. easy and quick access to EMDR was explicitly mentioned)
- Access to trauma-focussed therapies

One participant provided feedback around the skills and approach of the FWEW, which demonstrates the unique skillset required of this role:

> *"My FWEW is more there than my social worker, she helps me when I am anxious or low. Without her I would have nobody. I was thinking and overthinking but as she has supported me and helped listen to me. Every time I contact her, I feel safer and it's like I've known her for years, even when I am angry or upset, she is there for me, and I can open up to her"*

Stakeholders responding to the stakeholder survey commented on the ease and speed of access to therapies, specifically trauma-focussed therapeutic approaches, the choice of services on offer within the same pathway and how important the whole family approach is, offering therapeutic support for adults and children simultaneously:

"I think this service offers something special, especially the ease with which children and parents can access much needed therapeutic support, but also in the way it offers a 'menu' of services to families. I think if this service continued, we would start to see a real positive impact on the number of children who can safely remain with their parents, and reduction in the need to issue proceedings/ have children become looked after, especially for children over 9 who sadly don't always experience good outcomes through becoming looked after."

"Nobody else offers EMDR therapy or access to a psychology triage at short notice- free for families."

"I needed a therapeutic service to support 2 siblings who were ready for this type of intervention having experienced severe trauma, this was heavily impacting on the family to the point of edge of care. The wait for CAMHS was ridiculous but I am so glad that creating community was available as ***I prefer this service to CAMHS as it is a wrap-around service for the family****. The psychologist communicated well with myself and have recommended other therapies. I am very pleased with the service the family have received."*

"We have CAMHS but waiting list too long, also this service offers support to adults as well as children."

3.8 Average journey from a child's perspective

The following journey represents an example of a family's journey with the Wirral Whole Family High Intensity Therapeutic Interventions programme from the point of view of a child. Please note, this is a fictional example journey which was devised by the Project Manager in Wirral as a means of understanding any potential barriers to delivery and engagement for a child and their family.

Figure 6

I'm 10 years old and in my last year of Primary school. I live with my Mum, her boyfriend, my older brother and little sister. When I was 8, Dad left us. Mum and Dad used to yell at each other a lot and sometimes Mum would throw empty bottles at Dad, and they would smash. I felt scared and feel sad that I no longer see my Dad. Mum's boyfriend is ok, but he's not my Dad and so I don't like it when he tells me what to do. It makes me angry and then I end up shouting at my Mum. On Thursday night at the youth club, my older brother introduced me to Gary. Gary said that it might be good for me and Mum to go and speak to someone together to help us talk to each other better. He said he would talk to my Mum if I agreed. I said yes and so now Gary has introduced us to Jill. Jill is nice. She only lives down the road and me and Mum have started meeting her in the swing park after school. Mum also calls Jill on the weekend if she feels sad. Jill is arranging for me and Mum to go to meet someone who we can talk with together. Mum said she couldn't be bothered explaining our story to someone else, but Jill said that she would help and tell the new person the basics. Jill came with us the first few times we went but didn't come into the room. Now me and Mum walk through the park together after school every Wednesday to a place at the other side of the park to talk with Jill's friend Beth. I didn't really like Beth at first because she asked a lot of questions, but me and Mum haven't had an argument in over a week now and so I guess it might be helping. Mum's boyfriend has also come to talk with Beth once. It was good to hear his point of view. Beth says we only need to go and see her one last time next Wednesday and that will be 10 weeks since we first met her. Jill still calls round for a cup of tea with Mum every week and she has helped me get a place on the local footie team. I never had boots before, but Jill asked the club to get me some. Mum's boyfriend takes me to footie and watches me play on a weekend. I like this and we're getting on much better. We still have our ups and downs, but now when he tells me to do something, it's more like he's asking rather than telling and I don't mind as much. In school, I've not been in trouble as much and I even got 9/10 on my maths test last week. I feel like I can concentrate more in lessons because I'm not as angry as I was.

4. Results

4.1 Relevance

4.1.1 Outcomes Data

At point of writing, outcomes data is available for 224 / 507 individuals.

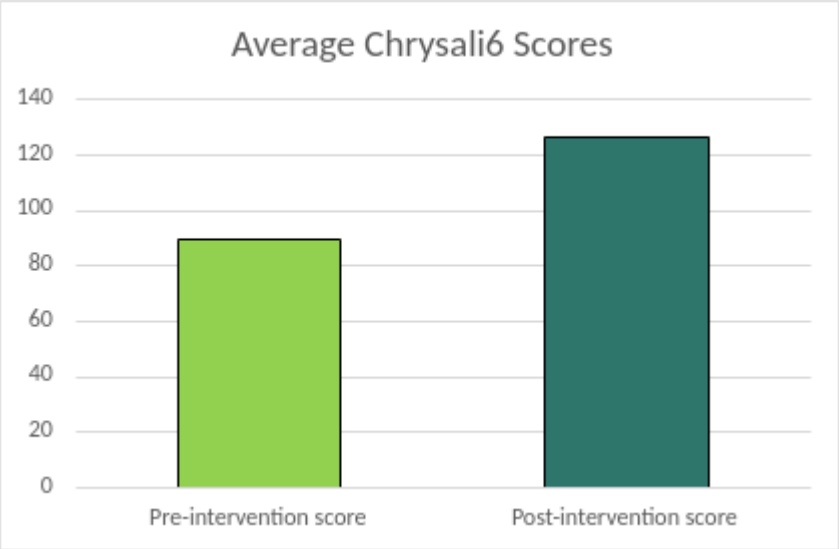
4.1.1a Chrysali6

The Chrysali6 is a thirty-item questionnaire measuring regulation, psychological, emotional, and social wellbeing. Designed for use in the project, it aimed to measure the six factors outlined in the project criteria. Each of the statement is rated on a 7-point scale; with 0 being strongly disagree, 1 being moderately disagree, 2 being disagree, 3 being neither agree nor disagree, 4 being agree, 5 being moderately agree and 6 being strongly agree.

The lower the score, the more negatives regarding the project criteria.

An increase in this assessment score is positive. The average score pre-intervention was 90 and the average score post-intervention was 126.9. The average increase in score was 36.85.

Figure 7



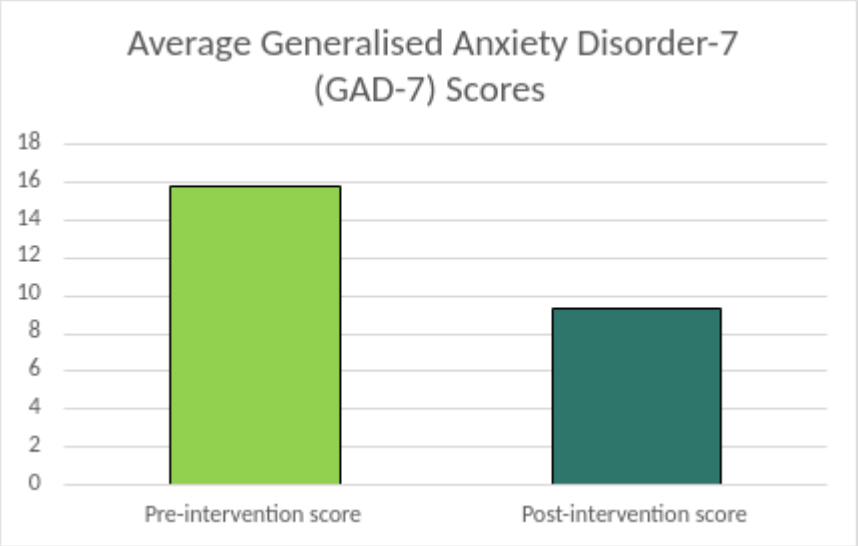
4.1.1b Generalised Anxiety Disorder Assessment (GAD-7)

The Generalised Anxiety Disorder-7 or GAD-7 (Spitzer, Kroenke, Williams and Lowe, 2006) is a seven-item questionnaire used to identify an individual's level of anxiety through looking at frequency of anxiety symptoms over the last two weeks. Each of the seven questions are rated on the frequency that they occurred; with 0 being not at all, 1 being several days, 2 being more than half the days and 3 being nearly every day. A collective score of 5 being mild, 10 being moderate and or 15 being severe anxiety.

The higher the score, the more they are struggling with their anxiety.

A decrease in score this assessment score is a positive. The average score pre-intervention was 15.76, and the average post-intervention was 9.38. The average decrease in score was -6.38.

Figure 8



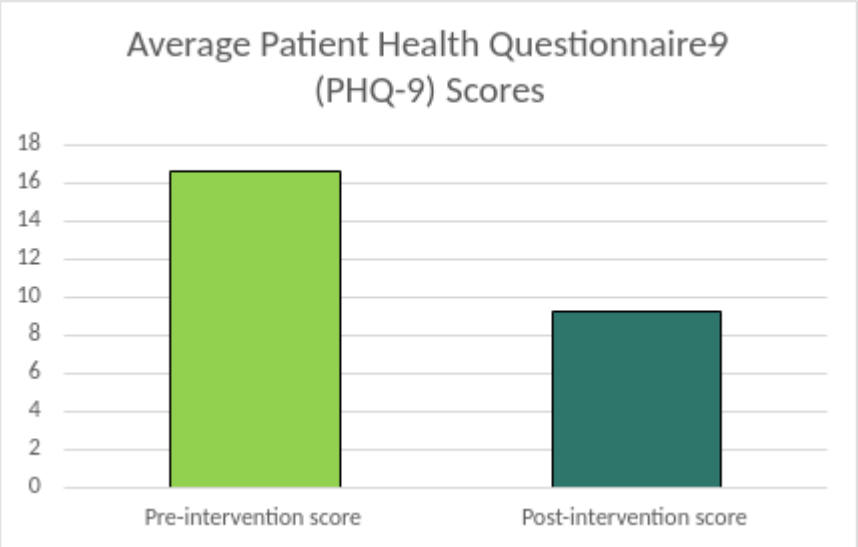
4.1.1c Patient Health Questionnaire (PHQ)

The Patient Health Questionaire-9 or PHQ-9 (Kroenke, Spitzer, Williams, 2001) is a nine-item questionnaire used to identify an individual's level of depression through looking at the frequency over the last two weeks. Each of the nine questions are rated on the frequency that they occurred; with 0 being not at all, 1 being several days, 2 being more than half the days and 3 being nearly every day. A collective score of 5 being mild, 10 being moderate, 15 being moderately severe and 20 being severe.

The higher the score the more likely an individual is struggling with their mental and physical health.

A decrease in assessment score is positive. The average pre-intervention score was 16.63, and the average post-intervention was 9.25. The average decrease in score was -7.39.

Figure 9



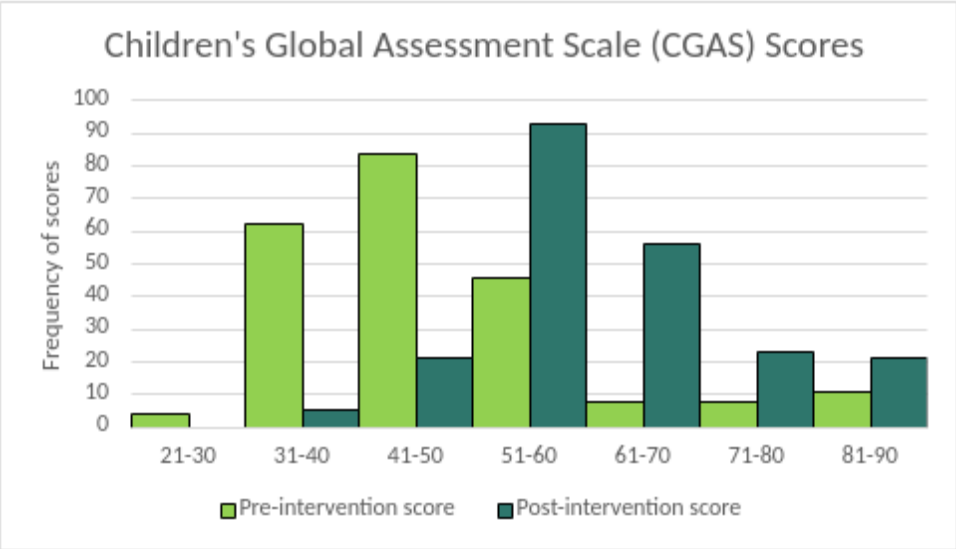
4.1.1d Children's Global Assessment Scale (CGAS)

The Childrens Global Assessment Scale or CGAS (Shaffer et al., 1983) assesses the psychological and social functioning of children aged 6-17 years old. The child is given a score between 1 and 100 reflecting their functioning, with higher scores denoting better functioning. There are 10 categories ranging from 'Doing very well (scores of 100-91)' to 'Extremely Impaired (scores of 10-1)'. Each of the 10 categories has a brief description outlining what the functioning of a child in that category would look like.

The lower the score, the more they are struggling with their life.

An increase in assessment score is positive. The average increase was 11.63. The average range pre-intervention was 41-50 with the average post-intervention score range 61-70.

Figure 10



4.1.2 Family Outcome Data

Alongside the clinical triage team and the FWEW, beneficiaries were asked to score themselves against the outcomes criteria on exit from the programme. The average score was 7 out of 10, representing significant improvements. Table 2 represents the percentage of beneficiaries referred based on the 6 intended outcomes, alongside the percentage of beneficiaries self-assessing as seeing significant or outstanding improvement upon exiting the programme.

Table 2

Outcome Criteria	Percentage at Point of Referral	Percentage assessed with significant or outstanding improvement*	Significant improvement	Outstanding improvement
1. Improve behaviour management and emotional control for child/ren, young person	87%	93%	54%	39%
2. Improve social, emotional, and educational wellbeing	95%	94%	55%	39%
3. Reduce opportunities for victimisation of bullying, criminal or antisocial behaviour	54%	90%	52%	38%
4. Identify opportunities to improve school or employment attendance/performance for any family members including the target child/ren or young persons in the home	67%	90%	55%	35%
5. Reduce acts of violence/ aggression through retaliation and/or aggressive behaviour	64%	93%	52%	41%
6. Reduce vulnerabilities by increasing or developing protective factors, for example trusted relationships with adults (family members of safe community members/volunteers) and/or develop positive peer networks	86%	95%	36%	60%

*Scores of 5-7 out of 10 represent significant improvement, whereas scores of 8 or higher represent outstanding improvement.

4.1.3 Special educational needs and disability (SEND) / educational health care plan (EHCP)

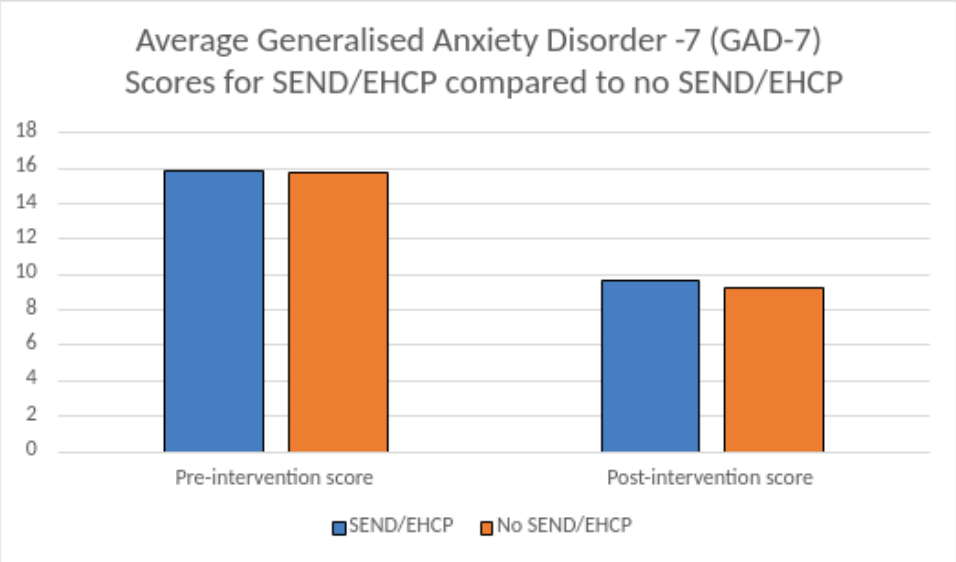
41% of children referred were SEND statemented or had an EHCP. As part of this evaluation, a brief comparison between individuals with and without SEND statements/EHCP has been made based on the assessment outcomes. When comparing the outcome scores for families with SEND/EHCP children and families without SEND/EHCP children, there appears to be no differences in pre- and post-intervention score change. Table 3 shows that there is little difference between the two cohorts.

Table 3

Assessment	**SEND**	**Non-SEND**
CH6	37	36
GAD-7	-6	-7
PHQ 9	-6	-7

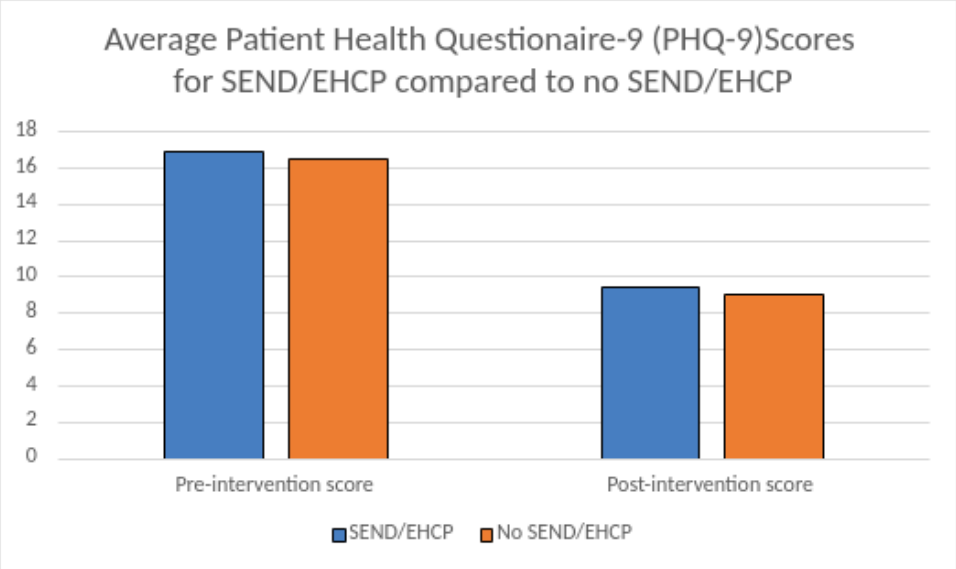
Post-intervention GAD-7 outcomes decreased by 6.22 and 6.49 for both SEND/EHCP and no SEND/EHCP respectively.

Figure 11



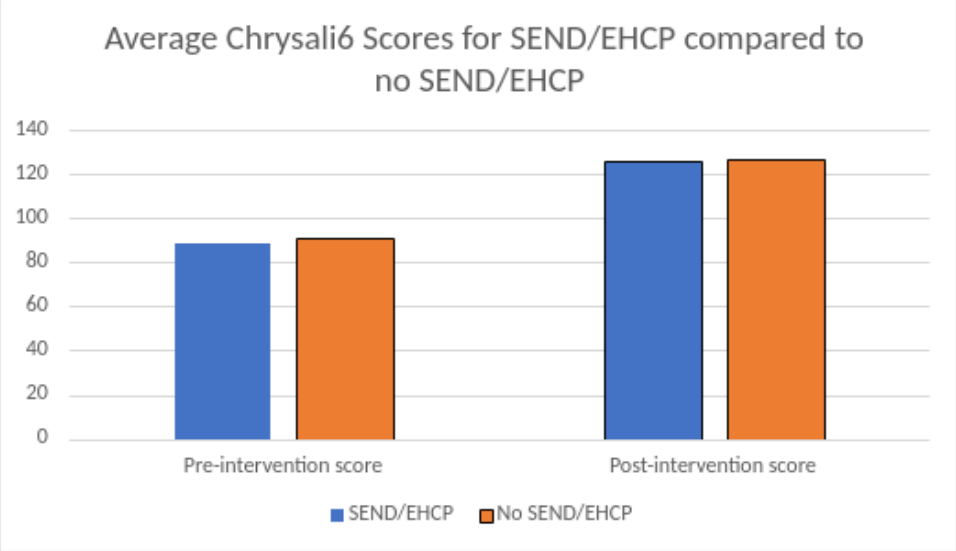
Similarly, the decrease in post-intervention PHQ-9 scores for SEND/EHCP and no SEND/EHCP was similar, being 7.41 and 7.37.

Figure 12



Post-intervention Chrysali6 scores both increased at a similar rate, with increases of 37.91 for SEND/EHCP families and 36.16 for no SEND/EHCP families.

Figure 13



Children's Global Assessment Scale (CGAS) scores shows comparative similarities between SEND/EHCP (Figure 14) and non-SEND/EHCP (Figure 15) cohorts.

Figure 14

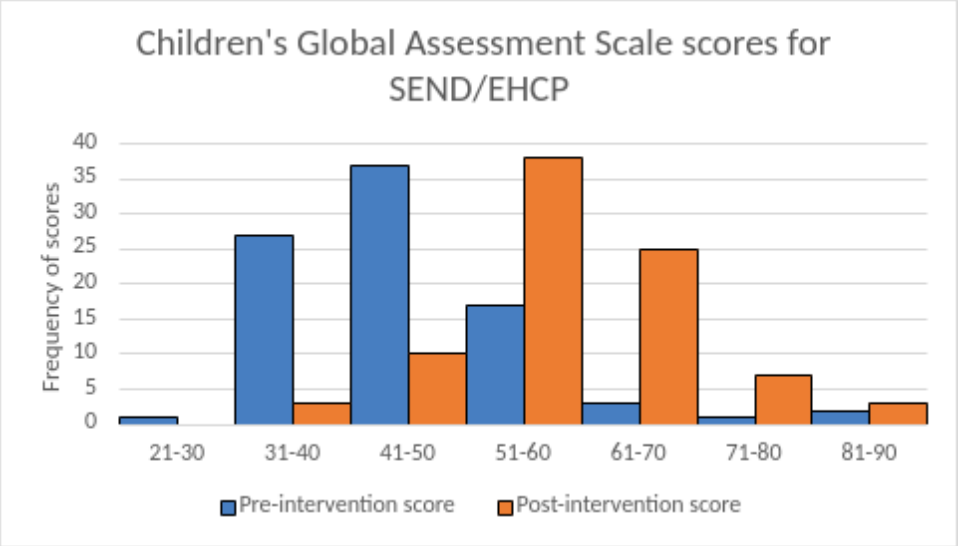
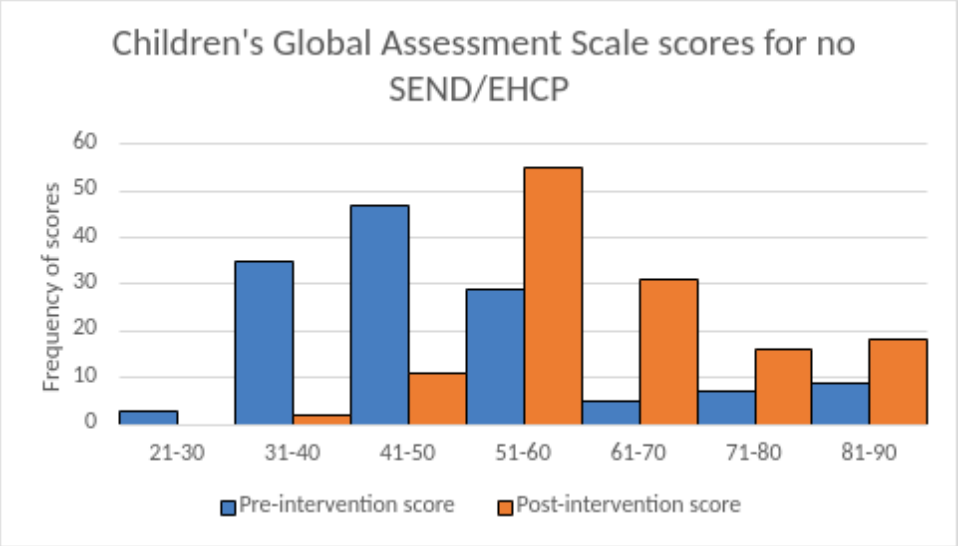


Figure 15



This is a significant early finding, illustrating that the project was accessible for all. It demonstrates that reasonable adjustments were made to ensure accessibility to the programme for all, providing equal impact on psychological development for SEND cohort as for non-SEND cohort. These findings are especially relevant for the scalability and further development of this approach.

4.1.4 Impact on Social Care Status

As an additional measure and benefit to using Liquid Logic, which is the system used by Social Care teams in Wirral, the programme tracked changes in social care status. The results for families were:

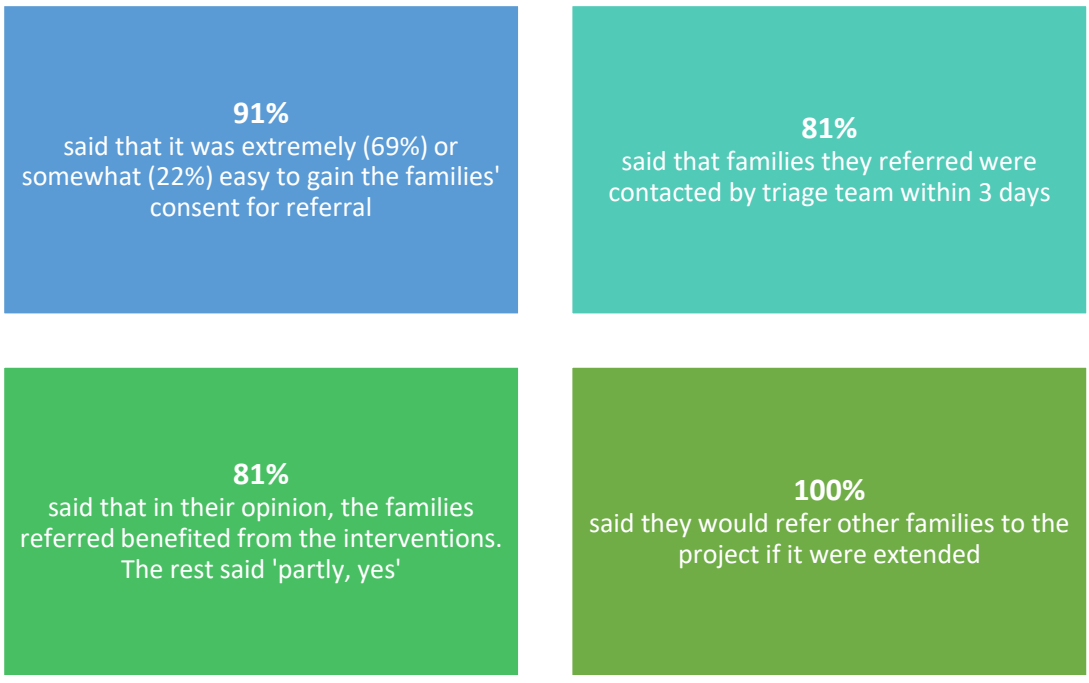
- 76% saw no change from referral to exit of the programme
- 11% escalated
- 14% de-escalated

Initially, the expectation was that a de-escalation of social care status would represent a positive success measure. However, in the circumstances where an escalation has taken place, the programme manager and co-ordinator have reflected that this is also a measure of success, having had the contact and trust with a family to uncover where social care involvement is needed or needs to escalate for child protection purposes.

4.2 Qualitative results

4.2.1 Stakeholder Survey (n = 32)

This survey was undertaken by Wirral Community Matters Partnership to capture stakeholder experiences of how the Whole Family High Intensity Therapeutic Interventions programme has supported the families they have referred, as well as their own professional experience working with the project. 68% of respondents were front-line workers. A full list of questions and responses can be found in Appendix B. Stakeholder Survey Questions. Key findings include:



53% said an area for improvement would be to extend age range below 9 years. However, 32% of children engaged were under 9-years-old. This is perhaps a reflection that the Home Office funding stipulated a greater focus on 10-14-year-olds and so it is likely that this was communicated to social care workers.

40% said they would want the service extended to parents with multiple needs whose children are not open to social care. However, 50% of children were not open to social care. This feedback could reflect that there may have been a higher proportion of stakeholders

responding to the survey from Children's Social Care, and so they were unaware of the other referral pathways being accessed.

Key strengths stakeholders identified:

Asked whether this service is duplicated elsewhere, overwhelmingly respondents said no and that this is a unique offer.

Additional comments included:

"When children are not attending school for significant amount of time due to the chaotic dynamics of family life over a number of years, this offers a whole family approach to changing the life chances of the CYP and the adults within the family. Wonderful initiative and wonderful feedback form the workers supporting the families."

"Crea8ing Careers has been amazing so far and I would be so disappointed to see the service end. This has plugged a gap in Wirral that was needed for our families and provides holistic, wrap-around and creative support. It has been greatly appreciated by the families I have referred to."

"We really need this service **it really works for the whole family**."

"Speaking from the feedback received from my family, this service has been fantastic and so helpful, **my young person has only had one session and absolutely loved it and can't wait for the next one**."

"This is a unique service that is desperately needed within Wirral - the fact they will continue to work with families who are no longer open to statutory services means that **families still benefit from an excellent service without the need for a SW**."

"The service has been a brilliant therapeutic input for all the families I have referred through. Families receive a high level of support and intervention that makes changes for them and almost all of the families I have referred have found it beneficial and engaged well. **Without this service it is likely that they would have been subject to longer periods of intervention as Social Workers** we do not have the time or knowledge to provide the support and intervention you are able to."

"I referred a family which was immediately picked up and full support was offered to enable the family to attend. The worker invited the family for a walk around before programme commenced. Excellent communication between myself as the family Worker and the crea8ting worker."

"This project has been **invaluable for my families who have loved it**. **I can't think of anything else that could replace this.**"

"From initial conversations to referral, the process has been excellent. The support from Crea8ing Community for professionals to identify need and the best support available has been excellent. The process is very simple and swift which enables families in need to get support quickly**. It is too early to review the support, but I am certain it will be very beneficial**."

4.2.2 Participant Feedback

The following feedback was collected by the clinical triage team from verbal exchanges with participants. From the feedback, the scope of the programme was relevant to families with many parents/carers implying impact of their lives which goes beyond the intended scope of the programme.

One parent/carer identifying that the support being available to younger age children was a strength, along with the activities available:

> *"Nothing is out there for my kids, they're just the wrong age, I have an 8-year-old and 10-year-old who have nothing they could access before here. Now they have done Meerkat and me, forest school, picnics, walks and activities at half term."*

Another participant identified that the programme could fill a gap in service for pre-/peri-natal period:

> *"There is nothing out there to support pregnant mothers, I wish this had been around or I had known about Crea8ing Community's project sooner, like when I was pregnant with my other kids. Maybe then I wouldn't have felt so alone and low."*

Feedback on the tiered approach and holistic offer with triage, FWEW and psychosocial courses as well as higher-intensity therapy was validated by participants:

> *"The full team helps in all aspects from the psychs to the family support and the facilitators they make sure everything is right for us and that we're in safe spaces where we feel heard and validated, whilst learning new things and getting amazing advice."*

> *"Such an amazing experience, listened so attentively and gave me time to process things, almost acted like the start of the therapy, getting me comfortable talking about things in a safe space. Made going to therapy a no brainer, because I felt so comforted and supported throughout the whole thing."*

Noteworthy is the implication that having a central co-located team in a single community-based organisation helps to create the most appropriate environment for engagement by creating a safe space. This is a key learning point when considering future commissioning of whole family approaches.

"This combines what lots of other places only do in small bits or more specific, whereas here covers everything."

"Been waiting on a CAMHs list forever and getting nowhere with things getting worse and Crea8ing community made us feel important and involved and directed us to and supported us with the interventions needed."

"Didn't feel like I was just part of someone's case load or a box to be ticked and actually like a person they cared about and gave a lot of thought around what was suited to me and my family."

Outcomes related to children specifically included reduction in risk factors related to emotional resilience, education engagement, community connectivity and development of positive relationships:

"He took away the breathing techniques and has a better understanding of his emotions."

"It has helped him to understand how and why he feels."

"He does find it difficult, but it has helped him with settling in with school and persisting with school."

"I don't think he would have stuck at school without counselling."

"She loved the life story work, I knew the two of them would really connect."

"I think he would have been in a much worse position having not had the therapy."

"I love the connections from pilgrim street, they helped them a lot to connect and feel understood."

"Doing something one on one with our child we built up a bond with them due to the course."

For adult family members, outcomes which were beyond the scope of the project include reduction in reliance on medicinal anti-depressants or using alcohol has a coping mechanism:

"Maybe it's the therapy, because I have come off the anti-depressants I feel less anxious as I am not as reliant on medicine."

"Prior to therapy if something in the morning like troubles with my kids it would impact on my whole day, my mood would be low and I would turn to a drink."

"I am not drinking as much which is helping me."

Positive outcomes for families with children with SEND are evident:

"'It's definitely a happier home, were are out and about more which is not only good for me but the kids, with my sons' autism and the twins there were times where I could not deal with them but I can now, I see out of the box more."

"She [the therapist] really understands ADHD and how it interacts with other things in my life."

Outcomes which are less easily measured by assessments and quantitative impact metrics include greater parental involvement/changes in parent-child relationships, improvements in the child's perceptions of home-environment, increased parental resilience, reduced isolation and anxiety to improve engagement with environment and community and the ability to enjoy life:

"I've gone from being a weekend dad to a full-time dad, which I absolutely love."

"Biggest thing I've got is my son refers to my house as HOME which he has never done."

"It's helped on many levels. On one hand, it's shown me that I'm a much better parent than I realised which has improved my mental health. On the other, it's given me skills and knowledge to apply in situations where I feel I have struggled previously."

"Even just popping out to the shop, I had a big thing with social anxiety following lockdown for a few months I did not leave the house but I am out and about more and I have the kids involved in new groups and even for me I have met new parents and have met new friends."

"I don't have that feeling of dread in my tummy and I am just enjoying things more, the anxiety has reduced"

4.2.3 Programme Staff Survey (n = 12)

To evaluate the design, process and delivery of the Whole Family High Intensity Therapeutic Programme, a survey was designed for staff who directly delivered on the programme to complete. Responses were provided by clinical triage team, therapists delivering high intensity therapy, FWEW, psychosocial course facilitators, and programme management. Key findings include:

- 83% of staff felt the programme met the needs of children, young people and families with the rest replying 'somewhat'
- 42% of staff felt that there were some needs which were not met by the programme:

"Some of the cases were very complex and were not the correct skill match for the therapists at the centre. A possible solution would be too engage more clinical psychologist who have experience of working with complex presentations in children"

"If felt that some clients would of benefitted from more sessions an that some would of benefitted from family therapy as they didn't want to attend individual sessions"

"The program could be allowed long term funding to implement all the support available for intergenerational social improvements."

"While the majority of families who wanted to engage have, there were families who were referred in but did not feel that they wanted any support or already has too much support set up."

"Maybe some shorter programmes for younger/SEN children"?

"Sometimes it is difficult for our Woking parents to access courses"

"Most families by the very nature of the referrals, were at a crisis point in their relationships. For some this was as a result of historical experiences, ACES, DV, poor mental health, substance misuse, bereavement and loss as well as many other challenging situations. This meant that some families came to the project at a point that they were not ready to work together on the rebuilding of their relationships, as they needed to engage in therapeutic interventions which had been identified to support them to address past traumas. As a result, some families found it too challenging to engage positively and productively in the process. For some who were referred to life story it was assessed that the process could actually be damaging for individuals, so alternatives were found to work with those families."

- Key strengths of the programme:

Grass roots level in the community

Quick response and a variety of different interventions geared at specific needs

The approach from all angles; therapy, trauma courses, coffee mornings.

Offering free help to those who may not be able to seek it otherwise

One point of call ... Family support

The wide range of immediate support available and the counselling therapeutic services.

The speed of contact from referral to having the first triage.

Consistent and caring check ins and support.

Interventions suited and catered to the individuals and the family.

Families we worked with enjoyed the creative projects and activities we offered. Some young people have gone on to join the organisation and participate in our programme.

Involvement of statutory, non-statutory and 3rd sector organisations

Learners more able to deal with their own strength using positive coping strategies; higher levels of resilience, able to cope with daily life more than before; families knowing where to go for support, more confident learners. The list is endless

- Areas for improvement:

"More courses online and more frequent courses"

"A course specific for parents of neurodivergent children."

"Further sites for courses and therapy to make it more accessible to those who could not drive or access public transport or taxis."

"At the height of referrals more family engagement workers where needed in order to provide quality over quantity"

"We delivered creative projects and it was felt families should be referred at the end of their interventions and therapy. This would mean they were in a better place to build upon their strengths, learn form each other, and develop mutual respect and understanding of each other."

"Due to the funding being received late, the process felt rushed. Ideally families would have been invited to an introduction of the project...and an opportunity to meet workers prior to starting. This would have helped allay any anxieties, fears, arriving at a new and unknow venue with unknown families."

"It takes time to build trusting relationships with professionals and each other. For some families this was missing as each project had to fit into a certain time frame"

"Families sometimes came with complex extreme and upsetting histories, and some of the referrals received were inappropriate for the projects and their aims"

"Possibly location as done families do not drive and some locations can be difficult to reach."

"There was a lack of understanding about what our projects were specifically offering and how it would be facilitated, particularly life story work. This led to inappropriate referrals being received. Time needs to be built in to enable projects to explain to referrers and practitioners what was on offer"

- Staff felt this programme helped meet the following local gaps in service

4.3 Case Studies

One Stakeholder responded with the following case study:

> "One of my mums is now working and holding down a part time job, has separated from her abusive partner and is doing very well. Another family - **the mother refused all services for the best part of a year most and said to me she felt comfortable to engage with yourselves** and added I want this programme to continue I will miss it when it ends. I believe there would be a gap in services if this was to cease. That is sad for the Wirral families."

Parents/Carers have shared the following impact:

> "By helping 1 child, the rest of the family have benefitted. Plus, there is always someone to give advice or a friendly hug if needed. You never feel alone and the children are given opportunities that they wouldn't usually have. Our eldest son is starting to open up which is enabling us to make progress as a family. We are finally getting somewhere! Thank you"

> "The guidance I've received has enabled me to deal with certain challenging behaviours with different approaches, and I've seen the difference in myself as well as my children"

> "M is teaching others what he has learnt that helps him. He is doing better in school and wants to help others, as he is telling other kids what he learnt and encouraging them with positive behaviours. He struggled before but was actually able to make friends. Things are much calmer at home and he is telling siblings how he calms down to help them. Amazing progress, changed so much in a positive way, much calmer, less angry and much happier in himself and with others."

> "[B is] more confident in self and open about emotions. Support has helped us communicate more as a family and work through things together. B made lots of friends and staff have been amazing and supportive, nurturing and caring. B being taught to understand his emotions and behaviours has helped him tell us how he feels which has made things easier. Very accessible, friendly and caring staff who are happy to help and always close by. Lots of progress made, more verbal about emotions, new logical consequences set up and more family time with less outbursts."

4.3.1 Case Study 1

[Pseudonymised]

Figure 16

Erin started having Parent led - CBT and reported that she is less confrontational and her response to situations are more considered and less reactionary. She feels better able to manage her son's difficult behaviours, responding with a calmer manner and has managed to get him to leave the house where he had previously refused for about 4 months.

His attendance at school is also better although there is still room for improvement. She is able to implement the strategies for both herself and her son which is allowing them both to deal with situations more positively. She is reporting that she has improved her self-care and wellbeing strategies, has become engaged in volunteering and is feeling positive about the future.

Erin says she has realised through the sessions that her son had been reflecting her behaviours and in applying tools and strategies to herself, he is now also using them for himself but additionally reminding her to use them too. She feels that their relationship has improved and will continue the work to further help her situation.

Erin reports that her son is presenting as happier, and that his behaviour have improved, and their relationship is greatly improved.

She says, "Personally I am feeling much better in myself. and my son is happier and we're spending more nice time together. He's managing more full days at the Special School he attends and just presents as much happier, and I am much happier too."

She feels that a "combination of me being involved in the programme and feeling in a better place. I am responding much more positively and calmer, and more able to deal with issues. He now catches himself before he uses poor language, his sense of humour has returned, and he's just more helpful and kind."

She reports that, "He had been violent towards me as mum but nothing for a long time. I think things improved because we are having a nicer time together and now, I have people to talk to when issues come up. I'm not sitting stewing about it…. And he is even agreeing to visit family more, so improved relationships all round."

4.3.2 Case Study 2

[Pseudonymised]

Figure 17

Martin has been having CBT therapy and reports it is allowing a new “maturity” in being able to change behaviours. He feels that his anxiety is reduced, and he is not procrastinating over important tasks. He is now able to stop trying to do everything for everyone, which is allowing him to deal with the issues of daily life such as spending more time with the family, processing his grief over recent bereavement and physical health condition affecting his youngest son.

This means he feels less angry and has not had any explosive outbursts since commencing. This has improved and reduced levels of parental conflict in the household and has also improved his relationship with his eldest teenage son who had become withdrawn and has now also agreed to engage with CBT himself.

Martin laughs and states “Life isn’t great, but I just feel better about coping with a s****y life”.

4.3.3 Video Case Study – Rock Ferry Primary School

Figure 18

https://youtu.be/1w4qoKh5WRU

4.3.4 Video Case Study – Parent and Volunteer

Figure 19

https://youtu.be/G-Mhzn4wgTM

5. Discussion

5.1 Feasibility

5.1.1 Data quality

5.1.1a Process of data collection and methods of extraction

Wirral Local Authority use the Liquid Logic system to manage information on families open to social care. The lead community organisation, Crea8ing Community, already had access to the Early Help Management (EHM) system in Liquid Logic as part of another piece of work being undertaken in partnership with the LA and so the cost of setting up Liquid Logic access in a community setting was minimal for the Home Office-funded High Intensity Therapeutic Interventions programme.

The Liquid Logic team in the LA set-up a new 'referrals tray' on EHM for this project so that referrals could be easily managed, and outcomes data collected. Power BI is the LA system which can be pointed at any system to produce analytical reports. It was crucial for programme managers and coordinators to have constant access to enable them to meet the monitoring schedule set by the Home Office, but it also supported them to address low uptake early-on in the project within the provider forum.

Initial information and consent were collected as part of the referral, either by social care worker (via Liquid Logic directly), or by the community referrer, using an e-referral form (see Appendix D – E-Form for Community Referral Pathway). An administrative role was required to input the information from the community referral form into Liquid Logic. The Clinical Triage team based at Crea8ing Community contacted the family, adding any additional information into Liquid Logic before introducing the FWEWs to the family. Feedback from staff in the evaluation survey showed that the community referral forms could be "hard to navigate" and "took a lot of time". The evaluation focus group reflected that the e-form for community referral had been designed to reflect the referral form in Liquid Logic. Based on feedback from community referrers, the form was reduced, and any additional information required was gathered with the family by clinical triage.

The FWEWs were not given access to Liquid Logic but were encouraged to record notes or narrative outcomes in the Crea8ing Community CRM system, which the administrative role would transfer into Liquid Logic. This ensured that GDPR procedures were met with only relevant information for operational success being shared with the FWEWs. Feedback from staff in the staff survey (n=12) highlighted some frustration with this, identifying an area for improvement as more "seamless integration" between Liquid Logic and the Crea8ing Community CRM. However, in an evaluation focus group (n=5) with programme managers, administration and clinical triage lead, this feedback was reflected upon, and it was concluded that all relevant information was shared with the FWEWs and information (such as contact details for current social worker) could be provided by the administrator.

Upon exit from the programme, the clinical triage team and administrator would input any post-intervention assessment information, outcome views and family feedback into Liquid Logic. The designed Power BI analysis for the programme did not include this qualitative data. During the evaluation focus group with programme managers, triage, administrator and LA Power BI manager, the group reflected on how qualitative feedback from families and comments from staff could be made more readily available for impact assessment and analysis by strategic leads. This is a key learning point for future data collection and reporting. Reflections included re-designing the Liquid Logic form to include separate text boxes for family reflections on strengths of the programme and impact, and another for reflections on challenges or areas for improvement. It was also noted that for monitoring progress prior to exiting the programme,

qualitative information available in Power BI would have supported ongoing evaluation of effectiveness, in the absence of quantitative outcomes data part way through a course of therapy.

5.1.1b The Good, The Bad and The Ugly

Home Office reporting

The Home Office required monthly monitoring updates, which were provided from September 2021-March 2022, an interim report in January 2022 and a final project report in May 2022. The monthly monitoring progress reports requested a breakdown of the intervention-type across the three tiers of delivery, the number of interventions delivered in the reporting period (which meant the number of individual sessions within each intervention delivered each month), and the number of unique children and young people reached (cumulative). A copy of the final Monthly Progress Report table taken from the March 2022 monthly report can be seen in Table 4.

Table 4

Intervention Type	The number of interventions delivered in the reporting period (month)	The number of unique children and young people reached (cumulative)
CBT (clinical therapy)	0	157
CBT (Open Door mentor-led CBT)	0	77
Lower Intensity Therapeutic Intervention	27	71
Extended Relationships	1	19
TOTAL	28	324

Across the duration of the programme, the average number of interventions accessed for each unique child and any adult family members referred against the child's name was three. Due to the different delivery formats and course lengths, reporting on the number of interventions delivered in the reporting period was not measurable until the completion of the programme.

The final monitoring report estimated that a total of 2030 clinical sessions were delivered to 157 unique children and 39 unique adults between September 2021 and March 2022. It estimated that 970 mentor-led CBT sessions had been delivered to 77 unique children and 14 adults. A conservative estimate of the number of lower-intensity therapeutic interventions delivered during the programme period was 3,840, but it was not possible to say how many of these sessions were delivered to unique children. These were estimations based on the average length of each intervention and are therefore not an accurate representation of delivery.

Challenges to Home Office data reporting

To report accurately on the Home Office metrics each month, data had to be extracted from Power BI following the last day of each month. Power BI reported on the interventions delivered against each child's Liquid Logic record. Therefore, a child and their family receiving more than one intervention on this programme would have their name duplicated.

For example, Child A has been triaged to receive Mentor-led CBT, with a parent/carer of Child A having been triaged to clinical CBT, and both are participating in an extended relationships project. The Power BI export would show Child A three times. A manual process of removing duplicate names, whilst maintaining the information to report on unique children receiving an intervention was required. Although on average a child/family would be participating in 3 interventions, the monthly report focussed more on the children receiving higher--intensity therapy (CBT (clinical therapy) and CBT (mentor-led)), as this was prioritised by the Home Office funding criteria. Therefore, if the number of unique children receiving high-intensity

therapeutic interventions is to continue to be a reporting requirement, changes will be needed to the way data is collected and reported on in Power BI.

5.1.2 Availability of Outcomes Data

During the evaluation focus group, the reason why quantitative outcomes data is not yet available for all participating families was provided. The process of data collection and inputting into Liquid Logic requires that the family have completed their course of therapy. Due to the short nature of the programme (September 2021-March 2022) and the long holiday period for Christmas, several families referred to clinical therapy deferred or delayed their course of therapy in January because of stress caused by the holiday, along with Covid illness and the need for isolation both for families and therapists. This affected the operational workflow and expectations of families completing their course of therapy. The families were coached to access psychosocial courses to help manage their stress responses and bring them to therapeutic readiness, meaning that they started therapy in March, but have not yet completed their course at point of evaluation. By using Liquid Logic system, access to data and information is possible beyond the length of the programme. This may allow for further evaluation of the timeframe and type of contact required to secure sustainable positive outcomes with families but would need to be added as a report within Power BI. The clinical triage lead also reflected how qualitative data supported the quantitative data, describing how for the family, a small improvement represented in quantitative outcomes data, often meant significantly more for the family in real terms.

A challenge identified in data collection, both early in the programme and towards the end, was that outcome criteria were changeable. Although the core six outcomes were clear from the start, the speed of set-up meant that the Home Office reporting criteria were still being outlined when the programme began delivery. It was not until closer to the end of the programme that additional criteria were identified which would have supported the programme's sustainability (such as alignment to Supporting Families framework). Liquid Logic does not capture educational information for children in the LA. Capita is used for this and so data on SEND statements and attendance reported in outcomes are incomplete for the full participating cohort. This administrative role was important, manually cross-referencing to enable analysis of educational outcomes (attendance and any specific trends in outcomes for children and families with SEND). A key learning point reflected in the evaluation focus group was that the Liquid Logic and data teams in the LA should have been involved earlier during the design of the programme, rather than at implementation phase.

An outcome which the programme coordinator and manager had wanted to capture but were unable to, due to data sharing restrictions around health, was whether a child/parents/carer either continued to be/or were added to a waiting list for mental health support following engagement in the programme. Had this outcome been measurable, it is possible there would have been a more empirical evidence-base for whole family approaches to mental health intervention.

5.1.3 Benefits to using Liquid Logic

The benefits of using Liquid Logic EHM were identified as being:

- Having a central referral mechanism to enable effective triage, reducing the need for families to have to re-tell their history/circumstance to a new professional, as case notes would be available.
- Having a central referral mechanism which was already embedded in the practice of social care workers, reducing additional burden of learning a new system and improving communication about programme across children's social care.
- Reduce duplication of provision or over-burdening of families, and to improve fidelity of outcome measures based on the approach of the Whole Family High Intensity Therapeutic programme.
  At the time of the funding awarded by the Home Office in July 2021, multiple other grants were awarded in the area and there was concern that some families could be referred to multiple programmes for support. By using a central case management system, clinical triage could see what other interventions a child/family was in receipt of/had previously received to determine whether acceptance of referral to this programme would interfere with existing support or suitability for this type of intervention.
- Improve data sharing practices and relationships between voluntary/community and statutory services.
- Live Power BI reporting makes analysis and information readily available.
- Allows for longitudinal impact evaluation, monitoring whether there is any engagement with services (e.g. youth justice or social care) in the future.

5.2 Risks and Mitigations

The first monthly report to the Home Office (October 2021) contained Table 5 outlining risks and mitigations.

By the following month, almost all risks had been mitigated and moved to green. By December (3 months into project delivery), the Home Office target to reach 120-180 children and young people had been achieved. An additional risk was added in February, around programme sustainability beyond March 2022 for which mitigations were documented.

A challenge and risk which was reflected upon in the evaluation focus group, and something from which learning should be taken, was that some families were referred under court mandate by children's services. This service was not deemed an appropriate support service for the complexity of these families' needs over the timeframe allowed for by the funding, but also because it did not provide the family with the option of consenting to referral. This lack of consent and the referral approach not being trauma-informed or therapeutic, understanding the journey which needs to be undertaken to be ready to access therapy was highlighted as something which would need to change should the programme continue or be up-scaled.

Table 5

Risk Description (50 words max)	RAG Rating (Red/Amber/ Green)	Mitigation (50 words max)
Referrals from Child Social Care of CYP/families	Amber	Lists of identified CYP and families are being monitored and social workers held to account for not referring families. Additional families have been identified for October/Nov intake. Training completed for Social Workers and community workers to use referral and working pathways. CSC managers are being held to account to ensure referrals are made to triage and to avoid duplication of referrals into other potential routes.
Below target number of referrals compared with initial delivery plan	Amber	Initial delay of funding meant that August was a set-up month and so delivery has only started from 14th September. We saw 40 referrals in 2 week and so we are confident that any shortfall in target numbers will be compensated for across this next quarter.
Project Evaluation system set-up	Amber	Liquid Logic, central social care database used for HITI triage, has presented some initial reporting issues. This is being addressed and is a project set-up teething issue only. We know that we have had 40 referrals for September, 37 of which are children.
Underspend	Amber	Due to the delay in funding award, we are seeing an actual underspend in this first quarter. However, we are currently reprofiling to mitigate this and have already identified an option of addition of Fender Primary support to support this mitigation.
Recruitment of Staff	Green	All staff have been recruited to the project and the appropriate number of counsellors identified.
Social distancing restrictions reintroduced due to Covid-19	Green	Currently this is not a risk that needs mitigating but plans for virtual delivery are ready to be implemented should this become a risk to delivery.
Challenges to delivery	Green	Programme forum has not identified any challenges to delivery. This will continue bi-weekly throughout the programme.

5.3 Impact and effect of interventions on risk factors and the target outcome

As discussed in 'outcomes data and impact', the six main referral and outcome criteria were designed to identify common risk factors known to correlate with experiences of violence. WHO World Report on Violence and Health identifies:

> *"No single factor explains why some individuals behave violently forward others or why violence is more prevalent in some communities than others. Violence is the result of the complex interplay of individual, relationship, social, cultural and environmental factors." (Krug, et al. 2002)*

The referral criteria include known risk factors for violence across the ecological model. The programme not only focuses on the individual child and their behaviours or experiences but looks beyond to the potential causes of these behaviours and experiences. This could be relationships with family or peers, and their home or school environment. It sought to empower children and their immediate families with the tools to build resilience.

Outcomes reported using clinical assessments, family outcome data and staff surveys show correlations which imply that the data collected is of a quality standard. Demographic data was available for 100% of participants, indicating consistency in approach to data collection across referral, triage team and FWEWs. Further, more in-depth evaluation into data collection would be required in future evaluations to determine the quality of data collection.

Qualitative outcomes feedback from stakeholders provides anecdotal insight into 'soft-outcomes' such as **reduced reliance on other services**; 81% of referrers saying they believe **those they referred benefited** with the rest saying, 'yes partly'; and 100% of referrers saying **they would refer more families or refer again to the programme.** Family feedback demonstrates the significance of the quantitative outcomes on families. One parent/carer said:

> *"My new techniques like breathing techniques are working at home, instead of going to the bridge like I used to I am breathing."*

When asked how staff delivering the programme would describe it to families, responses included:

> *"A trauma informed, holistic approach looking at all areas of life to find better ways of communicating with our community & family."*
>
> *"A social, educational and mental health support service which provides holistic programs at all family need levels."*
>
> *"A multi-faceted early intervention programme geared at supporting families who were at risk of anti-social behaviour and/or violence."*

Insight from staff demonstrates that the programme aims to reduce vulnerability to violence using a holistic programme of support to promote effective communication, social, emotional, and educational support is needed. There is recognition that programme addresses individual

risk factors by building relationships and communities, with staff describing it as a family programme, rather than support for individual children in isolation.

Although 'significant/outstanding' improvements against the referral criteria were perceived to have been made for most participating families (>90%) for whom we have outcomes data (data available for 44% (n = 224) of participants), this data only reflects short-term, quantitative impact. Qualitative outcome views and participant feedback is available (see

4.2 Qualitative results) and reflects the quantitative outcomes data. The programme outcomes are reflective of the whole programme, and it was not possible to report on outcomes for individual interventions accessed as part of the full programme. In family feedback, it is evident that families do not distinguish between the interventions, but rather feedback on the overall impact of the programme. To better understand the impact a whole family therapeutic approach has on reducing known risk factors for violence, a longitudinal study would be required.

An additional outcome, which was not captured in the core data and outcomes collection was the change in partners' approaches towards a trauma-informed, therapeutic approach. This was reflected during the focus group with senior programme staff:

> "People referring to the programme have traditionally worked within a 'social' model. The workforce development in trauma-skilled practice and therapeutic approaches to working with families that Crea8ing Careers were able to support referring partners to achieve within the short duration of the programme is a key strength."

> *"Crea8ing Careers staff were coaching both the practitioners in trauma-informed, therapeutic approaches, whilst simultaneously coaching families to manage their stress responses and anxieties towards practitioners, which had traditionally driven negative interactions. The resulting outcome for these cases has been improved relationships between social workers and families."*

Although this was not an intended outcome of the programme, it provides the programme with a legacy and opportunity for sustainable impact. It also improves protective factors in building relationships with figures of authority, which provides a positive model for children in the family as well as ameliorating their relationships with a trusted adult.

Almost 60% of individuals referred disclosed experiences of domestic abuse. In participant feedback about the impact of the programme, one parent/carer stated:

> *'I clawed back control following domestic violence.'*

Experiences of domestic abuse and violence in the home are recognised Adverse Childhood Experiences (ACEs) and emotional and behavioural effects on children are well-documented (McWhirter et al., 2008). Amongst the research, Straus & Gelles (1990) and Graham-Bermann et al. (2009) found that following experiences of domestic abuse, children who are not provided

with therapeutic support or “a psychological buffer” are more likely to experience long-term negative consequences. To understand whether the therapeutic approaches employed in this programme are the most impactful and that impact on families is sustainable/inter-generational, a more in-depth, clinical evaluation would be required. However, from stakeholder, staff and parental feedback, there is evidence that this programme has positively impacted families with experiences of domestic abuse. One stakeholder responded:

> *“This has been a highly invaluable set of services that have enabled the SW's to work with families in a range of settings and with a complex array of problems - they have supported families with DV, children who are struggling with homelessness and rebuilding family relationships- complex MH in young people and their families - they have never refused a service to us and have tried to tailor their skills and services to meet our family’s needs all my 108 children have been referred to the service and they have responded and communicated excellently.”*

5.4 Conclusions from the programme data and research

Decreases in GAD and PHQ scores and increases in Chrysali6 and CGAS scores after the interventions had been engaged with, support the efficacy of the project. Combination of high and low intensity therapeutic interventions had equal importance in decreasing GAD and PHQ scores, thus lowering anxiety and depressive symptoms. This combination was supported by Chan and Adams (2014) who found that low and high intensity therapies encouraged positive changes in reducing GAD and PHQ scores. CGAS scores increasing due to intervention was supported within psychiatric interventions too (Setoya et al., 2011). The Chrysali6 was specifically designed around the project’s criteria to measure key areas within an individual's life. The finding of improvements to the Chrysali6 score following intervention is supported by evidence which has found improvements in life satisfaction, namely achievement and social functioning following CBT (Eng et al., 2004) and emotional regulation (Jazaieri, Goldin and Gross 2017).

Along with the improvements in the outcome assessments, the post-intervention qualitative data suggests that the higher intensity therapies were beneficial in dealing with trauma. For example, one of the families explained:

> *“I have tried so many different things to address all the mess in my head from my traumas and not one has come close to scratching the surface, but EMDR literally rewired my brain, and I felt the fog of the trauma finally begin to lift”.*

Further to this another individual recognised that CBT was:

> *“massively beneficial, never considered things from that perspective before and didn’t realise how much I had got in my own way, now feel able to recognise those signs and stop them”.*

This outcome is supportive of previous evidence which suggest EDMR, and trauma focused CBT are effective at helping deal with trauma (Wilson, Becker and Tinker, 1995; Ponniah and Hollon, 2009) and effective in children and adolescents (Rodenburg et al., 2009; Karadag, Gokcen and Sarp, 2020; Lewey et al., 2018). Similarly, it has been identified that individuals who have experienced sexual or domestic abuse found reduced depression and increases in hope following EMDR (Schwarz et al., 2020) even when the trauma is childhood abuse (Edmond, Rubin and Wambach, 1999). One of the main outcomes not identified from the quantitative data but found in the qualitative feedback was improvements in positive cognitions and self-beliefs following the trauma focused therapies:

"therapy helped me recognise the positives about myself, things I hadn't taken the time to notice before or couldn't notice before because I was so buried in hating myself, but now I am learning with this boost of help to love me for me which as a previous self-harmer is so amazing, I don't want to hurt myself anymore".

This outcome again is supportive of previous findings suggesting therapies like EMDR improve positive cognitions (Wilson, Becker and Tinker, 1995).

When comparing families who have SEND children to families without SEND children, the change between pre-intervention and post-intervention remained similar. The similarity between the two groups is of particular note when compared to the previous literature. Evidence has found children with SEND had poorer mental health than non-send children during and post-COVID (Tso et al., 2022) and the families around the SEND children had felt overwhelmed and experienced poor mental health (Asbury et al., 2021). Thus, having improvements remaining consistent between the two groups is indicative of the accessibility to which the program was able to offer and cater to a variety of families groups.

Following the interventions, many of the families were spoken to regarding the efficacy and experience of receiving their support, many identified that along with the interventions, the wrap around service was very beneficial mental health. The benefits of this wraparound service have been noted by participants:

"from the beginning everyone from Crea8ing community has been there, from the first conversation at triage I actually felt listened to and heard, the Family support were there to check in personally and support in any way they could. Even on courses the facilitators were there for us just as much as there to teach us. Never known such consistent and caring support for not just me but my whole family".

The importance of complete wraparound support is not just an outcome identified by the project with other findings suggesting that multi-systemic therapy approach is beneficial in preventing violence (Henggeler et al., 1996). Further substantiates claims that wraparound is beneficial and has largely positive effects, even finding improvements on school functioning, mental health and functioning (Suter and Bruns, 2009; Olson et al., 2021). Thus, demonstrating the positive impact wraparound support has on changes made by the target

individual/family, where they don't feel overwhelmed with services and find a safe space within one collaboration.

Many of the families involved in the project demonstrate the need to implement interventions at an early help stage, as was originally intended due to early help support being psychologically, socially and economically beneficial (Fish, 2003). However, of note the project also highlighted significant benefits for individuals who were at crisis stage or past early help, as at present there is an unfulfilled demand for support at all stages of life and care including those who do not meet thresholds, such as older adults who are struggling (Vedel, Larsen & Aamand, 2020). Targeting ACEs to prevent anti-social and risk-taking behaviours has been found to positively affect physical health with ailments lessening (Finklehor, 2018), may also decrease hospital admissions for physical health ailments. Thus, not just focusing on those who meet thresholds may have further societal and public health benefits.

The qualitative data also revealed that not solely focusing on the main individual referred into the project was a crucial aspect to ensure everyone felt supported. Some families recognised that they were being referred into this project for one individual but had previously never felt supported themselves or the others had just been left:

> *"it's not just the ones who are struggling, they empower and support all of us, even the ones who are just quietly getting on with things, there was stuff to suit them. Thoughtful of everyone involved and how we were all impacted. The triage was the first time I was actually asked how I was doing instead of just focusing on my kids and I am so thankful for that".*

Family-focused approaches to interventions have been found to be effective for when adults and children have mental health struggles and school refusal in children (Solantaus, Toikka, Alasuutari, Beardslee and Paavonen, 2012; Carr, 2009) Similar to the pyramid of family care proposed by Mottaghipour and Bickerton (2005) whereby a tiered system which all the family is involved in the care and interventions are provided to as many people within the family system, this was found to be particularly effective for the families.

5.5 Cost Effectiveness

The cost of prevention is estimated to be 4 times less than the cost of treatment, recovery or rehabilitation (WHO, 2014). WHO (2014) present the case that:

> *"Interventions that affect health behaviours and enhance resilience – including improving mental health and reducing violence – can give early and longer-term returns on investment, with improved and social benefits."*

In particular, the social emotional learning and family support projects (which are included in this programme) are recognised by WHO as offering a return on investment within 0-5 years, with parenting programmes recognised as being cost-effective interventions. In 2007, the annual cost to society of mental illness in childhood has been estimated at £11,000-£59,000 per child (WHO, 2014).

Merseyside Violence Reduction Partnership (MVRP) commissioned a report on the cost of violence for Merseyside. Overall, in 2019/20, violence cost an estimated £185.4 million on Merseyside, through costs to the healthcare system, police and criminal justice system, and in lost productivity. The intangible costs of physical and emotional impacts on victims' quality of life were estimates at £194.8m. Full report available here.

The therapeutic interventions programme aims to prevent experiences of violence thereby reducing inflated cost of recovery. The programme focuses on supporting family recovery from trauma (reducing risk of inter-generational trauma), supporting the maintenance of positive relationships between family members to improve protective factors, and providing rapid and therapeutically appropriate support for children and young people displaying early signs of dysregulation which can develop into mental health difficulties for them or their parents/carers/siblings. Therefore, in addition to the estimated cost of violence, by taking a public health approach, providing support at safeguarding levels 2 and 3, it is important to consider the potential direct savings for both child and adult social care, and NHS primary care teams. This is not just about the cost of crisis mental health support, but consideration must be made to the impact of unsupported childhood mental health on future physical health, related to co-morbid conditions associated with Adverse Childhood Experiences and trauma.

The Home Office funding awarded for delivery between September 2021 and March 2022 was £852,666**.** This was initially intended to provide high-intensity therapy to a minimum of 120 children and young people and their families, costing in the wrap-around support. However, most of the budget (approximately 62%) were allocated as staffing costs. As the programme evolved, this budget structure enabled the flexibility to take on more than the intended number, and to provide more intense support to the wider family. The cost therefore reduced from the initial maximum expected £7,105.55 per child/young person, to an actual cost of £3,643.90 per unique child (accessing clinical or mentor-led CBT). This is around a third of the minimum estimated cost to society of mental illness in childhood (as aforementioned).

As this is a whole family programme, judging value for money and cost effectiveness based solely on the impact this has on unique children is potentially misleading. The crude cost per family engaged in this programme is therefore £2,631.70. However, it is important to also consider secondary beneficiaries (i.e. siblings, kinship children and other adult family members, let alone fellow pupils in school, peers and the wider community) and the cost to these people and places if this programme had not existed.

If the outcomes achieved in the short-term and presented in this evaluation are sustainable for children, young people, and families as a result of their participation in this programme, then there is little disputing the cost effectiveness of this programme. Future evaluations could consider reviewing more closely the social return on investment of improving relationships; improving social, emotional, and educational wellbeing; improving behaviour management and emotional control; reducing violence/aggression; improving engagement and productivity; and reducing opportunities for victimisation.

5.6 Scalability

Based on the data around importance, quantitative and qualitative outcomes and feedback collected as part of this evaluation, alongside the existing research on the impact of trauma-focused therapies delivered holistically with the whole family, there is a clear need for this programme in Wirral. The scale of the project developed from reaching a minimum of 120 individual children and their families over a 7-month period at programme inception, to reaching an actual total of 507 individuals across 324 families (234 individual children and young people) in the same period. Programme managers reflected in the evaluation focus group that this is not a sustainable increase and that the need and speed at which this programme gained momentum was beyond what was originally budgeted for. They also reflected that the complexity of some of the families accessing this support was also not the intention of the programme, as it is intended as early help support based on children and young people beginning to display signs of adversity and trauma.

Whereas other local projects such as the ADDER programme are targeted tertiary support, this programme is intended as a targeted primary/secondary service (safeguarding children's levels 2 and 3). As such, its scalability relies on multi-agency partnership joint commissioning over a longer timeframe, enabling more in-depth evaluation of impact across a range of health and social outcomes over time (ideally inter-generationally using a longitudinal study). As demonstrated, trauma and adversity in childhood can have significant long-term physical, emotional and social impact throughout a person's life. This programme must therefore bring together partners who are able to measure impact on a range of health and social outcomes. In the current emerging landscape, this programme could fit within the remit of developing Integrated Care Partnerships (ICP). However, fidelity to the delivery model enabling community-based access in spaces which engender trust and safety for those accessing support should be maintained.

It is important to add here that experiences of trauma and adversity are not related to deprivation or poverty (Harris, 2018). However, access to support to overcome the effects of trauma and adversity can be more difficult for those from deprived communities or who are living in poverty. When scaling-up or re-investing in delivery of this model, commissioners and delivery providers should note the importance of an accessible location to those for whom travel is a barrier to engagement. Consideration for scaling-up should include whether a 'hub and spoke' model can be implemented using local community assets to improve scale and access for communities, whilst maintaining fidelity to the uniqueness of this programme.

From disclosures made at point of triage for this programme, a significant number of families experienced trauma and domestic abuse, as well as alcohol/substance misuse. These disclosures were often made to the triage team by the adult family member, with some children also disclosing experiences of inter-generational risk. This demonstrates the need for adult family members to access therapeutic support to enable them to recover and build resilience, reducing the risk of inter-generational trauma and adversity. The simultaneous access to support for child, young person and adult family members is a significant factor in the success of this programme, as demonstrated by stakeholder, staff and participant feedback. As is a menu of support available which can be combined to make a bespoke package of support for individuals and families. This will require child/adolescent service commissioners and adult service commissioners to collaborate to create a joint commissioned pathway which embeds whole family support as a preventative service.

5.6.1 Improvements

Families and individuals benefited from the wraparound support as previously highlighted. However, ensuring there are enough FWEWs for caseloads, as this programme surpassed expectations with higher demand, would be a crucial improvement. The team of psychologists and FWEW's managed to ensure everyone referred had their needs met, but efforts to expand the number of FWEW's to be able to meet increasing demand more flexibly would benefit families more.

The qualitative feedback indicated that participants appreciated not "being put in a box" or "having to go to a million different places for one person's needs because it was all in one place". This is an area to continue improving as people disclosed, they didn't want to have reach out to different organisations within the project to access different services and preferred having "one core place to go to access help".

To make the services as easily accessible to all referred families as possible, the delivery of interventions was spaced out across Wirral. Central bases were used for certain interventions, namely the mentor-led CBT courses taking place in Birkenhead (North-Wirral) and the high intensity therapy taking place in Heswall (South Wirral). However, interventions like psycho-

social courses varied throughout North and South Wirral to ensure that people were able to attend courses local to them. Similarly, while therapy was mostly conducted in South Wirral, a therapist was working from the Crea8ing Community base on the Noctorum housing estate in North Wirral. Further developing this approach would improve scalability whilst maintaining fidelity to what has worked well during this programme.

The programme was designed during a period of easing national Covid-19 restrictions. Therefore, there was also an option for families to attend courses and therapies online to ensure accessibility for all, with some therapists in Heswall Hills also accommodated individuals with therapy over the phone. This supported those with agoraphobic conditions or anxieties related to Covid-19 and should continue to be considered and improved upon. While some families wanted to attend interventions in person, they may not have had the financial means to get to and from the therapy, therefore a transport support fund was established. This fund was applied for by the families with rail cards, bus passes and taxi fares were provided to the family. The transport support fund was offered to 22 families to help with travel to and from their interventions, facilitating transport to access interventions is likely to improve attendance and engagement (Statham & Beail, 2018). This was to remove barriers and financial strain that may be unintentionally placed on families from support being offered, which improved accessing of services. While this was very beneficial for families, the money allocated to this fund ought to be increased as families found it incredibly helpful, alleviating stress for them.

5.6.2 Recommendations

Quantitative feedback has been beneficial in highlighting the areas of change proficiently through statistics, however, most of the core elements highlighting what has worked, what the challenges are and what needs to be improved has stemmed from qualitative data. Whilst useful in a retrospective evaluation of the program to help understand more about families' thoughts and feelings, these qualitative reports did not undergo any qualitative analysis throughout the duration of the programme and thus were not a central focus of data outcomes unlike the quantitative assessments. Mixed qualitative and quantitative data have been recommended in evaluating and developing complex interventions as a virtuous blend (Green, 2016; Seymour, 2012). Therefore, a mixed methods evaluation is recommended as the qualitative data can substantiate the quantitative date as well as further explain it. Thus, it is recommended the qualitative data to be analysed through grounded theory (Corbin and Strauss, 1990) or thematic analysis (Braun and Clarke, 2012) to better focus conclusions drawn from verbal reports.

From a clinical standpoint, individualised programme monitoring may be beneficial. An approach for families to rate their progress quantitively and then explain why they have rated themselves at this point throughout their interventions. This would stimulate self-reflection and enable the therapists to adapt the therapy to suit their needs (Sales & Alves, 2012) helping better clinical practice (Lutz, 2010). Self-reflection is beneficial in empowering individuals and stimulating active engagement in therapy and within their daily life as they take ownership of this (DiMaggio et al., 2009; Philippi & Koenigs, 2014). Thus, qualitative data would be beneficial from an evaluative and clinical perspective, but also may increase engagement and supporting participants further.

Timelines and clear instructions of what is expected to be measured should be highlighted from the beginning of the project. This is to enforce operational consistency and ensure that all individuals have the same measures at the same points of time, so that these can be put in place on systems before commencement of project. Streamlined guidelines and expectations from beginning to end of the project need to be clearly defined and outlined,

enabling all software to be updated from the start with clear goals and all staff knowing what data should be collected from everyone involved. However, this project was expeditiously formed due to deadlines, so was satisfactory considering the circumstances and acts as learning for future projects.

It has been recognised some families struggled with the multi-agency contact. The offers of interventions were extensive and wide reaching to encapsulate as many individuals as possible of varying backgrounds. However, being triaged by the assistant psychologists and then contacted by other agencies seemed to cause issues. It worked for families only requiring support from two other services, yet those needing multiple services for differing family members indicated it was “confusing”, “unhelpful” and “made them not want to bother” if there were too many places trying to contact them. Therefore, a recommendation would be to have a role within the project to liaise with the desired services and co-ordinating and planning the family's involvement in different services.

Non-engagement needs to be clearly tracked across multi agency involvement, while this did occur, further communication across agencies to help understand the reasoning as to why some individuals will not consent to finalising post assessment scores. In line with a recent paper, we filled the gaps needed to try and prevent non-engagement through individually invited, trauma informed care, safe spaces, no pressure to share, supervision for staff and advice on how they could apply skills to real world (Harris et al., 2020). However, this paper was predominantly within an acute ward, so this would need to be adapted to community and council settings. Figuring out more collaborative ways of tracking non-engagement across teams to mitigate unattendance and ensure the support and interventions offered should be taken up in future projects.

5.6.3 Challenges

One of the main challenges faced through the program was the stigma of mental health. Stigma is inherent with mental health support is the stigma that comes attached to mental health which can impact on seeking treatment and help (Bharadwaj, Pai and Suzidelyte, 2017). As evidence has identified women with anxiety or depression symptoms perceived there to be more of a public stigma around seeking mental health support (Pedersen and Paves, 2014). Meanwhile, Wu et al., (2017) found amongst men who had high perceived need for mental health services and had self and public stigma around such services, they were less likely to seek out mental health support. While the challenge of stigma most likely played a role on non-engagement rates, crea8ing community made efforts to reduce the stigma around mental health. In adherence to the recommendations made by Rusch, Angermeyer and Corrigan (2005), crea8ing community had made efforts to educate around mental health and normalize it through the courses offered, along with the use of social groups and FWEW’s to improve contact and discourse around mental health.

Another aspect linked to the stigma and mental health is the notion of trauma, IPV and drug abuse being focused around deprived areas. While studies have linked neighbourhood deprivation in early life to domestic abuse (Yakubovich et al., 2020) along with lower social class, income and living in a deprived area all being linked to increased lifetime physical IPV (Khalifeh et al., 2013) this may be misleading. For instance, research by Herbet et al. (2020) found no relationship between low socioeconomic status and being the victim or perpetrator of IPV within the UK. Similarly, the lack of link between dating violence and socioeconomic status was also found in adolescence (Young et al., 2021). One of the main reasons for the two discrepancies in the data may lie in reporting the domestic abuse. As found by Walby and Allen (2004), women from households with an income of less than £20,000 per year were almost three times more likely to report domestic violence than households of over £20,000.

This was identified by Weitzman (2000) after suggesting the perception of domestic abuse being primarily in deprived areas created a stigma around domestic abuse for all classes. Similarly, research suggests that socioeconomic status does not buffer against the link between drug misuse and ACEs (Currie and Tough, 2021) and the links between ACEs and psychotropic medication use was similar across all socioeconomic groups (Bjorkenstam et al., 2013). Thus, the perception of stigma posed a problem for those referred into the project from a higher socioeconomic status and may have further impacted on engagement rates. Therefore, there needs to be a shift from just focusing predominantly on areas of deprivation to make it accessible to all regardless of socioeconomic background.

Finally, there was the challenge of court-mandated therapeutic referrals and the efficacy of this on engagement and outcome. Court-mandated therapy can pose some issues, namely the strain placed upon the therapeutic alliance when the individual has not willingly sought out therapy themselves, due to court involvement, can be seen as forced (Honea-Boles and Griffin, 2001). To prevent this Boria et al. (2013) and Hachtel, Vogel and Hubler (2019) place a focus on building a good therapeutic alliance through allowing individuals decision making powers around their therapy and the therapists taking a caring approach, which can mitigate the perceived mandated attendance. Similarly, some of the suggestions by Honea-Boles and Griffin (2001), such as maintaining boundaries from social services and the therapist, could help reinforce the idea of confidentiality. As such, while factors like perceived coercion and motivation may be problematic at the beginning, Snyder and Anderson (2009) indicate these factors are not determinant on outcome and there is a similarity between outcomes for voluntary and court-mandated therapies.

Whilst mitigating the issues related to court-mandated interventions were a problem, another problem that arose was some referrers having potentially unrealistic expectations of progress. Crea8ing Community have found that individuals respond better when they are ready and believe they have the control to start something they choose to do. A family may be tentative and only slowly progress through the therapeutic intervention tiers. This slow progression may have conflicted with some referrer's expectations, and as such a need to manage other agencies expectations of how services are provided, working collaboratively to support individuals to access interventions offered at a time that would benefit them.

6. Conclusions

6.1 Importance

This evaluation has demonstrated that there is a need in Wirral for an approach which addresses underlying causes of various health and social outcomes, especially those which correlate with mental ill health, drug, and alcohol misuse. This programme was designed to address community feedback around access to early help services and gaps in services in Wirral, but the findings and structure of the programme are transferrable and scalable to other areas of the region. There is a need to reduce strain on social care services and CAMHS. An all-encompassing service which addresses root causes of multiple behavioural, emotional and health outcomes for all families such as this could be an answer in both the short and long-term. Using early intervention focused on behaviours which indicate low resilience, it is expected that in the medium-long term, this holistic family approach will have an impact on anti-social and violent behaviours.

6.2 Relevance

Programme stakeholders, delivery staff and participants identified gaps in services as part of this evaluation, further supporting the Community Matters Insight presented in the introduction, which this programme was able to fill over a seven-month period. It supported the process utilised in existing early help structures to intervene earlier, whilst also providing access to more intense therapeutic support to those for whom access was otherwise more difficult, even those in crisis. Accessibility was a key strength of the programme, with barriers to accessing existing services including not meeting thresholds, being on long waiting lists, the offer was for an individual family member rather than all of those who needed it, there being a stigma or even practical barriers to accessing therapeutic support. The uniqueness of the programme made it relevant, not only to families participating, but also to those who made referrals to the programme.

6.3 Feasibility

By utilising structures which are already embedded within social care settings, this programme made transferring relevant information to appropriate people easier, improving the accessibility not only to the data to best measure impact, but also the accessibility of the programme to participants. Families did not have to repeat their stories to multiple professionals, and they were coached and supported by a Family Wellbeing Engagement Worker (FWEW) to be resilient to this if they did. The programme was quickly put together and this caused some challenges both in the set-up, but also in planning for sustainability. It benefited a significantly higher number of families than was originally intended, which has contributed to its cost-effectiveness. However, it is noted that the pace of delivery in this programme to the number of families is not sustainable without greater investment. Taking a public health approach which is targeted to levels 2 and 3 safeguarding needs, the programme comes in at a third of the minimum estimated cost to society of mental illness in childhood. Future projects should have a clear outline at the beginning, pertaining exactly what needs to be measured and at what points of the timeline of the project. Using a mixture of quantitative and qualitative data analysis to track progress at set points during and at the end of interventions to enable reflection on what is working and what must be adapted to better help families.

6.4 Scalability

The programme has demonstrated the importance of community collaboration to improve access to appropriate services to meet community need. It offered appropriate and evidence-based therapeutic support made accessible to all those in a family who need it, at the time when they need it, where they could most easily access it. The focus of this funding which

saw the inception of the whole family therapeutic programme in Wirral was on reducing risk factors for engagement in violence. However, by taking a trauma-focussed approach to recovery and resilience building, the impact on health outcomes could be far greater. Efforts should continue to be made to reduce stigma around mental health and trauma, along with improved access to support regardless of socioeconomic background. By easing inter-agency communication and increasing access to transport, more families would be able to access support. This is paramount to facilitating a more cohesive programme reducing as many barriers as possible. Based on the short-term outcomes demonstrated, the continuation of this programme should reduce strains on existing services in both the short- and long-term. With the right guidance, delivery providers, longer-term commitment from the right strategic leads and appropriate resources, this programme has the potential to make significant impact and consideration should be made as to how it can be rolled-out across the region to further evaluate the potential impact.

6.5 Summary

Overall, the project demonstrated that in a small amount of time, community driven agencies, providing full wraparound support to meet psychoeducational, therapeutic and social needs was effective at helping families. The results demonstrate the reduction of anxiety and depressive traits and the increase in self-esteem, wellbeing, social, emotional and psychological outcomes, all implicated in their role on increasing violence. The programme has demonstrated that through empowering individuals and families to collaborate with local community services, positive changes can be enacted by the individuals themselves, with minimal waiting times. The wraparound support allowed families to set the level of need for the service, which further facilitated active engagement. This project was unique and facilitated positive change in the short term. The evaluation recognises the importance of a central community delivery provider with a sustainable business model, to enable to continuation of relationships and support for families beyond their direct involvement in programme interventions. The main six project criteria were targeted and the outcomes from interventions indicate that these areas were reduced, highlighting the benefits of community services collaborations. Community is about unity in a time of need and this project exemplified that for the families who went through this process.

Glossary

ACE – Adverse Childhood Experience
APMS – Adult Psychiatric Morbidity Survey
CBT – Cognitive Behavioural Therapy
CCO – Children's Commissioner's Office
CGAS - Childrens Global Assessment Scale or CGAS
FWEW – Family Wellbeing Engagement Worker
GAD7 - Generalised Anxiety Disorder-7
HES – Hospital Episode Statistics
ICD10 – International Classification of Diseases, Tenth Revision
IMD – Index of Multiple Deprivation
IPV – Intimate Partner Violence
LA – Local Authority
LKIS - Local Knowledge and Intelligence Service
MST – Multi-Systemic Therapy
MVRP – Merseyside Violence Reduction Partnership
OHID – Office for Health Improvement & Disparities
PHAU – Public Health Analysis Unit
PHQ9 - Patient Health Questionaire-9
TIIG – Trauma &Injury, Intelligence Group Surveillance System
VRU – Violence Reduction Unit
WHO – World Health Organisation
YEF – Youth Endowment Fund

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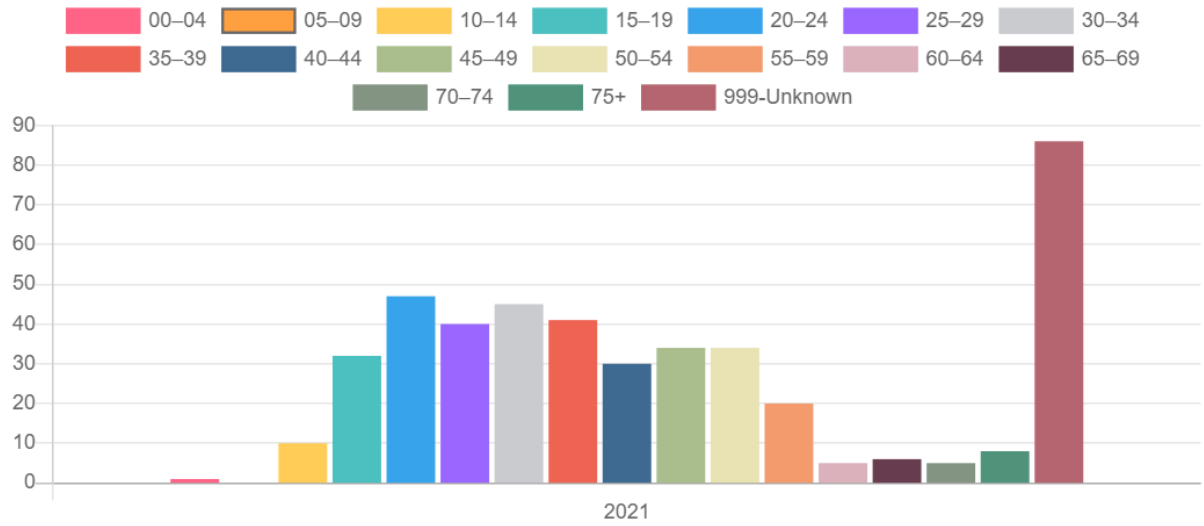
Appendix A: Additional TIIG Data

This data presents further supporting information to inform need and scalability of programme in Wirral.

Based on NWAS call-out data, coded as likely to be related to an assault (Advanced Medical Priority Dispatch System) between 1 January 2021 and 31 December 2021 for Wirral residents, the patients aged 20-24 years represented marginally more callouts than for 30-34-year-old patients. However, most age-group data is unknown 999 calls. See *Figure 2*. This data does not infer correlation between causes and violence-related outcome but is intended to show ages profiles of those experiencing violence.

Figure 20

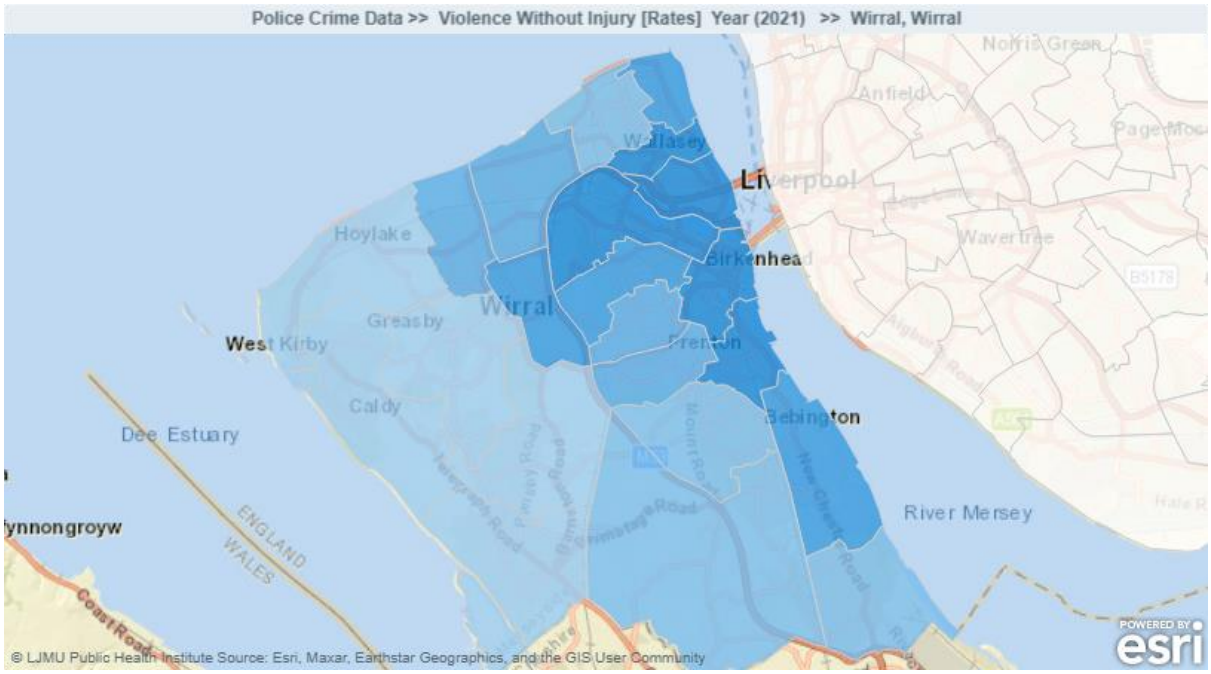


Source: TIIG, Violence Reduction Partnership Hub, Data Hub Charts, North-West Ambulance Service (NWAS), 01/01/2021 – 31/12/2021, Grouped by Age for Wirral LA residence.

Police Crime Data

Violence Without Injury is the most prevalent serious violence offence sub-classification for Wirral. *Figure 3* shows ward-level overviews of Violence Without Injury offences for the year 2021, with the darkest blue representing the highest rates of these types of offence. The top three wards are then broken down to show offence rates in more detail.

Figure 21



Birkenhead and Tranmere

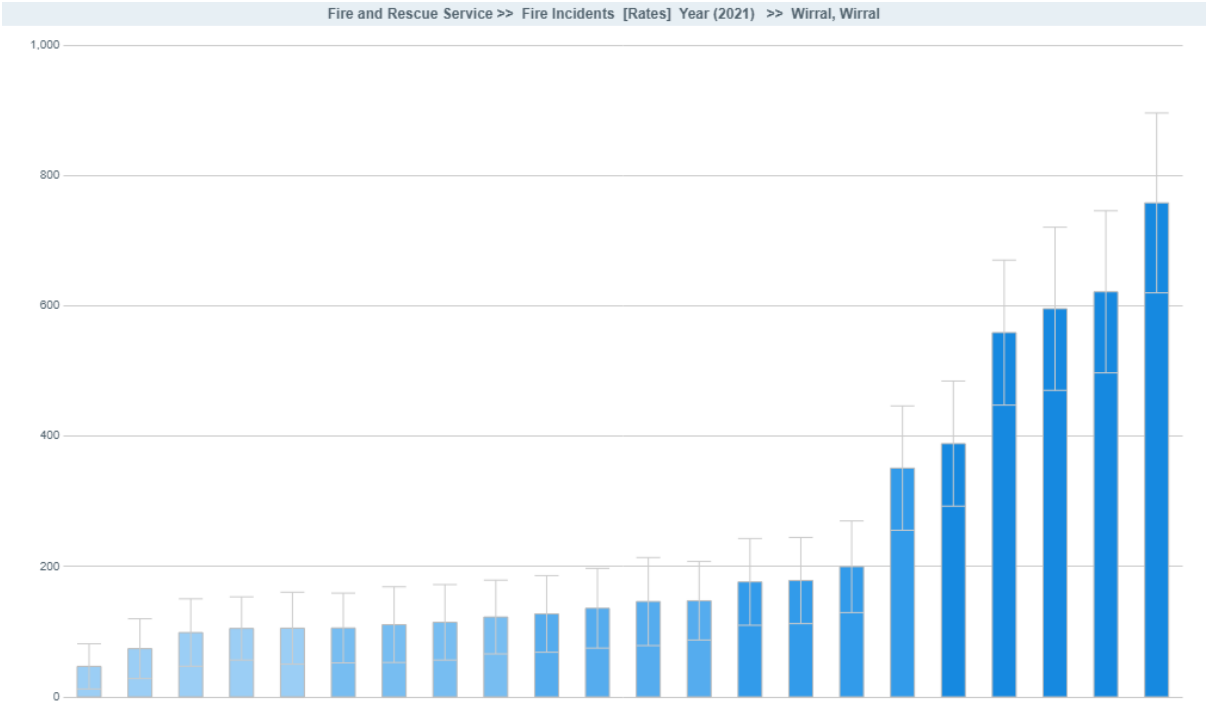
Bidston and St James

Seacombe

Merseyside Fire and Rescue Service (MFRS)

MFRS data for the year 2021 shows that the top three wards for Deliberate Fires were Bidston St James, Seacombe and Rock Ferry (followed closely by Birkenhead and Tranmere). See *Figure 4*.

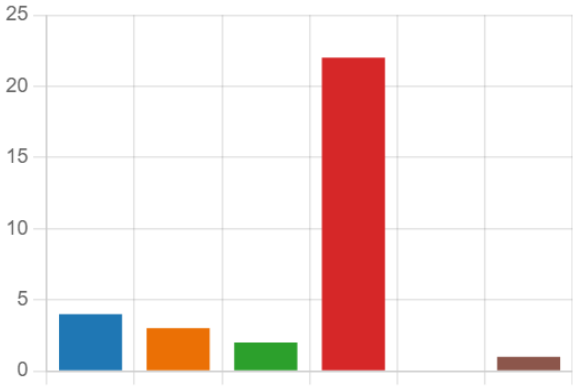
Figure 22


Fire and Rescue Service >> Fire Incidents [Rates] Year (2021) >> Wirral, Wirral
1,000
800
600
400
200
0

Appendix B. Stakeholder Survey Questions and Responses

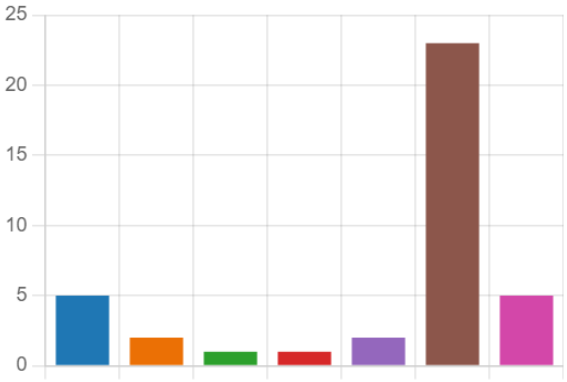
1. **Which description fits your role best**

Senior Strategic Manager (Hea...	4
Middle Manager (Service mana...	3
Team Leader	2
Front line worker (social worker/...	22
Community volunteer	0
Other	1



2. **Was your referral suggested following advice from a 'panel' meeting discussion such as:**

Accommodation Gateway Meeti...	5
Vulnerable Child Panel (VCP)	2
Integrated Response Panel (IRP)	1
Step Down Panel	1
Allocations meeting	2
No my referral was not a sugges...	23
Other	5



3. **How was it to gain a family's consent to the referral (based on the project offer)?**

Extremely easy	22
Somewhat easy	7
Neutral	3
Somewhat not easy	0
Extremely not easy	0

4. **Families referred on to the project were contacted by the psychologist triage team within 3 days of the referral being submitted. Parents told us they were happy to accept the support identified for them and their children. We want to clarify this is the view of those who referred the family. Do you agree or disagree these statements?**

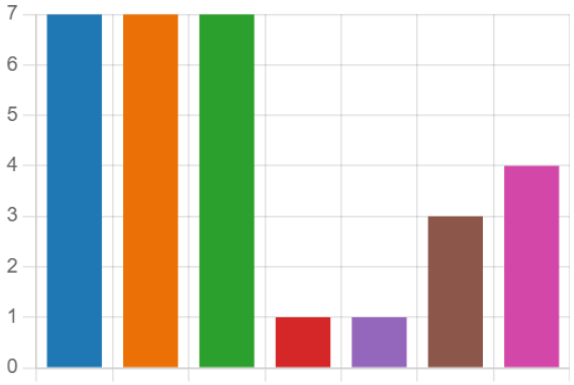
Yes most of the families I referre...	26
Yes most of the families I referre...	14
No, most of the families I referr...	0
No most of the families I referre...	0
Other	0

5. Did the families you referred take up the offer of support?

Yes all referred families took up ...	23
None of the referred families to...	2
Some of the referred families to...	5
Other	2

6. How many families did you refer?

1	7
2	7
3	7
4	1
5	1
more	3
N/A I am the manager this is no...	4



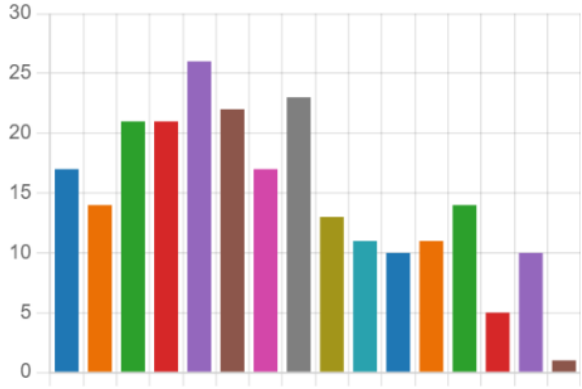
7. In your opinion have the families you referred benefited from the interventions offered?

Yes	26
No	0
Yes partly	3

8. Would you refer other families to the Family Therapeutic Interventions project if the project was extended?

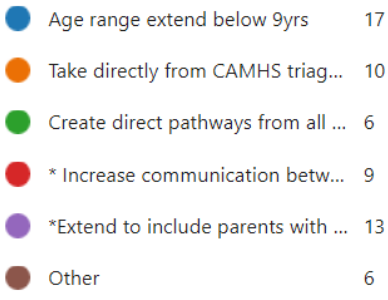
Yes	32
No	0

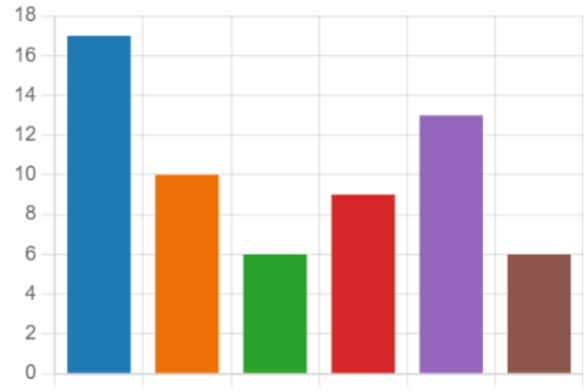
9. **What do you consider to be the key strengths of the Family Therapeutic Project? Please select the most relevant, there is a free text box at the end of the form for your views.**
    a. Fast easy referral
    b. Referral process embedded into familiar systems (no hunting for referral forms)
    c. All referrals /families are triaged by qualified psychologist within 3 working days
    d. Offers high intensity therapy to children and young people
    e. Offers high intensity therapy programmes to parents/carers and adult family members
    f. All families are allocated a FWEW who supports the family and ensures communication with referrer where required.
    g. Provides a planned fast timed approach for whole family therapies
    h. No waiting lists for therapy for CYP or adults
    i. Full engagement strategy to ease family members into high intensity therapy when they are ready
    j. Planned exit strategy to embed the family into local services to sustain improvements following therapy.
    k. Helps CYP who are struggling to maintain their place at school
    l. Retains a focus on helping CYP to identify, name and express emotions in a healthy way.
    m. Supports parents to understand ACEs and recover from adverse effects.
    n. Is inclusive of CYP with SEND and their family
    o. Supports families to recover from DA experiences in a way other DA services do not.
    p. Other



10. What do you consider to be the Key areas for improvement of the intervention. Please note * denotes there may be additional costs incurred. We have left room for your views in the free text box at the end of the survey.

a. Age range extend below 9yrs
b. Take directly from CAMHS triage to prevent escalation to Children's services
c. Create direct pathways from all panel meetings
d. * Increase communication between allocated FWEW and referrer
e. *Extend to include parents with multiple needs whose children are not already open to CSC.
f. Other

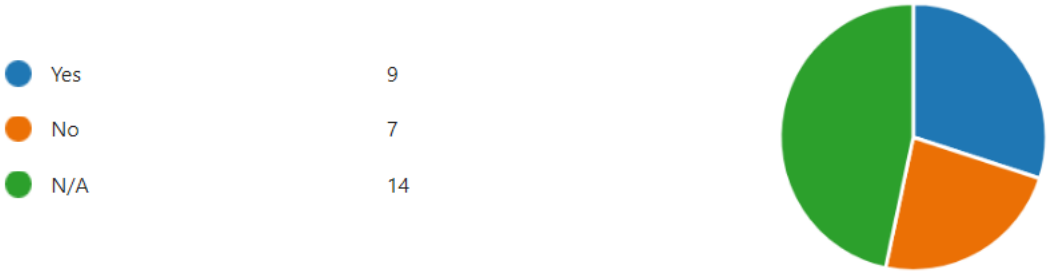




11. Did the family engagement with the interventions reduce the demand upon your service? (Your case was less complex, you could close your case following engagement, the child was better able to engage at school, the family feel empowered to access support locally within their community- reducing demand on your service).

a. There was a reduction in service demand.
b. No marked reduction in service demand
c. Some reduction in service demand
d. Yes
e. No

12. Where you able to close your case as a result of the family engaging in the Family Therapeutic Project?



13. In your professional opinion is this service duplicated elsewhere? Please tell us more about this below.

no
no - I think this service offers something special, especially the ease with which children and parents can access much needed therapeutic support, but also in the way it offers a 'menu' of services to families. i think it has taken a bit of time to embed understanding of this service offer within children's social care teams (I am a cp court team manager) but I can see a real increase in use of the service, engagement for families, and a positive impact of the service. I think if this service continued, we would start to see a real positive impact on the number of children who can safely remain with their parents, and reduction in the need to issue proceedings/ have children become looked after, especially for children over 9 who sadly don't always experience good outcomes through becoming looked after
no
This is a unique offer that supports our Breaking the Cycle vision to empower our families and build a resilient community
no
Not at all - I have never come across a service like this and it has been life-changing for the families I have referred to.
Not that I am aware of.
No, nobody else offers EMDR therapy or access to a psychology triage at short notice- free for families
No nothing else like this
This is the only service we currently have that offers this support/input.
No it is not. I needed a therapeutic service to support 2 siblings who were ready for this type of intervention having expereinced severe trauma, this was heavily impacting on the family to the point of edge of care. The wait for CAMHS was ridiculous but I am so glad that creating communities was available as I prefer this service to CAMHS as it is a wrap around service for the family. The psycologist communicate well with myself and have recommended other therapies. I am very pleased with the service the family have received.
This has been a highly invaluable set of services that have enabled the SW's to work with families in a range of setting and with a complex array of problems - they have support families with DV , chidlren who are struggling with homelessness and rebuilding family relationships- complex MH in young people and their families - they ahve never refused a service to us and have tried to tailor there skills and services to meet our families needs all my 108 children have been referred to the service and they have responded and communicated excellently .
Not to my knowledge
No
Yes some of the prgrammes are however the qualifity of the serivces you provide has been excellent for the famlies I currenlty work with .

No. Its another tool that is greatly needed when looking at different ways to support children and their families.
No this service is unique and has been a blessing and should continue
No
NO, we have CAMHS but waiting list too long, also this service offers support to adults as well as children
No
As a school, before this academic year, we were not aware of the services offered by Crea8ing Community but are now delighted to have a service to refer families to. We have not see this service and support duplicated elsewhere and it fits perfectly within our external services offer to families.
No, this is the only service I am aware of specifically for trauma related therapy,
No nothing like this service about
No it isn't and it is very local.

14. This is a free text box for you to tell us anything else you think we should know about the project.

support they provide is invaluable and a clear need for
When children are not attending school for significant amount of time due to the chaotic dynamics of family life over a number of years, this offers a whole family approach to changing the life chances of the CYP and the adults within the family. Wonderful initiative and wonderful feedback form the workers supporting the families

overall a very positive development!
Crea8ing Careers has been amazing so far and I would be so disappointed to see the service end. This has plugged a gap in Wirral that was needed for our families and provides holistic, wrap-around and creative support. It has been greatly appreciated by the families I have referred to. Speaking from the feedback recieved from my family, this service has been fantastic and so helpful, my yp has only had one session and absolutely loved it and cant wait for the next one.

It's a complete package of support for families, led by an experienced team. It is a very much needed service.

We really need this service it really works for the whole family
The service has been a brilliant therapeutic input for all the families I have referred through. Families receive a high level of support and intervention that makes changes for them and almost all of the families I have referred have found it beneficial and engaged well. Without this service it is likely that they would have been subject to longer periods of intervention as as Social Workers we do not have the time or knowledge to provide the support and intervention you are able to.
This is a unique service that is desperately needed within Wirral - the fact they will continue to work with families who are no longer open to statutory services means that families still benefit from an excellent services without the need for a SW

The project proceeded well considering the small amount of time provided to embed the pathways to other service providers

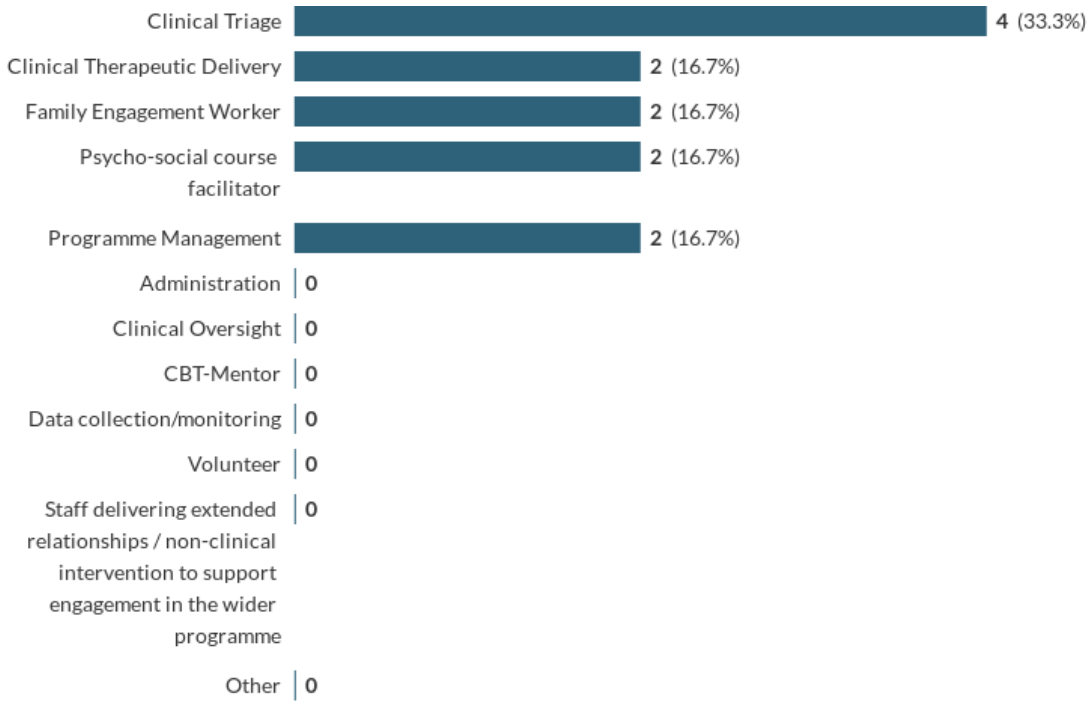
This project has been invaluable for my families who have loved it. I can't think of anything else that could replace this.
one of my mums is now working and holding down a part time job, has separted from her abusive partner and is doing very well. Antoher family - the mother refused all serivces for the best part of a years most and said to me she felt comfortable to engage with yourselves and added I want this programme to contnue I will miss it when it ends. I beleive there woudl be a gap in services if this agencies was to cease. That is sad for the Wirral families.

Just that it needs a further extension, to truly see the benefit of the support for families on the Wirral.

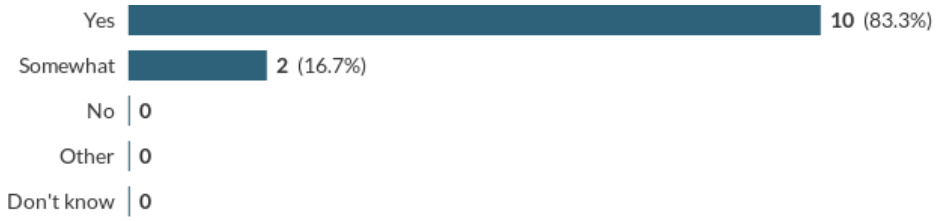
Brilliant service which is so needed.
I referred a family which was immediately picked up and full support was offered to enable the family to attend. The worker invited the family for a walk around before programme commenced. Excellent communication between myself as the family Worker and the crea8ting worker.
From initial conversations to referral, the process has been excellent. The support from Crea8ing Community for professionals to identify need and the best support available has been excellent. The process is very simple and swift which enables families in need to get support quickly. It is too early to review the support but I am certain it will be very beneficial.
As the provider of the creative, therapeutic activities and project, the outcome for the families and their involvement has been positive, with good feedback from the adults and young people. There are sections on this form that would be dealt with by our partners, Creative Youth Development, and therefore have been left blank.

Appendix C. Staff Survey Questions and Responses

1. **What was your role in the programme?**



2. **Do you feel the programme met the needs of children, young people and families you encountered as part of the programme?**



3. **Were there any children, young people or families who's needs you felt could not be met by the programme?**

3b. If so, what were these needs and do you think there are ways the programme could be developed to support them?

Some of the case were very complex and were not the correct skill match for the therapists at the centre. A possible solution would be too engage more clinical psychologist who have experience of working with complex presentations in children
More one on one approach. They were very materialistic, concerned about image, social media presence.
If felt that some clients would of benefitted from more sessions an that some would of benefitted from family therapy as they didn't want to attend individual sessions
Na
The program could be allowed long term funding to implement all the support available for intergenerational social improvements.
While the majority of families who wanted to engage have, there were families who were referred in but did not feel that they wanted any support or already has too much support set up.
Only those who did not engage did not have their needs met, but they refused triage and intervention.
n/a
Maybe some shorter programmes for younger/SEN children?
NA
Most families by the very nature of the referrals, were at a crisis point in their relationships. For some this was as a result of historical experiences, ACES, DV, poor mental health, substance misuse, bereavement and loss as well as many other challenging situations. This meant that some families came to the project at a point that they were not ready to work together on the rebuilding of their relationships, as they needed to engage in therapeutic interventions which had been identified to support them to address past traumas. As a result, some families found it too challenging to engage positively and productively in the process. For some who were referred to life story it was assessed that the process could actually be damaging for individuals, so alternatives were found to work with those families.
Sometimes it is difficult for our Woking parents to access courses

4. **How would you explain this programme to a new family you were considering referring onto the programme?**

A multi faceted early intervention programme geared at supporting families who were at risk of anti social behaviour and/or violence
A trauma informed, holistic approach looking at all areas of life to find better ways of communicating with our community & family.
I would explain that the program offers different types of counselling/therapy to suit individual needs but the 10 sessions may not allow for the client to cover all there anxieties in this time an that seeking further counselling maybe needed.
Program of wrap around care for the whole family , which includes specialist targeted therapy, allocated family support , parental and therapeutic courses, support groups and family hub
A social, educational and mental health support service which provides holistic programs at all family need levels.
The programme offers a variety of support, from social, educational and more therapeutic interventions. There is a level of support that anyone can access and it is very adaptable to the needs of the family.
Wraparound support system there to help as much as you want and need, with courses, events, therapeutic interventions and support from referral, through triage, intervention, closes and after.
A programme that allows families to holistically explore their needs and have easy access to the support that might help
Life changing!

A charity based in Birkenhead & Prenton who work with families across the Wirral. They provide support in a number of different ways, including coffee mornings, as well as courses for children and adults
this programme was designed to engage families (parents/carers and their children) whose relationships had been challenged in the past. The programme will offer opportunities for parents/carers and their child/children to enable them to rebuild their relationships in a supportive and creative way. There are a range of creative projects which would sit alongside more intensive therapeutic interventions (which were being offered by other professionals) to address issues such as parental mental health, ACES, DV, substance misuse, death and bereavement.

The projects were to be facilitated by youth workers and art practitioners, experienced and appropriate family support organisations, family support workers, and social workers and professionals who could enable the families to work in collaborative ways, which would help them to have an insight into their relationship, the strengths and how they could move on positively together. the project is via referral from a professional

This programme is constructed to your individual needs and requirements and you are fully assessed to meet those needs whilst being fully supported via family engagement worker through out the whole process

5. What do you consider to have been the key strengths of the programme?

Grass roots level in the community Quick response and a variety of different interventions geared at specific needs
The approach from all angles; therapy, trauma courses, coffee mornings.
Offering free help to those who may not be able to seek it otherwise
One point of call .....Family support
The wide range of immediate support available and the counselling therapeutic services.
The speed of contact from referral to having the first triage.

The wrap around service from family wellbeing engagement workers.

Having a wide variety of interventions and being so flexible.
Within 24 hour contact from referral being received.

Full wraparound support throughout the whole process.

Consistent and caring check ins and support.

Interventions suited and catered to the individuals and the family.

Accessible services and reasonable adjustments made to suit individuals; including transportation.
Fluidity of referrals to interventions

Fully rounded support offered to all families

Learners more able to deal with their own strength using positive coping strategies; higher levels of resilience, able to cope with daily life more than before; families knowing where to go for support, more confident learners. The list is endless
It's wrap around approach - they support the whole family. Its approach to supporting families is more relaxed and doesn't have a clinical feel, which a lot of families find more accessible

Wrap around offer of services and interventions to support parents / adult care givers as well as opportunities for young people and children. Tailored approach to each family.

families we worked with enjoyed the creative projects and activities we offered. some young people have gone on to join the organisation and participate in our programme.

involvement of statutory, non statutory and 3rd sector organisations
Therapy offered and the continued support given to the families.

6. **Where there any aspects of the programme which you felt could have been improved? (Please consider your answer from the point of view of children, young people and families, but also consider how your own professional experience of the programme could be improved).**

No
No
I feel some clients would of liked to continue. I personally found the referral forms hard to navigate as in some cases it contained the whole families information, I feel the background to this information could be obtained during the first phone call to parents.
Ideally I would have preferred a more seamless integration of government CRM and our own.
At the height of referrals more family engagement workers where needed in order to provide quality over quantity
There could have been quicker and more cohesive referrals from social services to the CC program.
Having more courses online and more frequent courses.

improved communication amongst the different organisations.

Liquid Logic needed to work more consistently.

Having more support for 8-11 year olds and very young infants.

A course specific for parents of neurodivergent children.
Liquid logic needed to work more consistently.

Gaps in services for 8-11 year olds.

Further sites for courses and therapy to make it more accessible to those who could not drive or access public transport or taxis.

Referral process was quite detailed and took a lot of time, however data is required to prove the benefit of the offer so I understand why
N/A
Less waiting time to get onto a course
we delivered creative projects and it was felt families should be referred at the end of their interventions and therapy. This would mean they were in a better place to build upon their strengths, learn form each other, and develop mutual respect and understanding of each other

Due to the funding being received late, the process felt rushed. Ideally families would have been invited to an introduction of the project, tour of Pilgrim Street and an opportunity to meet workers prior to starting. This would have helped allay any anxieties, fears, arriving at a new and unknow venue with unknown families.

It takes time to build trusting relationships with professionals and each other. For some families this was missing as each project had to fit into a certain time frame

Families sometimes came with complex extreme and upsetting histories, and some of the referrals received were inappropriate for the projects and their aims

There was a lack of understanding about what our projects were specifically offering and how it would be facilitated, particularly life story work. This led to inappropriate referrals being received. Time needs to be built in to enable projects to explain to referrers and practitioners what was on offer

Possibly location as done families do not drive and some locations can be difficult to reach.

7. **Where there any other gaps in services you felt the introduction of this programme helped to meet? If so, please explain.**

The programme meant that the participants were able to receive counselling within a much shorter time frame than the current providers in the NHS

Young children access to emotional regulation workshops; meerkat & me.

Unsure

Early help

Absolutely. This is the only service to my knowledge that offers an instantly available range of trauma informed programs, group support, education, and 1-1 theraputic services for children, young people and adults from all social backgrounds suffering a full range of difficulties. The phenomenal success rate speaks for itself.

Children not meeting CAMHS thresholds

Those who were stuck on waitlists

Those who felt they were the product of box ticking exercises to get them off caseloads.

Support for older neurodivergent teens/adults

Support for parents struggling on all levels, most age groups supported and able to be offered appropriate interventions, support spanning all areas of life, family, work, education, finance, clothing, food, home, activities etc. Support during crisis or early help or pregnancy. Able to offer support across all areas, whether youth groups, therapy, courses for parents and kids to understand and mitigate negative effects of trauma. People not accepted by CAMHs or on waiting lists and felt stuck. People who felt they couldn't access higher services due to money, stigma or embarrassment.

A fully rounded support for the families, who felt that everyone they spoke to had an idea of the support they were accessing or if not, they why they were accessing it

Teenagers

The programme works with parents, not just children. This tackles intergenerational trauma and helps parents to act as buffers when the child experiences adversity

wrap around offer form several professional organisations

therapy and counselling support

family - ie adult care giver and child opportunities

The support offered to the families whilst attending therapy and courses, also the fact that each person was triaged so the programme offered was best suited to that family.

8. **Do you have anything additional you would like to feed back as part of this review?**

I hope it continues as it seems to be in line with recently announced government policy
I found it hard to contact some referrals an sometimes not at all so feel that each referral must be ready to start once referral taken an commit to the 10 sessions so counsellor aren't left owing sessions.

The 6 month funding contract was far too short.
Managed to fill a lot of gaps identified by families, where they have been unable to previously access support.

An incredible, all round therapeutic programme...absolutely amazing!
i think it important to offer value for money, but to also understand that this isn't about numbers of people on projects. this can be more expensive and the support is more intensive, and needs more staffing. The best interventions offered were when families could be worked with individually, as opposed in a group, or in very small groups. Due to trauma, families needed time to explore that and receive support, time and quality service.
I have had such positive feedback from my family's and they have expressed a positive change in their family life due to attending courses and working with crea,8ing community.

Appendix D – E-Form for Community Referral Pathway

Wirral

Wirral EHM

Tel:
Fax:

Crea8ing Careers - Therapeutic Project Referral

Consent and Confidentiality

Has this referral been discussed with the parent/carer?	
Has the parent given consent to the referral being made?	
What are the parents/carers views about this referral?	
Has the referral been discussed with the child/young person?	
What are the child/young person's views about this referral?	
Is there any information contained in this referral that needs to remain confidential? If yes please outline specific information to remain confidential and why.	

Referral Details

Referrer Details

Referrer's Name:	
Referrer's Job title:	
Agency:	
Address:	
Tel No:	
Email:	
Date of referral	

Family Details

Address	
Main contact telephone number for parent/carer	
Email:	

All Relationships

Related Case No	Relationship	Name	Age	Address	Parental Responsibility

Services Currently involved with the family

Agency/ School	Professionals Name	Specify which family member

Project Criteria

Project criteria

Are you seeking to:	Yes/No	Please provide rationale for your selection If no, please enter N/A
Improve behaviour management and emotional control for child/ren, young person.		
Improve social, emotional, and educational wellbeing.		
If the child/young person has been a victim of bullying, criminal violent or antisocial behaviour are you hoping to reduce opportunities for re-victimisation?		
Identify opportunities to improve school or employment attendance/performance for any family members including the target child/ren or young persons in the home.		
Reduce acts of violence/ aggression through retaliation and/or aggressive behaviour.		
Are you hoping to reduce vulnerabilities by increasing or developing protective factors, for example trusted relationships with adults (family members or safe community members/volunteers) and/or develop positive peer networks.		

Please detail in your own words the reason for this referral for therapeutic intervention support:	
Has a history of trauma been disclosed?	
What can you or the family tell us about previous support provided, are there any known gaps in services, history of trauma or upset that child/ren or parents/carers/ adult family members may have experienced that may have impacted the family? Why are you or any other professionals involved? Tell us what you can.	
Please describe what is working well, or has previously worked well. Please attach any documents that the family may want to share that will help us to understand the family's needs.	

Have any family members disclosed any special or medical needs or circumstances of any family member, this may include physical and mental health, known or suspected neurological conditions (ADD, ASD, ADHD, OCD etc)	
Have any family members disclosed any alcohol and/or substance misuse needs?	
Has there been any experiences of Domestic Abuse?	
Are there any potential risks that would affect staff visiting the home?	
Consent and Information Sharing	
Does the parent/carer understand the information that is recorded on this form and that it will be only be stored and shared for the purposes of providing services to them and their family?	
Have they had the reasons for information sharing explained to them and do they understand them?	
Do they understand they may add to or withdraw consent at any time?	
Do they agree to the sharing of information, as agreed, between all the services considered appropriate?	
Signed by referrer completing this form with consent of named parent/carer named. This can be added in type.	
Date:	

Please submit this referral to: Referrals@crea8ingcareers.com