



**THE IMPACT OF SURE START LOCAL
PROGRAMMES ON OUTCOMES FOR
CHILDREN REFERRED TO CHILDREN'S
SOCIAL CARE IN LINCOLNSHIRE**



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EXECUTIVE SUMMARY

Background

Sure Start is one of a range of government initiatives designed to prevent social exclusion and address the root causes of disadvantage and inequity. A total of 524 Sure Start local programmes (SSLPs) have been set up across England on an incremental basis. They aim to promote physical, intellectual, social and emotional development in working with children, and their parents, at the pre-school stage of life. In order to achieve this aim, resources are focused on the provision of support and services, particularly to those who are disadvantaged, within communities identified as deprived (Houston, 2003).

All SSLPs have a responsibility to provide high quality, effective family support services to ensure preventative services are available to minimise the incidence and contribute to the prevention of families going into crisis. They have a key role in working with Social Care Services, in partnership with parents, to support the transition from targeted to universal services and to ensure targeted services can effectively boost universal provision to reduce the number of families needing specialist provision.

As integrated working is further developed, it is essential that there is evidence to illustrate the characteristics of services which effectively support and improve outcomes for children, young people and their families. Evidence gathered locally on the efficiency of SSLPs in improving outcomes for some of the most vulnerable children in our society, is vital to inform service development and practice for the future.

This study was jointly commissioned by the seven SSLPs in Lincolnshire and overseen by the Programme Managers.

Methodology

Research took place over a ten month period and was divided into three distinct parts.

- **Part 1** involved examination of statistical data held by the Local Authority relating to the SSLP areas and comparison of this with data for the whole County in order to investigate the impact of SSLPs on the numbers of referrals to Children's Social Care; children on the Child Protection Register (CPR); re-registrations on the CPR and Children Looked After in respect of children under 4.
- In **Part 2** data relating to a cohort of children under 4, who were referred to Children's Social Care and eligible for Sure Start services, were examined in order to

investigate the take up of Sure Start services and the impact of this provision on case activity outcomes following referral to Children's Social Care Services. This involved statistical analysis of data relating to those children who received services and those who did not. The outcomes considered were registration, de-registration and re-registration on the CPR; any periods of being Looked After; closure and re-referral.

- **Part 3** involved the use of a pluralistic approach (Fuller & Petch, 1995) in the qualitative analysis of perceptions of the role of Sure Start Services in preventing the need for more intensive support through statutory services and their impact on outcomes for children referred to Children's Social Care services.

Conclusions and Recommendations for Future Service Development and Practice

- Whilst results from **Part 1** showed that referral rates to Children's Social Care had dropped in three of the four SSLPs for which data was available, the fact that the data available from the Local Authority was limited to that required by NESS precludes any conclusions being drawn from this. In addition, examination of data over a longer period of years might have been more helpful in detecting trends, as suggested in a study undertaken by Carpenter, Griffin and Brown (2005). Differences and similarities between countywide and individual SSLP data are nevertheless noteworthy and we would suggest that data gathering processes are put in place by the Local Authority to facilitate further investigation in this area. The absence of any link between the Social Care and Sure Start databases also needs addressing, though it is assumed that the difficulties this creates will be remedied by the introduction of a shared database to underpin the Common Assessment Framework (CAF) process.
- Carpenter, Griffin and Brown (2005) reported difficulty in drawing any inference from data relating to CPR activity because of the low numbers of children registered. The same may also be said of numbers of children Looked After. This was an issue here in both **Part 1 and Part 2** and results relating to this data may not therefore be relied on.
- Results in **Part 2** which showed that children who were re-referred to Children's Social Care were more likely to have received Sure Start services reflect the findings of a local evaluation cited in the background to this study, where an increase in the number of re-referrals was noted in a SSLP area. These findings reinforce the notion that there is "no quick fix".
- All five parents featured in **Part 3** of this study were struggling with mental health problems and unresolved issues from the past. Relationship problems between parents and their children and with extended family members were also identified in all five cases and domestic violence was an issue in three. Problems like these are complex and take time and expertise to unravel. They are likely to

require more help than Sure Start alone can offer. However, the forthcoming implementation of the CAF process should facilitate earlier identification of need and improve communication, as suggested by the workers taking part in the study. It will hopefully also bring more formalised support; a holistic overview; focus on need and provide clarity in respect of individual roles, all seen as advantages of Social care involvement. In the longer term this should lead to referrals and re-referrals to Social Care being limited to those cases where their involvement, as a statutory agency, is truly required.

- Where Sure Start services were delivered on an individual basis, or both an individual and group basis, referrals to Children's Social Care were more likely, subsequently, to be closed. This was also the case where Sure Start family support services were provided, though these had been provided less frequently than health and play and learning interventions. These results suggest that where support mirroring that provided by Social Care, i.e. that delivered to families on an individual basis, is in place, continued involvement by Social Care is less likely following a referral. A link may be made here with the view expressed in **Part 3** of the study that, despite being unable to prevent the need for a referral to Social Care, Sure Start and other agencies and organisations had been able to reduce the extent to which they needed to be involved and the intensity of that involvement. There is a strong case here for an increase in services providing family support on an individual basis.
- Sure Start was seen, in **Part 3** of the study, to have been instrumental in the positive outcomes achieved by parents, whereas improvement in Every Child Matters (ECM) outcomes for children was attributed to a combination of support from the various services accessed, as well as to extended family support and improved maternal well being. This suggests that Sure Start is best placed to assist parents in achieving positive outcomes that will in turn benefit their children. Consideration should therefore be given to increasing provision, in the future, of services identified here as helpful to parents; namely those that assist in raising self esteem; emotional support including counselling; parenting support; practical help and support to integrate them into the community. Much of this support was considered to have a 'knock on' effect on outcomes for children, but subsidised child care provided by Sure Start was believed to have helped them directly and identified as having impacted positively on ECM outcomes. Increased provision of this type of support should therefore also be considered.
- Whilst the study identified the positive impact of Sure Start services, results in **Part 2** showed that Sure Start was not involved with almost 50% of a cohort of 586 children under 4 who had been referred to Children's Social Care. This highlights that access to Sure Start services for vulnerable families is an issue.
- **Part 3** of the study revealed that despite initial resistance, parents accessed support more readily once services were involved. Work needs to be undertaken to identify ways of engaging parents in vulnerable families, taking into account

reasons identified here for their failure to access services; i.e. lack of confidence; low self esteem; denial of or failure to acknowledge difficulties and the controlling nature of relationships featuring domestic violence.

- Difficulties surrounding access to services may be alleviated by a number of measures. The nature of the relationship between parent and worker was seen as highly relevant to the progress and outcome of most cases in **Part 3** of the study. The knowledge that support was readily available from workers was seen as a key positive for parents, as was the quality of their relationships with those providing support. Flexible access to services provided by those with whom they had forged trusting relationships over time was seen as something that might have made a difference in some cases and as required to sustain progress in others. Local access to services providing counselling and mental health support; help with substance misuse; midwifery and speech and language therapy was suggested as something which might assist in addressing difficulty experienced in engaging vulnerable families. These issues should be taken into account in developing services for the future.
- Whilst extended family relationships were seen as problematic in all five cases in **Part 3** of the study, more support from extended family was also identified as key to the possibility of a different outcome in every case. This highlights both the value of utilising extended family support where this is available and the need for caution where relationships have the potential for impacting negatively rather than positively on the situation. Increased use of family group conferences should assist in maximising the use of extended family support where this is likely to be beneficial. Where it is not available because families are isolated or extended family relationships are poor, consideration should be given to developing support that mirrors that usually provided by extended family, given the emphasis placed here on the positive impact of significant relationships developed between parents and workers.

This study demonstrates that parents in vulnerable families with complex needs require flexibly available support delivered in a way that mirrors what might otherwise have been provided by their extended family. It shows that improved self esteem in parents has a 'knock on' effect on positive outcomes for children. Unsurprisingly, these are the ingredients of four approaches which seek to increase security of attachment between infants and parents in order to improve children's socio-emotional development through:

- changing parents' behaviour in interaction with their children
- changing parents' internal working model of self and others
- providing increased social support
- improving maternal mental health and well-being

(Howe, 2005)

Development of services and practice in line with the recommendations of this study would be in keeping with the focus of these interventions and Sure Start's aims to promote physical, intellectual, social and emotional development in working with children, and their parents, at the pre-school stage of life.

Key Recommendations

- That data gathering processes are put in place by the Local Authority to facilitate further investigation into differences and similarities between countywide and individual SSLP data
- That the absence of any link between the Social Care and Sure Start databases is addressed
- Provision of family support on an individual basis is increased
- Increased provision of services identified as helpful to parents:
 1. Services that assist in raising self esteem
 2. Emotional support, including counselling
 3. Parenting support
 4. Practical help
 5. Support to integrate parents into the community
- Increased provision of subsidised child care
- Work needs to be undertaken to identify ways of engaging parents in vulnerable families, taking into account reasons identified here for their failure to access services
- Access to services, provided by those with whom parents have forged trusting relationships over time, should be flexible
- Counselling and mental health support; help with substance misuse; midwifery and speech and language therapy should be available locally
- Increased use of family group conferences to assist in maximising the use of extended family support where this is likely to be beneficial
- Development of support that can mirror that usually provided by extended family, where extended family support is not available because families are isolated or extended family relationships are poor

Introduction

Background

Sure Start is one of a range of government initiatives designed to prevent social exclusion and address the root causes of disadvantage and inequity. A total of 524 Sure Start local programmes (SSLPs) have been set up across England on an incremental basis. They aim to promote physical, intellectual, social and emotional development in working with children, and their parents, at the pre-school stage of life. In order to achieve this aim, resources are focused on the provision of support and services, particularly to those who are disadvantaged, within communities identified as deprived (Houston, 2003).

In order to monitor progress towards its aims, Sure Start has been set a range of targets, one of which is to

“Reduce by specified percentages the proportion of children aged 0-3 in the Sure Start areas who are re-registered within 12 months on Child Protection Registers” (Eisenstadt, 2006)

This suggests the need for evidence that SSLPs are impacting directly on the need for statutory intervention. The challenges faced by programmes in meeting the targets set within required timescales are acknowledged in the first report produced by the National Evaluation of Sure Start (NESS) (2002).

In their study of the *Impact of Sure Start on Social Services* in four local authorities in the North of England (2005), Carpenter, Griffin and Brown highlight the fact that statistics relating to the number of referrals of children and young people to children’s social care services; numbers on the Child Protection Register (CPR) and the number of children ‘looked after’ by local authorities are collected by NESS to inform understanding of the impact of SSLPs on the need to provide more intensive support through statutory services. They also refer to the rationale, that the number of children requiring such support can be reduced by reshaping mainstream services in line with the preventative approach developed by SSLPs, put forward in *Every Child Matters* (2003). The findings of the study, however, show little evidence of any impact on the number of referrals to children’s social care services or numbers of children placed on the CPR in the SSLP areas in question.

A study undertaken elsewhere in the country as part of a local evaluation programme considers the contribution of a SSLP in reducing referrals to children’s social care services. Here, whilst little fluctuation was found in the overall number of referrals, an increase in the number of re-referrals was noted. Additionally a huge increase (50%) in the number of referrals with a child protection element was identified.

A summary of findings from NESS, published in 2004, acknowledges that whilst their results are promising they are

“not inconsistent with other studies of early years intervention programmes which show that positive effects tend to emerge after longer durations of receiving the intervention and later in life”

This message is reiterated in subsequent reports published by NESS in 2005, which describe findings showing limited differences between SSLP areas and comparison areas and, whilst identifying beneficial effects on parenting in non-teenage mothers, point to adverse effects on children of teenage mothers. The cautionary note suggests that overly strong conclusions should not be drawn from the findings at this stage.

Commenting on the anticipated content of the forthcoming report from NESS in the Guardian in September 2005; Polly Toynbee refers to the inherent difficulty in measuring the impact of Sure Start, pressure on the part of the government for early results and expert warnings that only longitudinal studies will produce effective results. Reflecting on her comments, Professor Saville Kushner refers to large-scale programme evaluations undertaken in the USA:

“What those analyses almost invariably show is that national evaluators miss the nuance and the particularity of local action, so obsessed are they with imposing a one-size-fits-all measurement. Sure Start may be a national programme but it is locally defined and carried out, too diverse in its creative thinking and action to be apprehended by national evaluation teams”

Despite the challenges and complexities involved in attempting to assess the impact of SSLPs, the need to do so cannot be denied. Children and families who require statutory intervention from Social Care Services have significant levels of need and are arguably the most vulnerable children in the Sure Start population.

The financial and emotional impact of children being Looked After by the Local Authority is considerable, and it is recognised that Looked After children can expect less favourable outcomes in later life than children maintained within their own family environment.

All SSLPs have a responsibility to provide high quality, effective family support services to ensure preventative services are available to minimise the incidence and contribute to the prevention of families going into crisis. They have a key role in working with Social Care Services, in partnership with parents, to support the transition from targeted to universal services and to ensure targeted services can effectively boost universal provision to reduce the number of families needing specialist provision.

As integrated working is further developed, it is essential that there is evidence to illustrate the characteristics of services which effectively support and improve outcomes for children, young people and their families. Evidence gathered locally on the efficiency of SSLPs in improving outcomes for some of the most vulnerable children in our society, is vital to inform service development and practice for the future.

Aims

This study aimed to explore the impact of SSLPs in Lincolnshire on outcomes for children who are open cases to Children's Social Care Services by seeking answers to the following questions:

1. What is the impact of SSLPs on:
 - a. The number of accepted referrals to Children's Social Care Services (i.e. Number of open cases)?
 - b. The number of children on the Child Protection Register (CPR)?
 - c. The number of Children Looked After?
 - d. The number of children re-registered on the CPR within 12 months of de-registration?
2. What are the characteristics of Sure Start involvement, in particular the nature of access and reach in cases open to Children's Social Care Services?
3. What are the opinions of workers on Sure Start services and their role in preventing registration on /supporting de-registration from the CPR?
4. What conclusions can be drawn on the impact of SSLP activity, through comparison of the outcomes for children at the point of referral to Children's Social Care Services with those at the end of intervention by Children's Social Care Services, on the basis of the views of parents and assessments undertaken by professionals?

Methodology

The study was jointly commissioned by the seven SSLPs in Lincolnshire and overseen by the Programme Managers, who set up a steering group and organised regular meetings with the researcher. Access to information held on Lincolnshire County Council's children's social care database (SWIFT) was agreed at the outset and a number of key personnel within the Children's Services Directorate were involved to facilitate this process.

Research took place over a ten month period and was divided into three distinct parts. Part 1 involved examination of statistical data relating to the SSLP areas and comparison of this with data for the whole County in order to investigate the impact of SSLPs on the numbers of referrals to Children's Social Care; children on the CPR; re-registrations on the CPR and Children Looked After in respect of children under 4.

The rationale for focusing on the under 4 age group was that these were the children who were originally eligible for Sure Start services, though it is accepted that the age range has changed over time. Sure Start provision has been incremental across Lincolnshire and, as might be expected, it has taken time to get services up and running in each of the SSLP areas. Each programme was asked, therefore, to identify the year in which the delivery of services commenced and data was sought from the Children's Services Directorate in

relation to the postcodes covered by the programme from that date onwards. Data for the whole county was requested from the date that the first SSLP began to deliver services.

In Part 2 data relating to a cohort of children under 4, who were referred to Children's Social Care and eligible for Sure Start services were examined in order to investigate the take up of Sure Start services and the impact of this provision on case activity outcomes following referral to Children's Social Care Services. This involved statistical analysis of data relating to those children who received services and those who did not. The outcomes considered were registration, de-registration and re-registration on the CPR; any periods of being Looked After; closure and re-referral. On the basis that individual children are likely to benefit from the knock-on effect of services delivered to parents it was agreed that services provided to children or their parents, or both, would be taken into account.

Part 3 involved the use of a pluralistic approach (Fuller & Petch, 1995) in the qualitative analysis of perceptions of the role of Sure Start Services in preventing the need for more intensive support through statutory services and their impact on outcomes for children referred to Children's Social Care services. Houston (2003) cites this approach as one which may be used to assist the evaluation process in complex programmes such as Sure Start.

The original intention was to undertake a case study in each of the seven SSLP areas but due to time constraints this was subsequently limited to one in each of the five most established programmes. Interviews were undertaken with parents and front line staff from a range of agencies and organisations, including social workers and Sure Start staff, involved in supporting the family following referral of their child to Children's Social Care services. Data from the interviews was analysed, and findings are reported, in terms of emerging themes.

This report describes each part of the study in detail, including methods used and findings. The overall usefulness of these in informing future service development and practice is discussed at the conclusion stage.

Part 1

The Impact of Sure Start Local Programmes on: the Total Number of Referrals to Children's Social Care Services; the Number of Children Registered on the Child Protection Register; the Number of Children Looked After and the percentage of Children Re-registered on the Child Protection Register

1.1. Introduction

When the Local Authority's Customer Service Centre is contacted by a professional, a parent or a member of the public to express concerns about or request services for a child, a decision is made as to whether a referral to Children's Social Care is appropriate, on the basis of the Local Authority's duty to provide services for children in need and protection for those at risk of significant harm (Children Act, 1989). Where there has previously been a referral and this remains open, the information is passed on but no new referral is raised. Children are registered on the Child Protection Register (CPR), held by Children's Social Care, where a decision is made at a Child Protection (CP) Conference that a multi-agency plan is required to protect them from harm. Subsequent conferences are held to consider whether the need for a plan remains and, at the point that it is considered that this is no longer the case, de-registration takes place. Where fresh child protection concerns arise after de-registration, a further CP conference may consider re-registration to be appropriate, in which case the process is repeated. The term 'Looked After' refers to any child accommodated by the Local Authority on the basis of its duties under the Children Act 1989. Data relating to all of the above is held on the Local Authority's Social Care database (SWIFT).

1.2. Method

The Local Authority was asked to provide data on: the total number of referrals to Children's Social Care for children under 4; the total number of children under 4 on the CPR; the number of children under 4 on the CPR who had previously been registered (whilst the original plan had been to consider re-registrations within a twelve month period it had become clear in early discussions with the Local Authority that the necessary data would not be available) and the total number of children under 4 Looked After; for each year between 01/04/01 and 31/03/06. They were also asked to provide details of the number of children in each category who were eligible for Sure Start services (broken down by Sure Start area). The fact that Sure Start provision had been incremental meant that the data required was different from year to year, as follows, depending on the year in which the delivery of services commenced:

2001-02 Lincoln Birchwood only

- 2002-03 Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon
- 2003-04 Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon; Gainsborough; Lincoln North
- 2004-05 Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon; Gainsborough; Lincoln North; Lincoln Central; Grantham
- 2005-06 Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon; Gainsborough; Lincoln North; Lincoln Central; Grantham

The Local Authority was not able to provide us with the exact data that we requested. It is required to provide data to NESS, on a yearly basis, in respect of the total number of referrals to Children's Social Care during the year; the number of registrations on the CPR during the year; the number of children and young people on the CPR (at 31st March each year); the percentage of children registered during the year on the CPR who had previously been registered and the number of children Looked After (at 31st March each year). This data is broken down by Sure Start area and by age group and was provided to us in response to our request. However, because the data is broken down, for the purposes of NESS, into age groups of under 1 year; 1-4 years; 5-9 years; 10-15 years and 16-17 years it was not possible to consider the under 4 age group.

The data provided to NESS had been collected for Birchwood, Boston, East Lindsey Coastal Ribbon and Gainsborough since 2001-2 and had not been collected for Lincoln North, Lincoln Central and Grantham Sure Starts until 2005-6. It was not therefore possible to break down the data into Sure Start and non Sure Start areas for comparison purposes. Additionally, data for the whole county was not available for 2001-2. Findings are thus restricted to descriptions of the data provided in respect of the whole county for the period April 2002 to March 2006 and comparison of that relating to Birchwood, Boston, East Lindsey Coastal Ribbon and Gainsborough SSLPs between April 2001 and March 2006.

1.3. Results

The tables and figures in the following section provide an overview of both countywide data and the comparisons of data trends for Birchwood, Boston, East Lindsey Coastal Ribbon, and Gainsborough SSLPs.

1.3.1. Countywide Data (children 4 and under)

Table 1.1. Countywide data trends from 2001 to 2006

	2001/02	2002/03	2003/04	2004/05	2005/06
Number of Referrals during the year	Missing	1409	2028	1871	1969
No of Children on the CPR at 31st March	Missing	120	128	142	141
Number of Registrations During the Year	Missing	177	207	203	198
Percentage of those registered during the year, previously registered	Missing	9.1%	4.83%	8.87%	7.58%
Number of Children Looked After at 31st March	Missing	145	152	155	123

1.3.2. Total Number of Referrals to Children's Social Care Services (for children 4 and under) During the Year

Table 1.2.

	April 2001- March 2002	April 2002- March 2003	April 2003- March 2004	April 2004- March 2005	April 2005- March 2006
Birchwood	52	58	83	104	96
Boston	56	62	84	119	76
ELCR	47	21	55	64	42
Gainsborough	73	91	103	123	124
Countywide	Missing	1409	2028	1871	1969

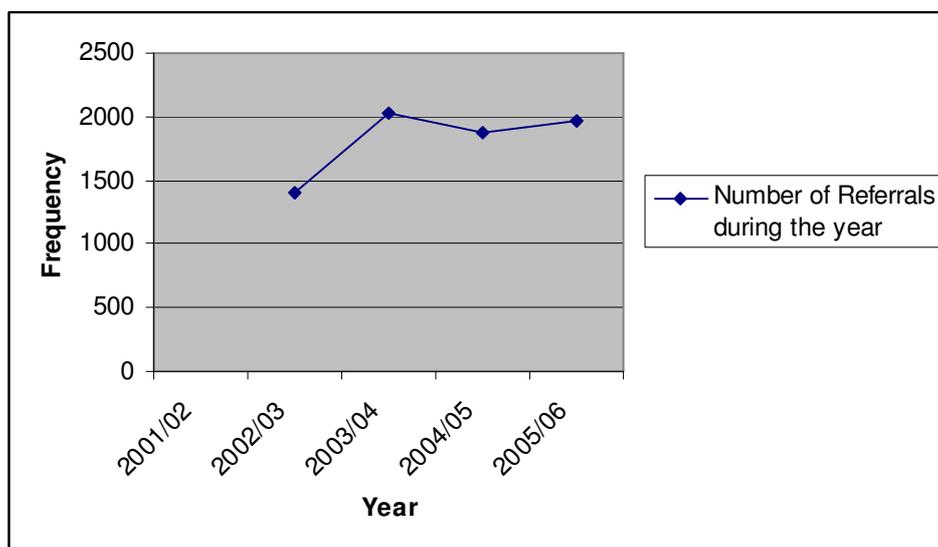


Figure 1.1. Number of referrals, countywide, during the year, 2001 to 2006

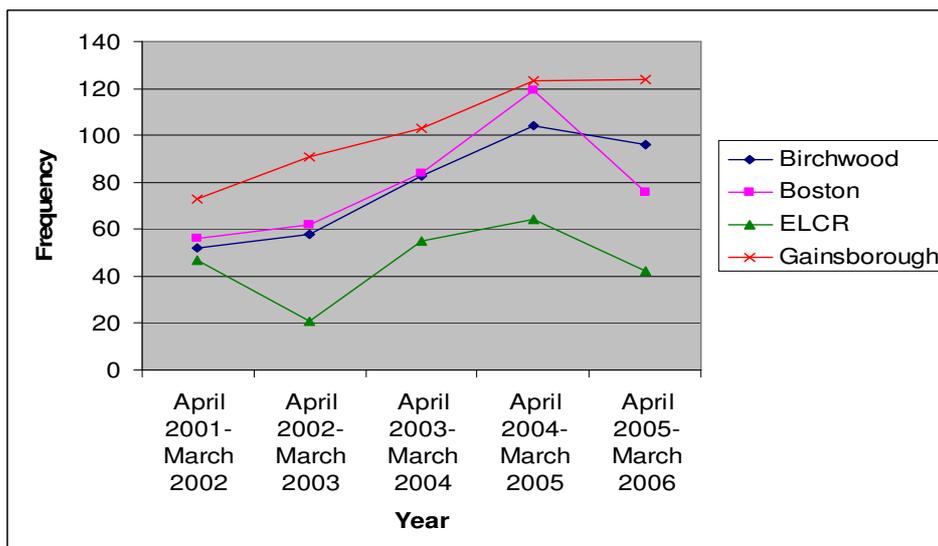


Figure 1.2. Number of referrals during the year for each SSLP

1.3.3. Number of Children (4 and under) on the Child Protection Register (as at 31st March)

Table 1.3.

	As at 31st March 2002	As at 31st March 2003	As at 31st March 2004	As at 31st March 2005	As at 31st March 2006
Birchwood	3	5	9	7	13
Boston	5	6	7	14	10
ELCR	3	1	3	5	1
Gainsborough	11	8	11	11	10
Countywide	Missing	120	128	142	141

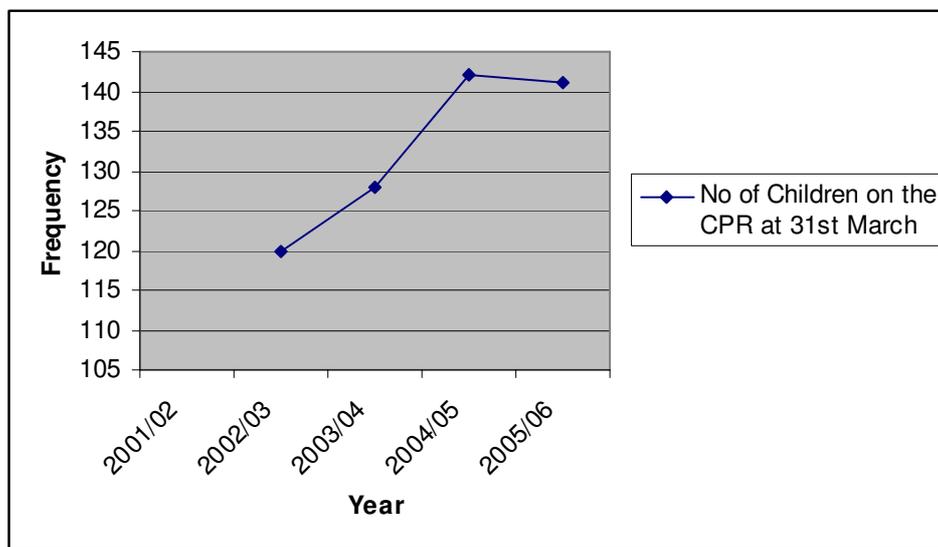


Figure 1.3. Number of children on the CPR, countywide, as at 31st March

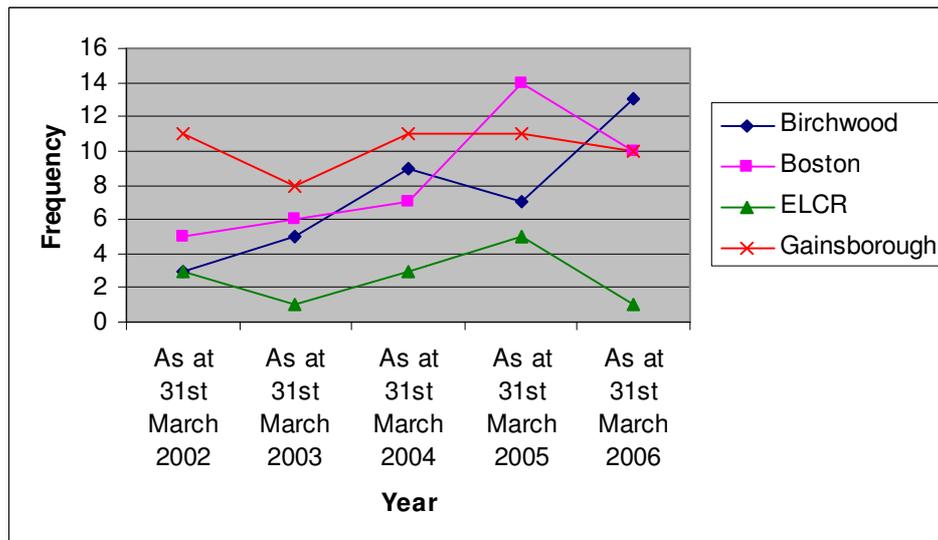


Figure 1.4. Number of children on the CPR, as at 31st March, for each SLP area

1.3.4. Number of Registrations on the CPR during the Year (children 4 and under)

Table 1.4.

	April 2001- March 2002	April 2002- March 2003	April 2003- March 2004	April 2004- March 2005	April 2005 - March 2006
Birchwood	5	8	11	11	13
Boston	9	9	13	15	17
ELCR	3	4	4	6	3
Gainsborough	9	8	19	16	9
Countywide	Missing	177	207	203	198

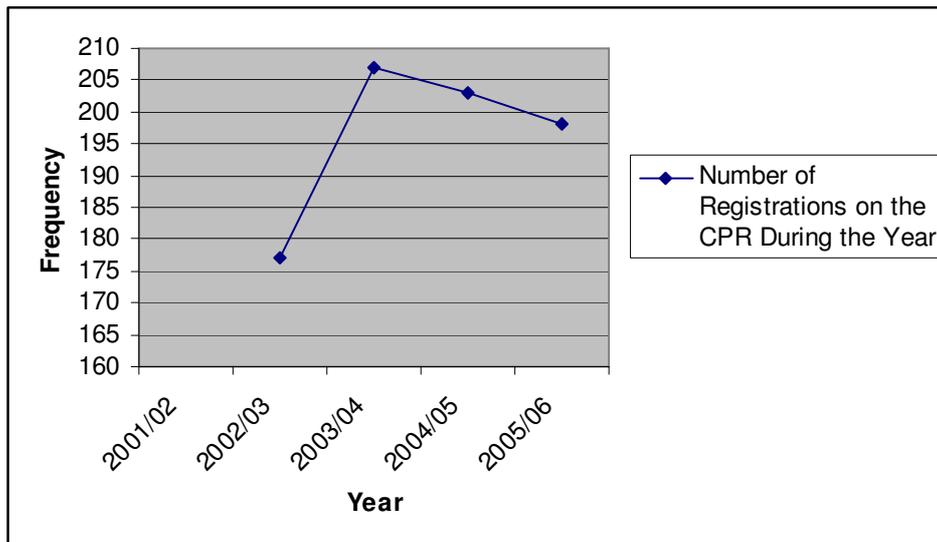


Figure 1.5. Number registrations on the CPR, countywide, during the year

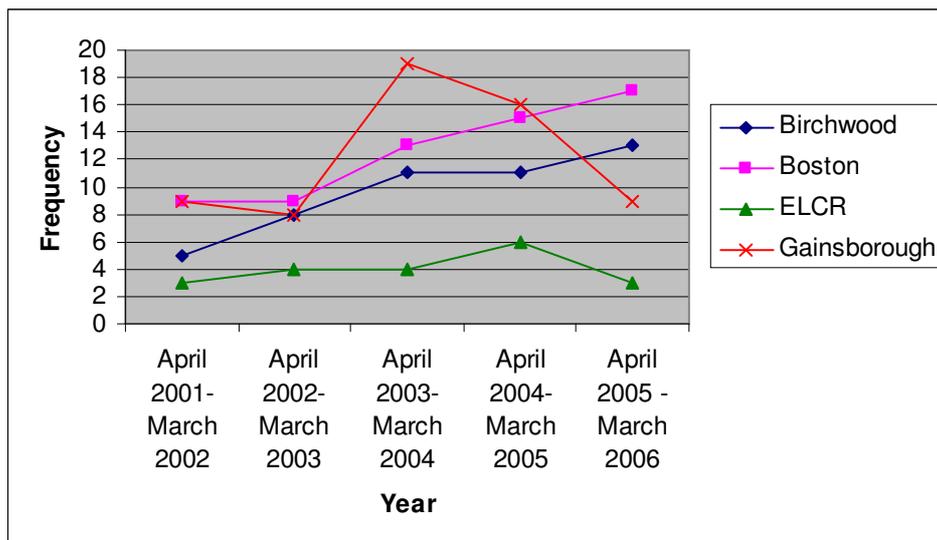


Figure 1.6. Number of registrations on the CPR, during the year, for each SLP

1.3.5. Percentage of Children (4 and under) Registered During the Year on the CPR who had been Previously Registered

Table 1.5.

	Year ending March 2002	Year ending March 2003	Year ending March 2004	Year ending March 2005	Year ending March 2006
Birchwood	25%	27.3%	13.7%	26.3%	18.2%
Boston	25%	29.4%	9.5%	2.4%	12.1%
ELCR	0%	0%	0%	38.5%	0%
Gainsborough	20%	15.8%	12.9%	37.9%	36.0%
Countywide	Missing	9.1%	4.83%	8.87%	7.58%

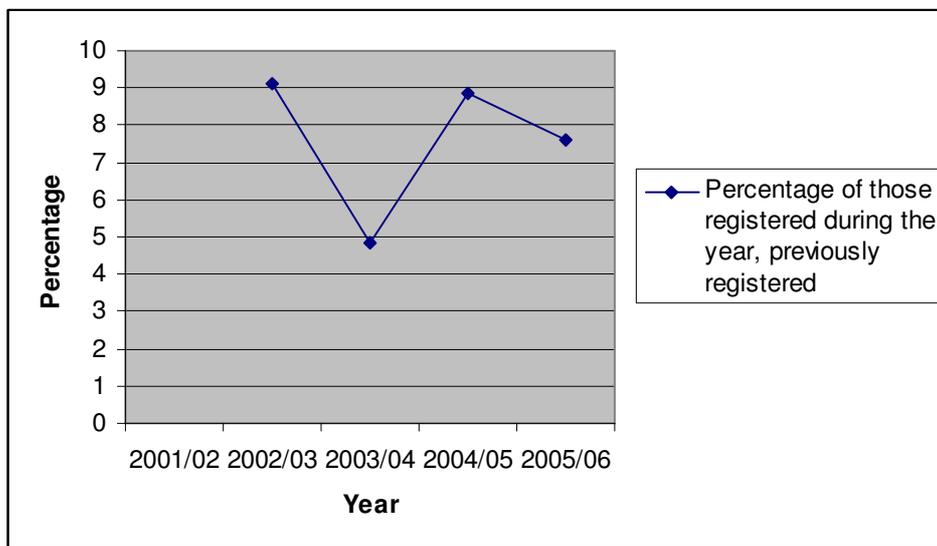


Figure 1.7. Percentage of children re-registered on the CPR, countywide

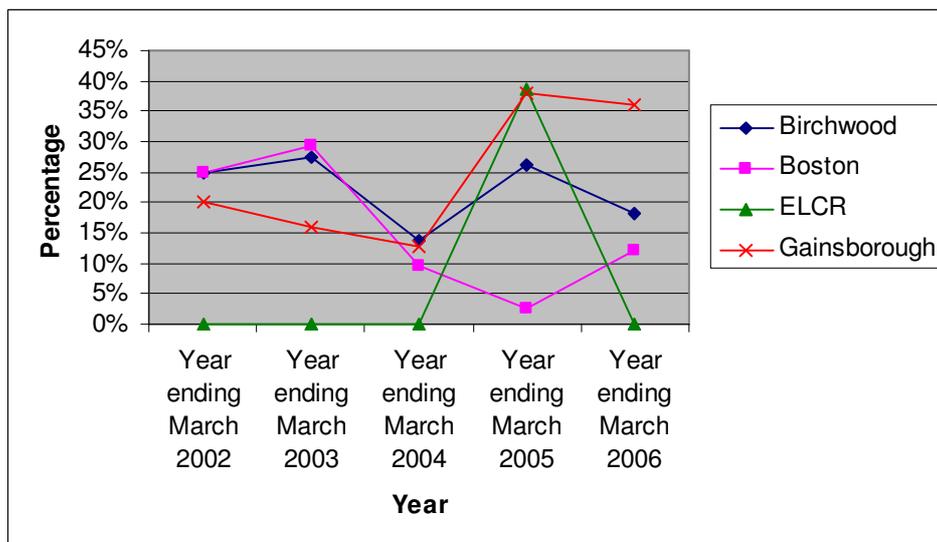


Figure 1.8. Percentage of children re-registered on the CPR, for each SSLP

1.3.6. Number of Children (4 and under) Looked After as at Year End

Table 1.6.

	March 31st 2002	March 31st 2003	March 31st 2004	March 31st 2005	March 31st 2006
Birchwood	7	6	4	6	9
Boston	8	8	9	13	6
ELCR	4	3	4	11	4
Gainsborough	9	8	4	12	5
Countywide	Missing	145	152	155	123

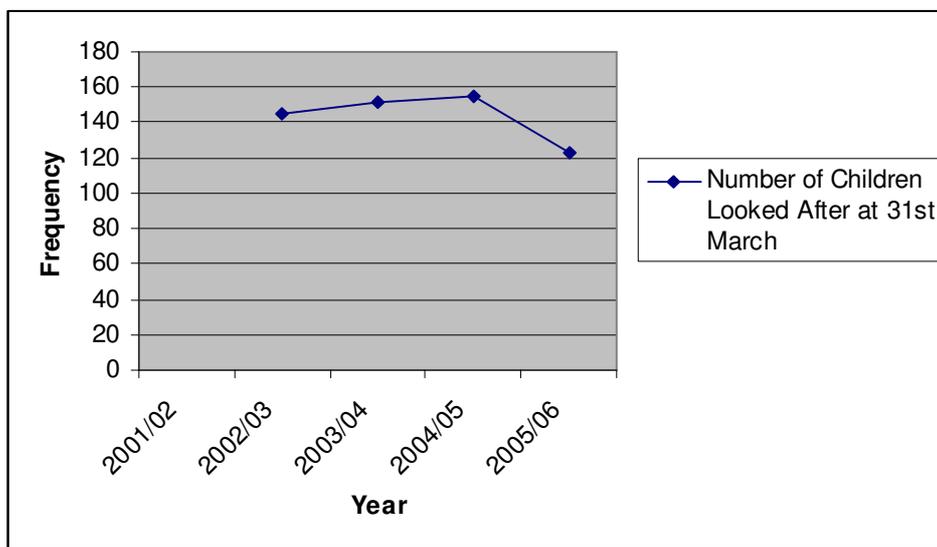


Figure 1.9. Number of children looked after, countywide, as at year end

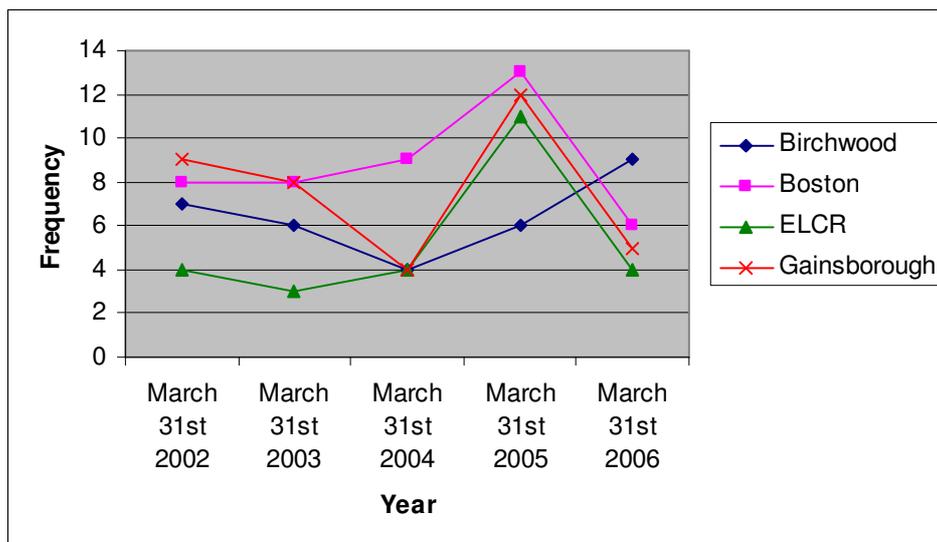


Figure 1.10 Number of children looked after, as at year end, for each SSLP

1.4. Discussion

Following a sharp rise in referrals to Children's Social Care across Lincolnshire, in respect of children aged four and under, between 2002/3 and 2003/4, variation in referral rates has since been less dramatic. Referral rates in three of the four SSLPs for which data was available, however, peaked in 2004/5 but have since declined. This suggests that, whilst initially the presence of Sure Start in a local area may have led to an increase in referrals, these SSLPs are now having a positive impact on referral rates for children aged four and under. Referrals in the Gainsborough SSLP area have continued to rise, but this programme began delivering services a year later than the others, so any impact on referral rates might also be expected somewhat later.

The number of children aged four and under on the CPR, as at 31st March each year, rose sharply on a countywide basis between 2003 and 2005 but remained fairly static between 2005 and 2006. Numbers in three of the four SSLPs declined between 2005 and 2006 which could be seen to suggest that Sure Start services had begun to impact on CPR activity at this stage, following earlier periods during which numbers had increased in these areas. The small numbers of children on the CPR in each area must be taken into account here however, given the fact that a relatively dramatic rise or fall in numbers could be accounted for by registration or de-registration of one sibling group. Notwithstanding the difficulty posed to interpretation by small numbers, it is interesting to note a rise in the number of children on the CPR in the Birchwood SSLP area in 2005/6, especially given the decrease in numbers in the previous year.

A sharp increase in the number of children aged four and under registered on the CPR, countywide, was noted between 2002/3 and 2003/4 followed by a gradual decline over the subsequent two years. Trends varied amongst the four SSLPs though all but ELCR also experienced increases between 2002/3 and 2003/4. Of particular note is the dramatic increase in CP registrations during that period in the Gainsborough SSLP, where an evaluation of Reach identified an estimated increase in the population of 0-15 year olds of 25% between 2001 and 2003 (Partners in Change, 2006). Again, the small numbers of children involved must be taken into account. Additionally the possibility that variation in subsequent trends (i.e. the fact that numbers in two SSLP areas have continued to rise, whilst they declined after peaking in the others) might be due to differences in thresholds for CP registration across the County cannot be discounted.

The percentage of children aged four and under registered on the CPR, who had previously been registered, remained less than 10%, countywide, between 2002/3 and 2005/6. Given the low numbers of children registered on the CPR in each of the four SSLP areas, caution must be exercised in attempting to interpret any trends. As stated previously, fluctuation that might otherwise be interpreted as fairly dramatic may reflect re-registration of one or more large sibling groups.

The number of children aged four and under who were Looked After, countywide, rose slightly between 2002/3 and 2004/5, but dropped quite sharply in 2005/6. This reflects a drive by the Local Authority to reduce the numbers of children in public care. Again,

trends varied amongst the four SSLP areas; however numbers of children Looked After in three of the four peaked in 2004/5 and dropped quite dramatically in the following year in line with what might be expected given the Local Authority's policy at that time. Though caution must once again be exercised in relation to the low numbers involved, the continuing upward trend in the Birchwood SSLP area suggests the need for further investigation into the reasons for this, given that trends in CP registration in this area are also moving against those identified for the County as a whole.

Part 2

The Characteristics of Sure Start Involvement in Relation to Nature of Access and Reach in Cases Open to Children's Social Care Services and the Impact of this on Outcomes

2.1. Introduction

A range of universal services, funded by Sure Start, is on offer in the area covered by each of the SSLPs. These services are designed to improve outcomes for children by providing services in four key areas: Health; Play & Learning; Family Support and Community Involvement.

- Health services are those which improve access to information and support regarding children and their family's health. These services also provide opportunities for families to engage in activities which promote their child's development and early identification and intervention for additional needs.
- Play & Learning services for children and families promote parental involvement in children's learning through play. They also provide opportunities for children to play and learn independently and develop positive interactions with their peers.
- Family Support services seek to enable families to access services and thereby benefit from additional support to meet their identified needs, such as help to manage their children's behaviour; with debt or during crisis.
- Community Involvement involves parents in supporting the communities in which they live, encouraging their personal development through taking on a role on the management board or similar committee, for example, or through accessing training opportunities.

Sure Start support is delivered on an individual and group basis to both children and their parents. Each SSLP maintains a database of the services accessed by members of families who are registered with Sure Start, with dates.

Not all children who are eligible for Sure Start services, i.e. children under 4 living in the area covered by a SSLP, actually receive these as they are accessed by families on a voluntary basis. The term 'Reach' refers to the number of children reached by Sure Start in a SSLP area, in that services are accessed by the child, their parent(s) or both. There is no link between the database held by Children's Social Care and the Sure Start databases.

For the purposes of this part of the study outcomes are defined in terms of case activity following referral to Children's Social Care Services.

2.2. Method

Data relating to all children under 4 who were referred to Children's Social Care between 1st April 2004 and 31st March 2005 and eligible for Sure Start services was requested from the Children's Services Directorate, with details of their subsequent progress through the social care system up until 31st March 2006, in terms of registration, de-registration and re-registration on the CPR; any periods of being Looked After; closure and re-referral. Indication as to whether children had previously been referred or referred and registered on the CPR was also asked for. The start date was chosen to coincide with the earliest date at which all seven SSLPs were providing services.

Once the cohort of children had been identified each SSLP was asked to cross reference the names of children eligible for services in their area with their own database to identify which children were known to them and what Sure Start services they had received. On the assumption that individual children are likely to benefit from the knock-on effect of services delivered to parents, it was agreed that details of services provided to all members of the child's family would be identified. This exercise produced data identifying which children were known to each SSLP with details of services provided to all family members including dates.

The original data was subsequently narrowed down using the criteria 'Sure Start provided service to child or parent or both after 1st April 2004 = Sure Start involved' to identify the reach of Sure Start services and subjected to chi-square analysis, using SPSS (Statistical Package for Social Sciences), to explore the impact of Sure Start involvement on the following outcomes:

- Registered on the CPR following referral, prior to 31/03/06
- Registered on the CPR following referral; subsequently de-registered prior to 31/03/06
- Registered on the CPR following referral; subsequently de-registered and re-registered prior to 31/03/06
- Looked After following referral, prior to 31/03/06
- Referral subsequently closed, prior to 31/03/06
- Re-referral made prior to 31/03/06

As detailed in Part 1, above, when a referral to Children's Social Care remains open, any further contact made on the case should be recorded as such, on a contact information record, rather than as a new referral. This record should then be linked with the original referral. It became clear, however, through discussions with the Local Authority, that some new contacts made whilst referrals remained open had been progressed as a fresh referral, resulting in this being recorded as a re-referral on an open case. A similar problem was noted in the study undertaken in four local authorities by Carpenter, Griffin and Brown (2005). For the purposes of this study no distinction is made between fresh contacts and re-referrals on the basis that both will have been the result of a new contact with the Local Authority's Customer Service Centre, which suggests that the person making that contact was sufficiently concerned about the needs of or risks to the child to make them known.

Though indication of which children had previously been referred and which had previously been referred and registered on the CPR was requested and this data was provided, it was not used on the basis that it would have necessitated analysis of data relating to a period prior to 1st April 2004, when not all of the SSLPs were providing services.

Analysis of the combined data overall, i.e. that relating to all seven SSLPs, broken down in terms of Sure Start involved/not involved was conducted first. This was then repeated for the five most established SSLPs: Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon; Gainsborough and Lincoln North; followed by analysis of data relating to each of the seven individual programmes.

In order to identify the nature of access to Sure Start services, each SSLP was asked to code the services it provided using an agreed formula:

H = Health	I = individual contact i.e. 1:1
P = Play & Learning	G = group
F = Family Support	B = both (1:1 & group contact)
C = Community Involvement	

It must be acknowledged that this process was open, to some degree, to the individual interpretation of the person undertaking the coding exercise. Due to the fact that all services had been set up independently of one another and were therefore unique, despite similarities, it would not have been possible for the researchers to apply a common coding system across the board without a full understanding of every service provided across all seven SSLPs, which time did not permit.

Codes were subsequently assigned to services identified within the data as having been received by children and parents in the 'Sure Start involved' group. The nature of access to Sure Start services was thus identified and subjected to chi-square analysis as before to explore the impact on outcomes, using SPSS.

Data relating to mode of delivery (individual contact; group; both individual and group) was analysed first followed by that relating to type of intervention (Health; Play & Learning; Family Support; Community Involvement).

2.3. Data analysis

The chi-square statistical test is a non-parametric test which is used for categorical or nominal data. Categorical variables are variables that usually describe categories of people. There are different types of categorical variables, but in theory a person or case should fall into only one category. One good example of a categorical variable is gender (with very few exceptions people can be only biologically male or biologically female). Patterns in categorical data can be tested using the chi-square test. This test examines whether there is an association between two categorical variables (examples from the present study include whether a child has received Sure Start services and whether they

were subsequently re-referred to social care). As part of the analysis SPSS produces a contingency table, or crosstabulation, which shows how the data falls into each category (these tables are included in the following results sections). The analysis also produces a separate table which includes the chi-square statistic and its significance value. The chi-square statistic tests whether the two variables are independent. If the significance value is small enough (conventionally less than 0.05) then one can reject the hypothesis that the variables are independent and accept the hypothesis that they are in some way related.

For the chi-square to be meaningful it is imperative that the data meet certain key assumptions. The first assumption is that each person or case must contribute to only one cell of the contingency table (for example, in terms of the present study, a child can not be represented in both the 'received Sure Start services' and the 'not received Sure Start services' cells as they either have, or they haven't, received Sure Start services). A second important assumption is that the expected frequencies should be greater than 5. Expected frequencies, or counts, depict how the data would fall into categories if there was no association between the variables. As sample sizes get smaller the expected values also get smaller as there is less data which can fall in either of the categories. Thus, when sample sizes are too small the expected values become less than 5. As a consequence the main assumption of the chi-square test is not met and the results of the analysis are meaningless.

In the present study some of the categorical variables became too small and as a consequence, the results of the analysis are not presented. In particular, data concerning child protection registration caused problems as very few children were registered on the CPR. The significant results that did meet the assumptions of the Chi-square test are described.

The analysis of the impact of mode of delivery and type of services provided also presented some difficulties in terms of the required expected frequencies. There were very few cases where a child, parent, or both had received just either an individual or group intervention. Also it was even rarer for a child, parent, or both to have received just one of the four possible types of services without also having received another. For this reason it was decided that the data be categorised and coded in a different way. The analysis was as such based on the categorisation that a child, parent, or both either had received a Sure Start service on an individual basis or not, but this was not exclusive so that the child, parent or both may also have had a group intervention at the same time. Analysis conducted on the type of services provided was similar in that it looked at the impact of a type of service (health, play and learning, family support, or community involvement) but not on the basis of each type of service being provided exclusively. Given that every type of Sure Start service provision was treated in the same way in all analyses the significant results provided are considered to represent the true distribution of the data and all effects found are deemed valid.

For the reasons outlined immediately above, only those analyses where all assumptions are met are reported. Also, only those findings which are significant or near significant and of notable interest are detailed.

2.4. Results

2.4.1. Chi-square Analysis of Combined Data for all SSLPs

Figure 2.1., below, shows the percentage of those children referred to Children's Social Care between 01/04/04 and 31/03/05 where Sure Start was involved after 01/04/04.

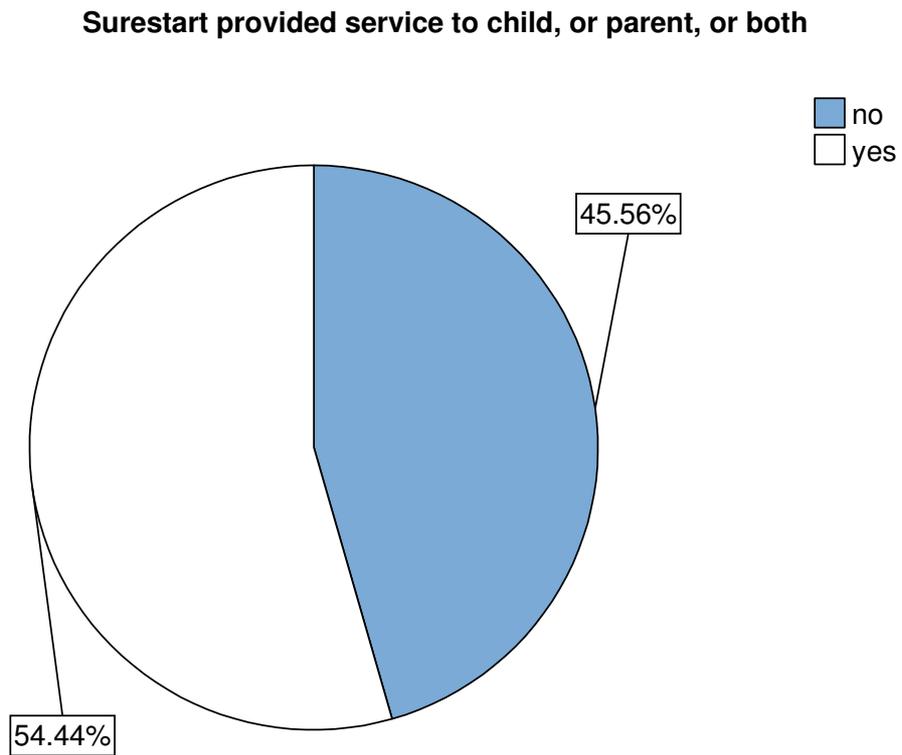


Figure 2.1. Overall percentage of children (or parents, or both) receiving Sure Start services, across all SSLPs

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2.4.1.1. Subsequently re-referred to social care / not re-referred to social care

The crosstabulation below shows that children from families supported by Sure Start were more likely to be re-referred to social care than those children from families who have had no support. However, these results could be interpreted in a different way. Those children who have been re-referred are more likely to have had Sure Start support than those that haven't. The low number of cases here supports this interpretation. A chi-square analysis showed this to be a significant effect, $\chi^2(1, N=586) = 4.48, p < 0.05$.

Table 2.1.

Re-referred to social care * Surestart provided service to child or parent, or both Crosstabulation

			Surestart provided service to child or parent, or both		Total
			no	yes	
Re-referred to social care	no	Count	184	193	377
		% of Total	31.4%	32.9%	64.3%
	yes	Count	83	126	209
		% of Total	14.2%	21.5%	35.7%
Total		Count	267	319	586
		% of Total	45.6%	54.4%	100.0%

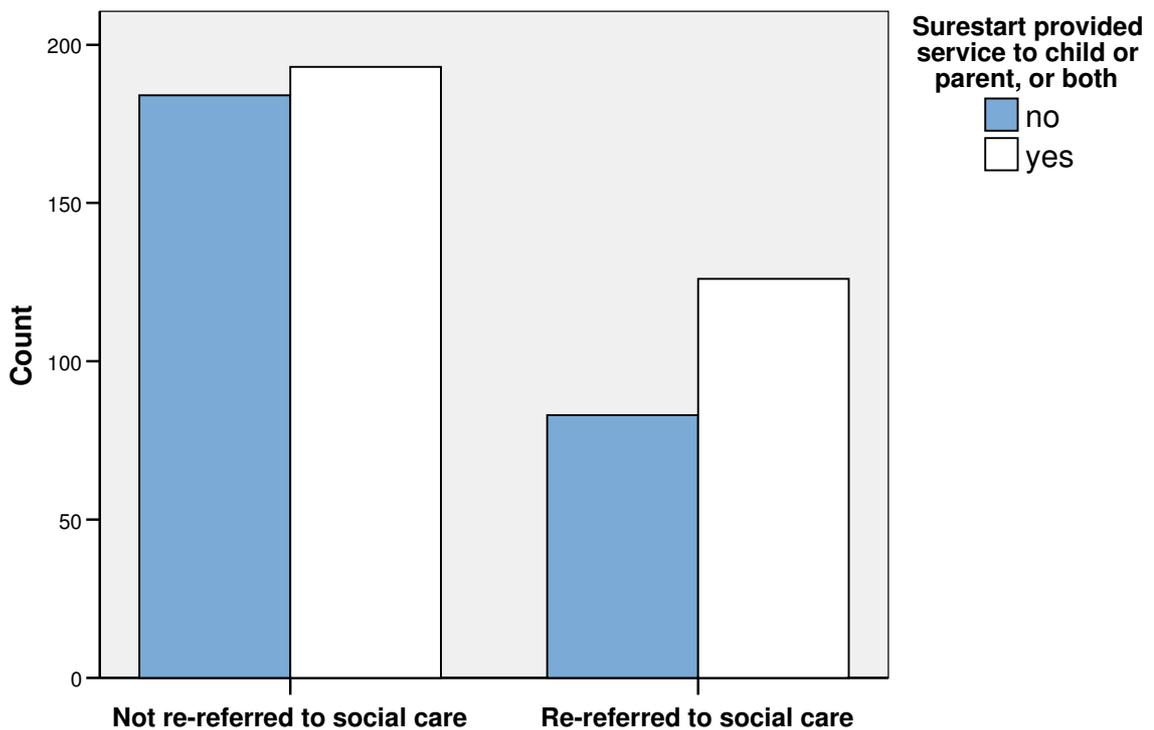


Figure 2.2. Number of cases re-referred to social care and provision of Sure Start services

2.4.2. Chi-square Analysis for Five Most Established SSLPs

2.4.2.1. Subsequently re-referred to social care / not re-referred to social care

The table below shows that children from families supported by Sure Start were more likely to be re-referred to social care than those children from families who have had no support. However, these results could be interpreted in a different way. Those children who have been re-referred are more likely to have had Sure Start support than those that haven't. The low number of cases here supports this interpretation. A chi-square analysis showed this to be a significant effect, $\chi^2(1, N= 433) = 5.57, p<0.05$.

Table 2.2.

Re-referred to social care * Surestart provided service to child or parent, or both Crosstabulation

			Surestart provided service to child or parent, or both		Total
			no	yes	
Re-referred to social care	no	Count	129	164	293
		% of Total	29.8%	37.9%	67.7%
	yes	Count	45	95	140
		% of Total	10.4%	21.9%	32.3%
Total		Count	174	259	433
		% of Total	40.2%	59.8%	100.0%

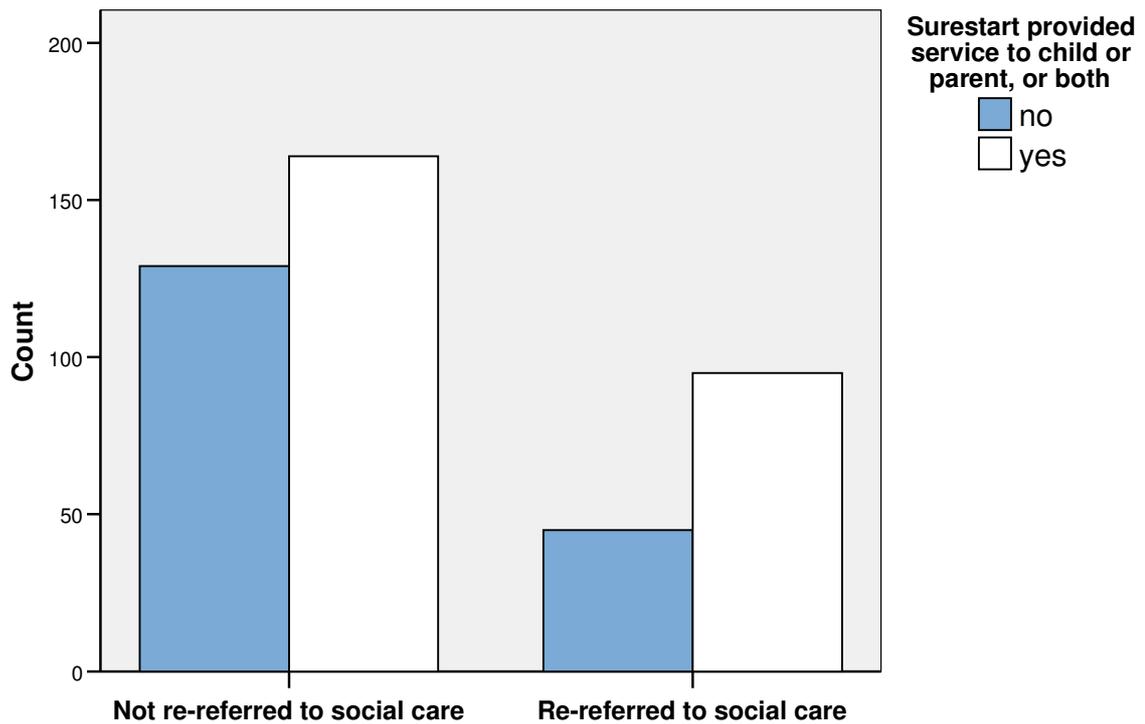


Figure 2.3. Number of cases re-referred to social care and provision of Sure Start services, for the five most established SSLPs

2.4.3. Individual SSLP Chi-square Analysis

2.4.3.1. Birchwood Chi-square Analysis

All results were non-significant.

2.4.3.2. East Lindsey Coastal Ribbon Chi-square Analysis

All results were non-significant

2.4.3.3. Gainsborough Chi-square Analysis

All results were non-significant

2.4.3.4. Lincoln North Chi-square Analysis

All results were non-significant

2.4.3.5. Boston Chi-square Analysis

As the table below shows, there is a relationship between Sure Start involvement and subsequent referral closure. When Sure Start has been involved significantly less referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=114) = 6.92, p < 0.01$.

Table 2.3.

Referral Subsequently Closed * Surestart provided service to child or parent, or both Crosstabulation

			Surestart provided service to child or parent, or both		Total
			no	yes	
Referral Subsequently Closed	No	Count	19	22	41
		% of Total	16.7%	19.3%	36.0%
	Yes	Count	52	21	73
		% of Total	45.6%	18.4%	64.0%
Total		Count	71	43	114
		% of Total	62.3%	37.7%	100.0%

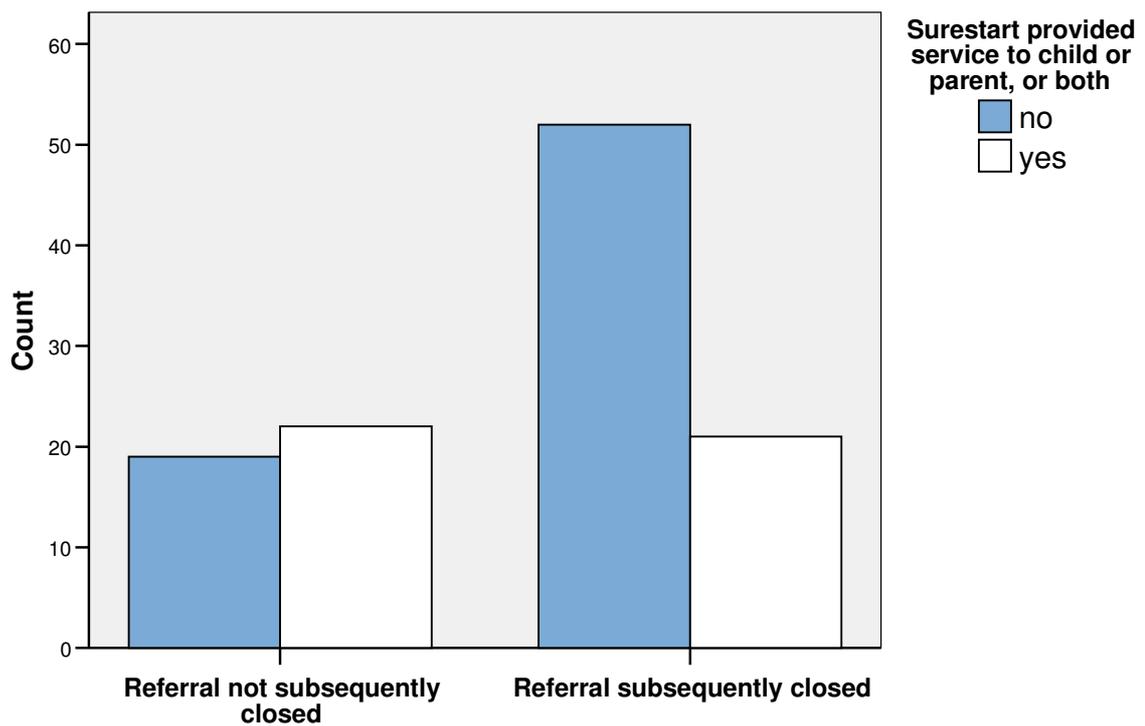


Figure 2.4. Number of cases where referrals were subsequently closed and provision of Sure Start services, for the Boston SSLP

2.4.3.6. Grantham Chi-square Analysis

The table below shows there is a relationship between Sure Start involvement and subsequent referral closure. When Sure Start has been involved significantly less referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=70) = 4.19, p<0.05$.

Table 2.4.

Referral Subsequently Closed * Surestart provided service to child or parent, or both Crosstabulation

			Surestart provided service to child or parent, or both		Total
			no	yes	
Referral Subsequently Closed	No	Count	5	13	18
		% of Total	7.1%	18.6%	25.7%
	Yes	Count	29	23	52
		% of Total	41.4%	32.9%	74.3%
Total		Count	34	36	70
		% of Total	48.6%	51.4%	100.0%

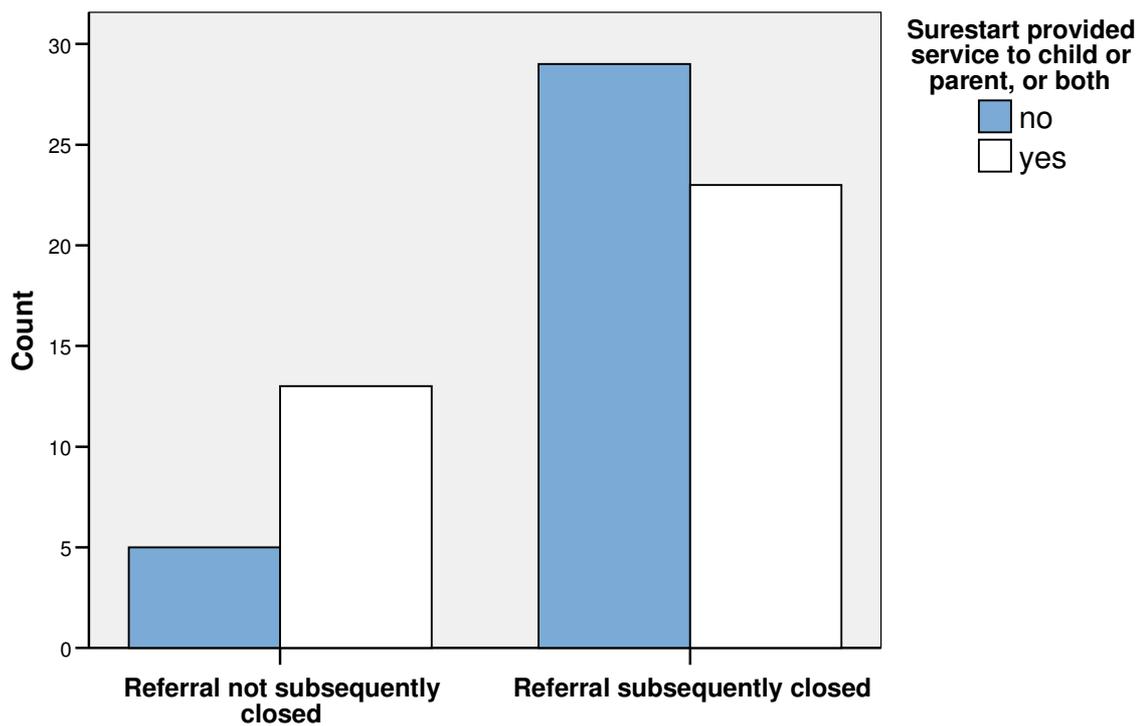


Figure 2.5. Number of cases where referrals were subsequently closed and provision of Sure Start services, for the Grantham SSLP

2.4.3.7. Lincoln Central Chi-square Analysis

The table below shows, there is a relationship between Sure Start involvement and subsequent referral closure. When Sure Start has been involved significantly less referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=83) = 7.21, p<0.01$.

Table 2.5.

Referral Subsequently Closed * Surestart provided service to child or parent, or both Crosstabulation

			Surestart provided service to child or parent, or both		Total
			no	yes	
Referral Subsequently Closed	No	Count	7	9	16
		% of Total	8.4%	10.8%	19.3%
	Yes	Count	52	15	67
		% of Total	62.7%	18.1%	80.7%
Total		Count	59	24	83
		% of Total	71.1%	28.9%	100.0%

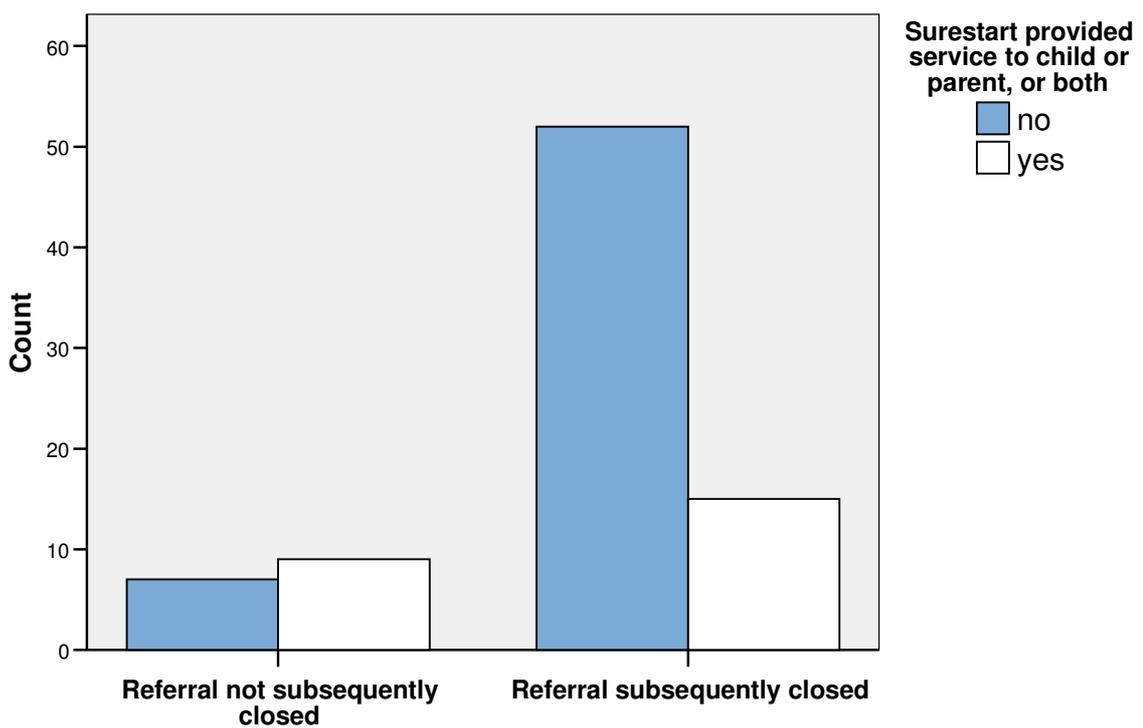


Figure 2.6. Number of cases where referrals were subsequently closed and provision of Sure Start services, for the Lincoln Central SSLP

2.4.4. Summary of Chi-square Analyses for Mode of Delivery

Figures 2.7. to 2.9. below show frequency pie-charts for the mode of delivery of Sure Start services on an individual basis, as part of a group, or on both an individual and group basis.

Child or parent has received an individual surestart intervention

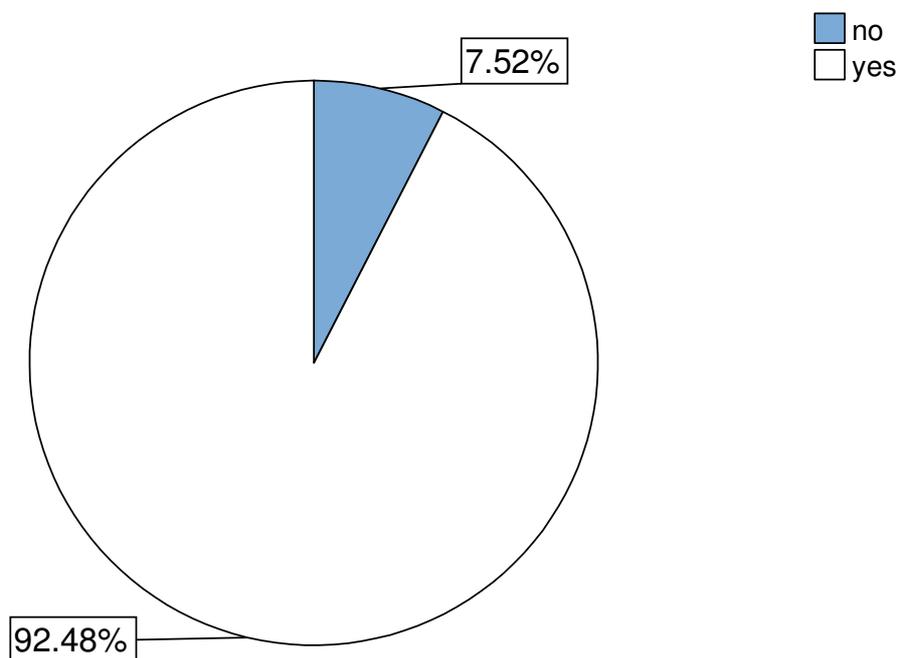


Figure 2.7. Overall percentage of children (or parents, or both) receiving Sure Start services on an individual basis

Child or parent has received a surestart intervention as part of a group

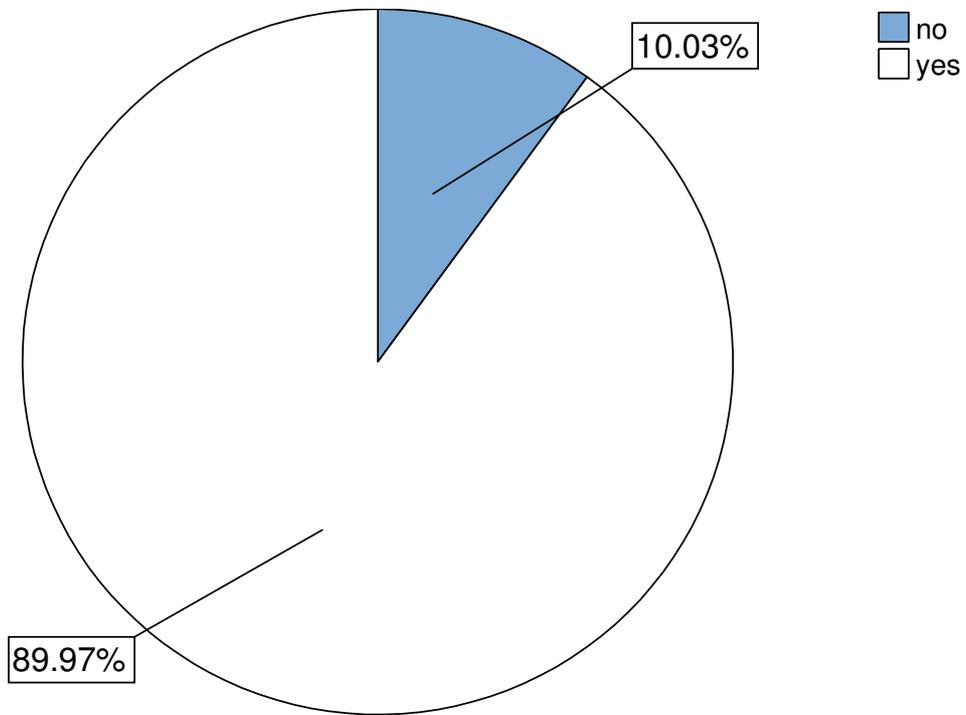


Figure 2.8. Overall percentage of children (or parents, or both) receiving Sure Start services as part of a group

Child or parent has received both an individual surestart intervention and a surestart intervention as part of a group

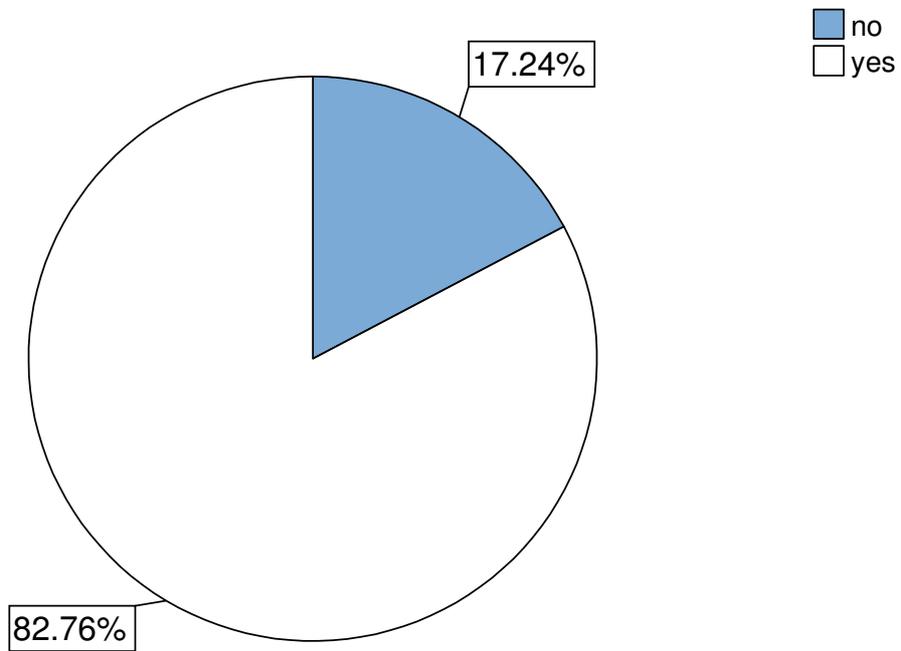


Figure 2.9. Overall percentage of children (or parents, or both) receiving Sure Start services on both an individual and group basis

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2.4.4.1. Individual Contact

2.4.4.1.1. Referral subsequently closed / referral not subsequently closed

As the table below shows, there is a relationship between individual Sure Start involvement and subsequent referral closure. When Sure Start has been involved on an individual basis significantly more referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 7.41, p < 0.01$.

Table 2.6.

Referral Subsequently Closed * Child or parent received intervention on an individual basis Crosstabulation

			Child or parent received intervention on an individual basis		Total
			no	yes	
Referral Subsequently Closed	No	Count	1	89	90
		% of Total	.3%	27.9%	28.2%
	Yes	Count	23	206	229
		% of Total	7.2%	64.6%	71.8%
Total		Count	24	295	319
		% of Total	7.5%	92.5%	100.0%

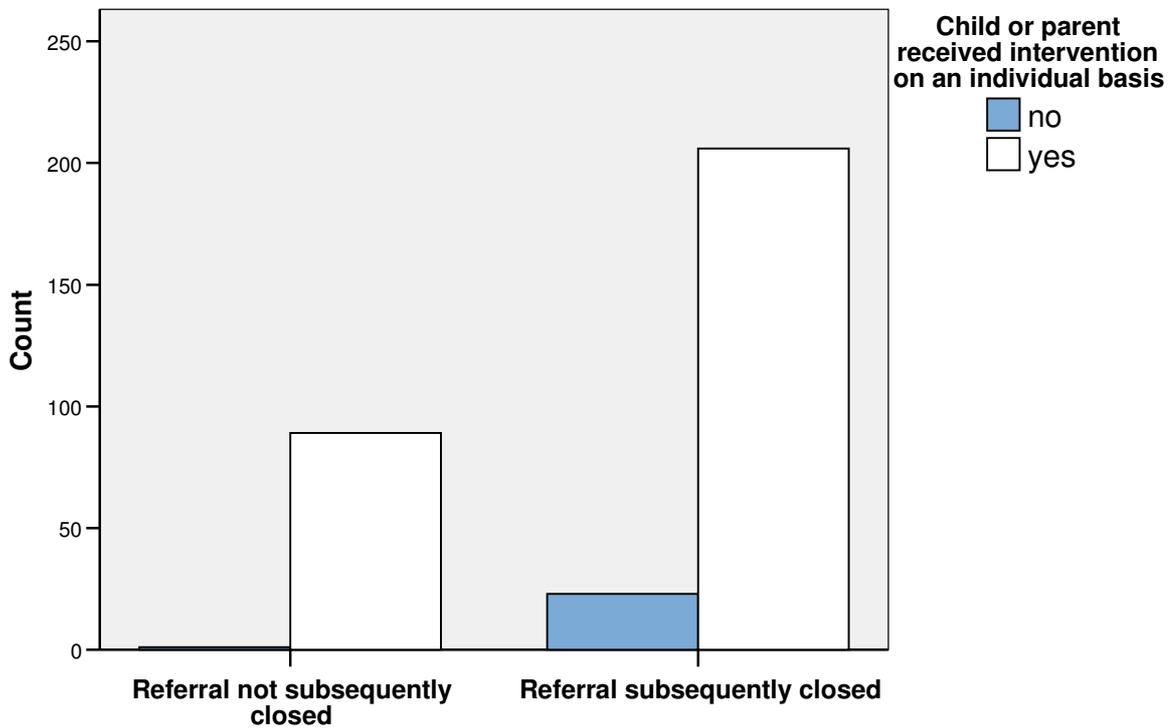


Figure 2.10. Number of cases where referrals were subsequently closed and provision of Sure Start services, on an individual basis

2.4.4.2. Group Contact

2.4.4.2.1. Referral subsequently closed / referral not subsequently closed

As the table below shows, there is a relationship between individual Sure Start involvement and subsequent referral closure. When Sure Start has been involved on a group basis more referrals have been subsequently closed. However a chi-square analysis showed an interesting but non-significant effect, $\chi^2(1, N=319) = .72, p>0.01$.

Table 2.7.

Referral Subsequently Closed * Child or parent received intervention as part of a group Crosstabulation

			Child or parent received intervention as part of a group		Total
			no	yes	
Referral Subsequently Closed	No	Count	7	83	90
		% of Total	2.2%	26.0%	28.2%
	Yes	Count	25	204	229
		% of Total	7.8%	63.9%	71.8%
Total	Count	32	287	319	
	% of Total	10.0%	90.0%	100.0%	

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2.4.4.3. Both Individual and Group Contact

2.4.4.3.1. Name placed on CPR after referral / not placed on CPR after referral

As the table below shows, there is a relationship between both individual and group Sure Start involvement and placement on the child protection register. It seems that although there are very few instances of children being placed on CPR the majority of these cases have received both individual and group interventions. Also, however a large majority of the children that have had both individual and group interventions have not been placed on the CPR. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 4.11$, $p < 0.05$.

Table 2.8.

Placed on CPR * Child or parent received both individual and group intervention Crosstabulation

		Child or parent received both individual and group intervention		Total
		no	yes	
Placed on CPR	No	Count 52	Count 222	Count 274
		% of Total 16.3%	% of Total 69.6%	% of Total 85.9%
	Yes	Count 3	Count 42	Count 45
		% of Total .9%	% of Total 13.2%	% of Total 14.1%
Total		Count 55	Count 264	Count 319
		% of Total 17.2%	% of Total 82.8%	% of Total 100.0%

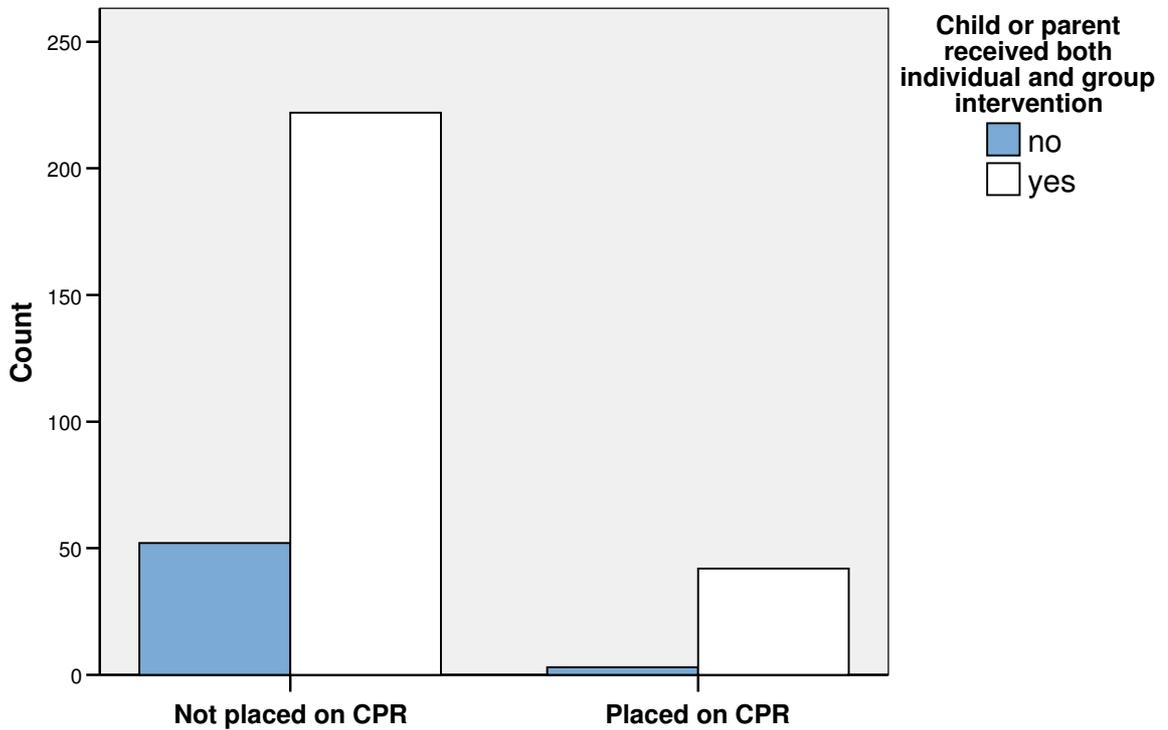


Figure 2.11. Number of children placed on the CPR and provision of Sure Start services, on both a group and individual basis

2.4.4.3.2. Referral subsequently closed / referral not subsequently closed

As the table below shows, there is a relationship between both individual and group Sure Start involvement and subsequent referral closure. When Sure Start has been involved on both an individual and group basis more referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 6.13, p<0.05$.

Table 2.9.

Referral Subsequently Closed * Child or parent received both individual and group intervention Crosstabulation

			Child or parent received both individual and group intervention		Total
			no	yes	
Referral Subsequently Closed	No	Count 8	82	90	
		% of Total 2.5%	25.7%	28.2%	
	Yes	Count 47	182	229	
		% of Total 14.7%	57.1%	71.8%	
Total		Count 55	264	319	
		% of Total 17.2%	82.8%	100.0%	

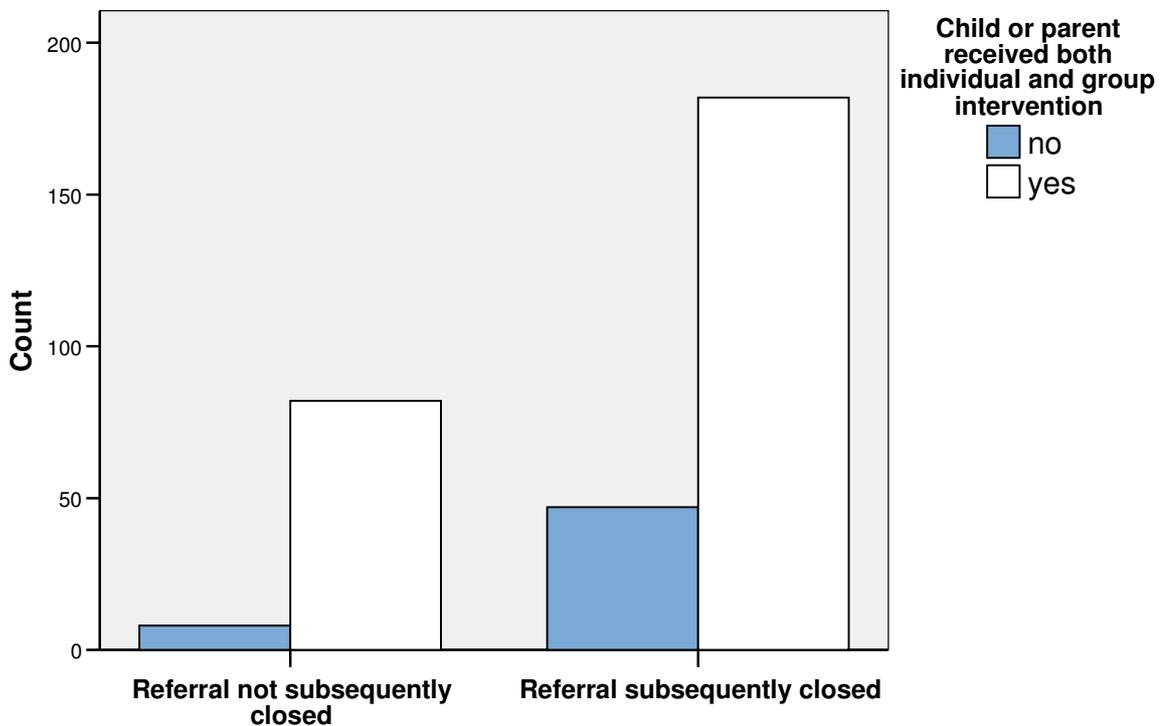


Figure 2.12. Number of cases where referrals were subsequently closed and provision of Sure Start services, on both an individual and group basis

2.4.5. Summary of Chi-square Analyses for Type of Intervention

Figures 2.13. to 2.16. below show frequency pie-charts for type of Sure Start intervention: health related, play and learning, family support, or community involvement.

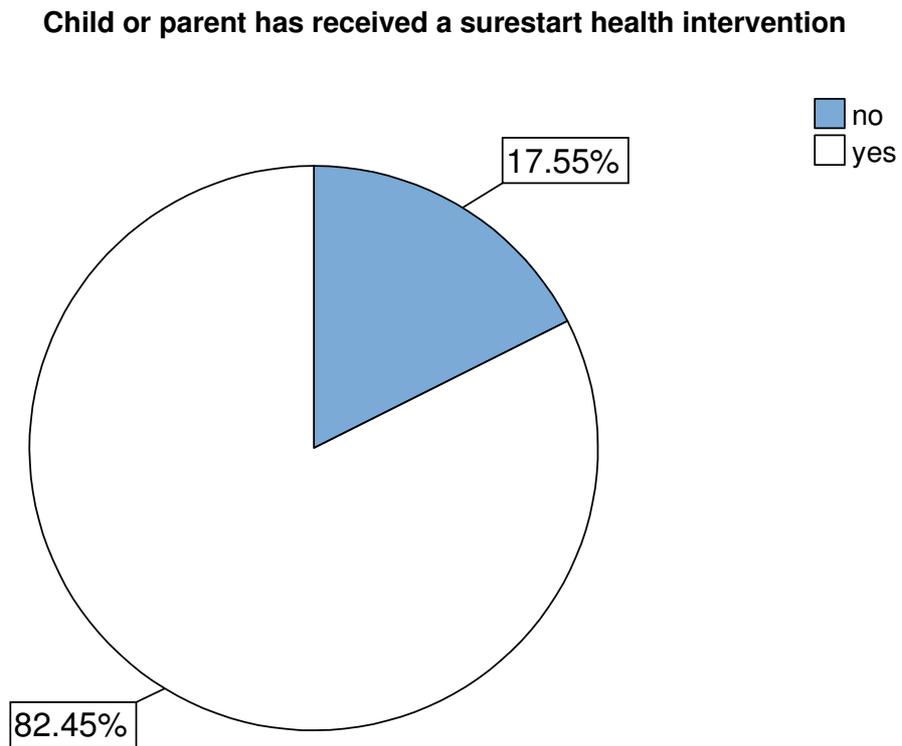


Figure 2.13. Overall percentage of children (or parents, or both) receiving Sure Start health services

Child or parent has received a play and learning intervention

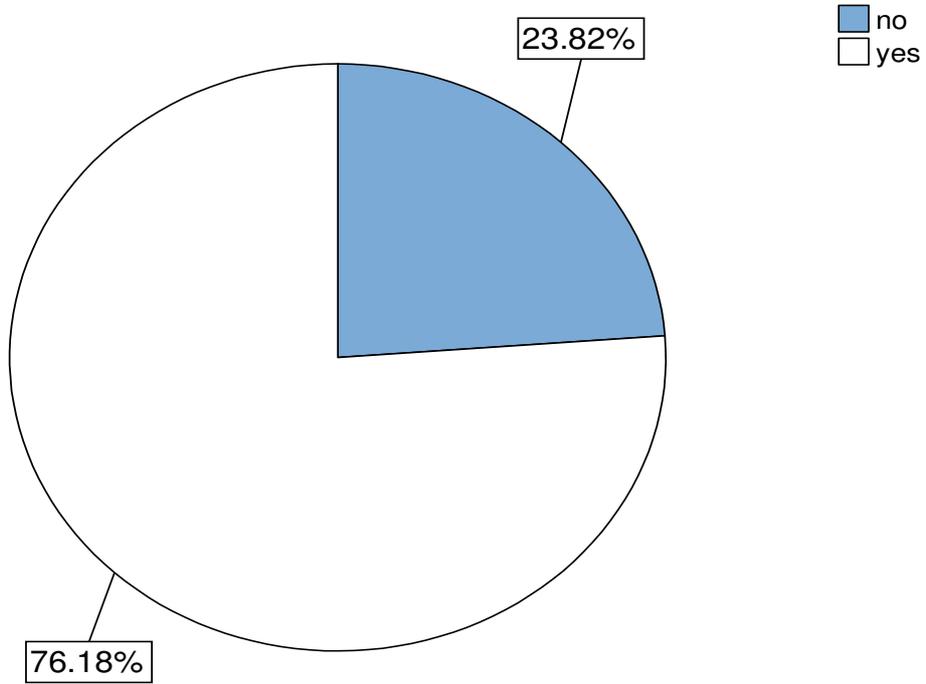


Figure 2.14. Overall percentage of children (or parents, or both) receiving Sure Start play and learning services

Child or parent has received a family support intervention

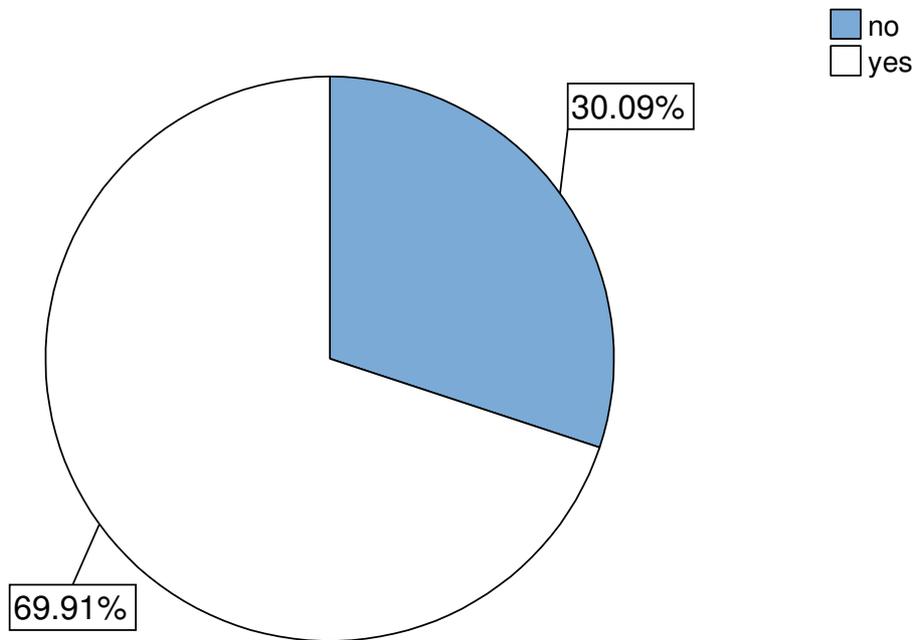


Figure 2.15. Overall percentage of children (or parents, or both) receiving Sure Start family support services

Child or parent has received a community involvement intervention

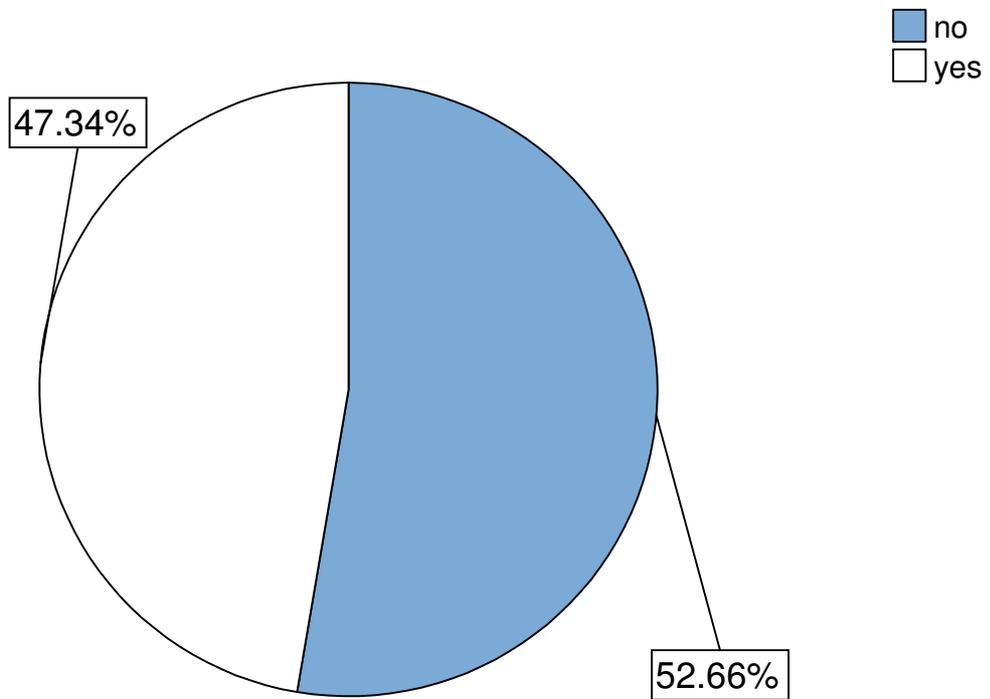


Figure 2.16. Overall percentage of children (or parents, or both) receiving Sure Start community involvement services

2.4.5.1. Health

No significant effects

2.4.5.2. Play and Learning

No significant effects

2.4.5.3. Family Support

2.4.5.3.1. Name placed on CPR after referral / not placed on CPR after referral

As the table below shows, there is a relationship between Sure Start family support provision and placement on the child protection register. It seems that although there are very few instances of children being placed on CPR the majority of these cases have received family support. Also, however, a large majority of the children that have received family support have not been placed on the CPR. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 16.38, p < 0.001$.

Table 2.10

**Placed on CPR * Child or parent received family support intervention
Crosstabulation**

		Child or parent received family support intervention		Total
		no	yes	
Placed on CPR	No	Count 94	Count 180	Count 274
		% of Total 29.5%	% of Total 56.4%	% of Total 85.9%
	Yes	Count 2	Count 43	Count 45
		% of Total .6%	% of Total 13.5%	% of Total 14.1%
Total		Count 96	Count 223	Count 319
		% of Total 30.1%	% of Total 69.9%	% of Total 100.0%

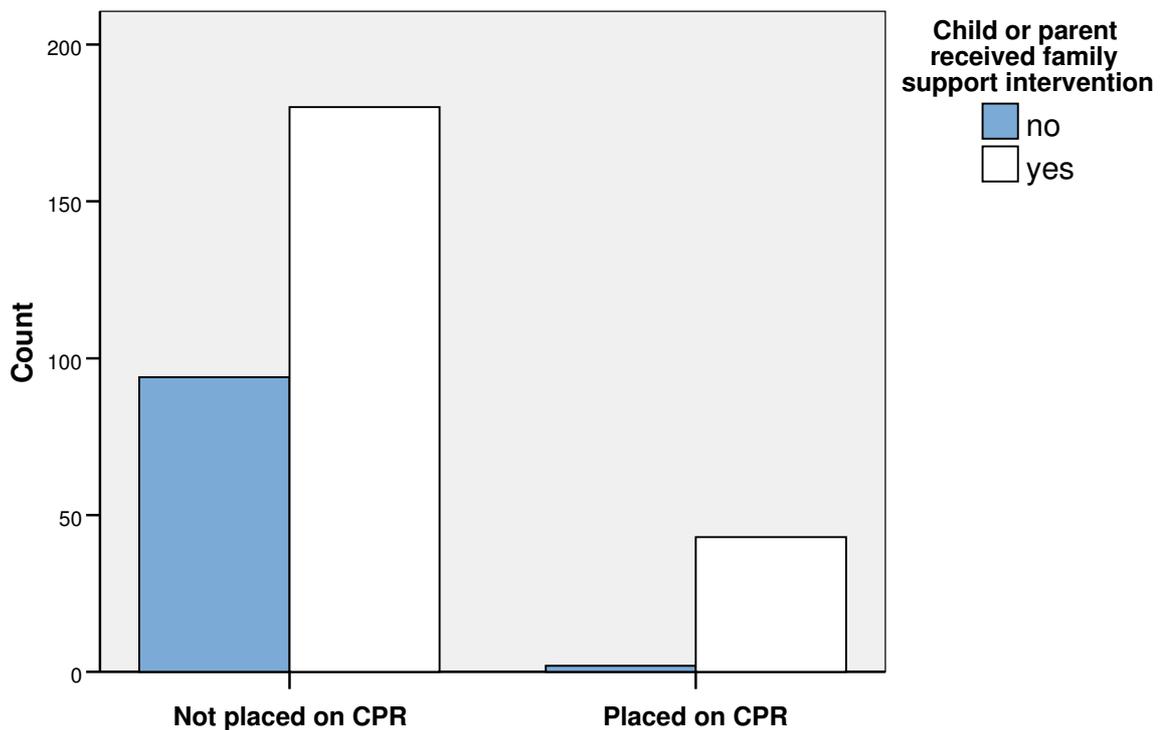


Figure 2.17. Number of children placed on the CPR and provision of Sure Start family support services

2.4.5.3.2. Child became looked after following referral / child not looked after following referral

As the table below shows, there is a relationship between Sure Start family support services provision and children being looked after. It seems that although there are very few instances of children becoming Looked After, the majority of these cases have received family support. Also, however, a large majority of the children that have received family support have not become Looked After. A chi-square analysis showed a near significant effect, $\chi^2(1, N=319) = 3.65, p < 0.06$.

Table 2.11.

CLA after Referral * Child or parent received family support intervention Crosstabulation

			Child or parent received family support intervention		Total
			no	yes	
CLA after Referral	No	Count	92	199	291
		% of Total	28.8%	62.4%	91.2%
	Yes	Count	4	24	28
		% of Total	1.3%	7.5%	8.8%
Total		Count	96	223	319
		% of Total	30.1%	69.9%	100.0%

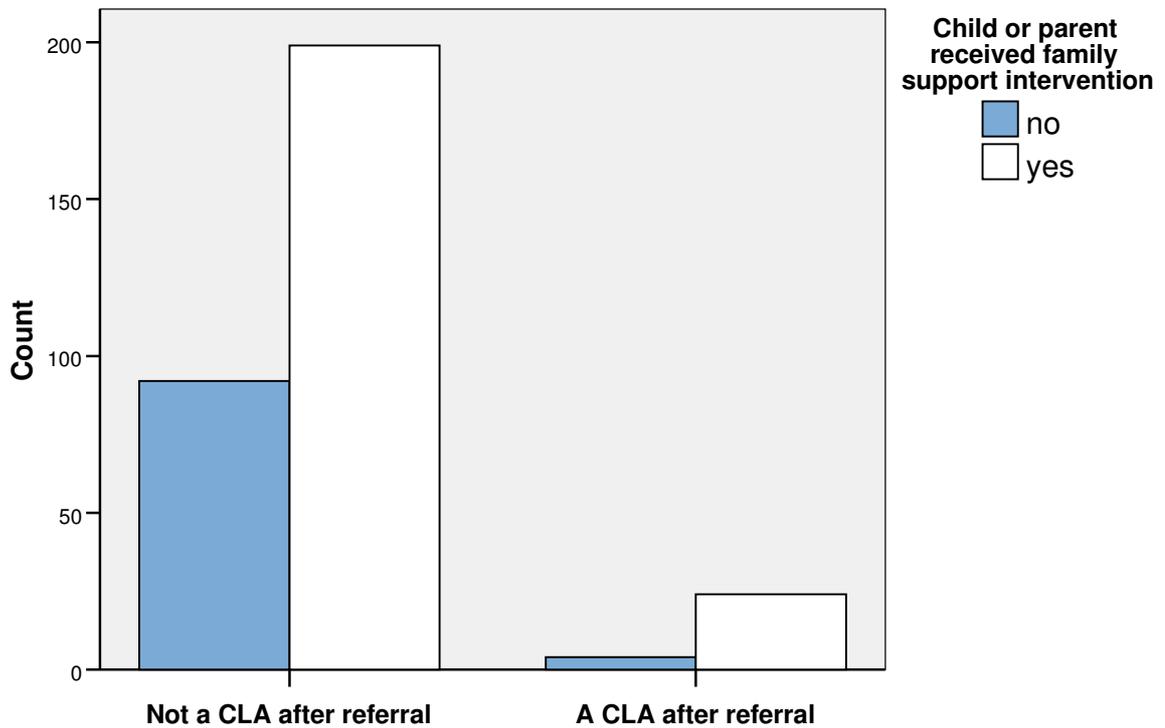


Figure 2.18. Number of CLA and provision of Sure Start family support services

2.4.5.3.3. Referral subsequently closed / referral not subsequently closed

As the table below shows, there is a relationship between the provision of Sure Start family support and subsequent referral closure. When Sure Start has been involved on a family support basis more referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 7.48, p < 0.01$.

Table 2.12

Referral Subsequently Closed * Child or parent received family support intervention Crosstabulation

		Child or parent received family support intervention		Total
		no	yes	
Referral Subsequently Closed	No	Count 17	Count 73	Count 90
		% of Total 5.3%	% of Total 22.9%	% of Total 28.2%
	Yes	Count 79	Count 150	Count 229
		% of Total 24.8%	% of Total 47.0%	% of Total 71.8%
Total		Count 96	Count 223	Count 319
		% of Total 30.1%	% of Total 69.9%	% of Total 100.0%

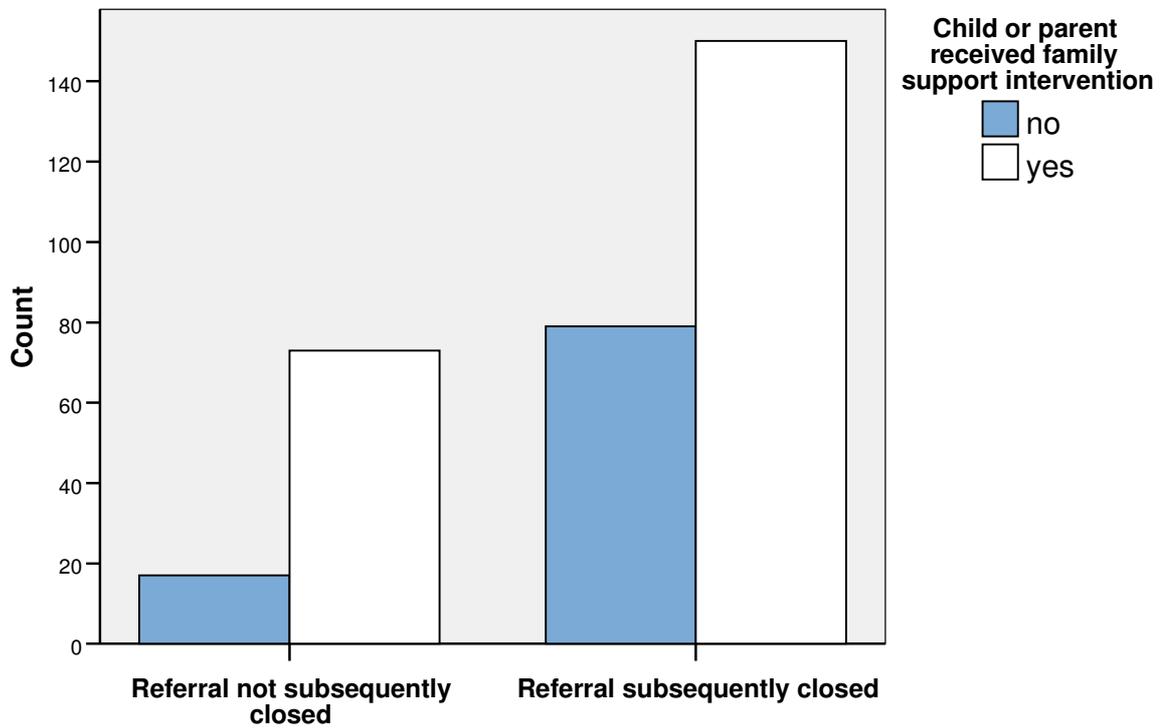


Figure 2.19. Number of cases where referrals were subsequently closed and provision of Sure Start family support services

2.4.5.4. Community Involvement

2.4.5.4.1. Name placed on CPR after referral / not placed on CPR after referral

As the table below shows, there is a relationship between Sure Start community involvement and placement on the child protection register. It seems that the majority of families have both not received community involvement support and have not been placed on the child protection register. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 4.66, p < 0.05$.

Table 2.13

Placed on CPR * Child or parent received community involvement intervention Crosstabulation

		Child or parent received community involvement intervention		Total
		no	yes	
Placed on CPR	No	Count 151	Count 123	Count 274
		% of Total 47.3%	% of Total 38.6%	% of Total 85.9%
	Yes	Count 17	Count 28	Count 45
		% of Total 5.3%	% of Total 8.8%	% of Total 14.1%
Total		Count 168	Count 151	Count 319
		% of Total 52.7%	% of Total 47.3%	% of Total 100.0%

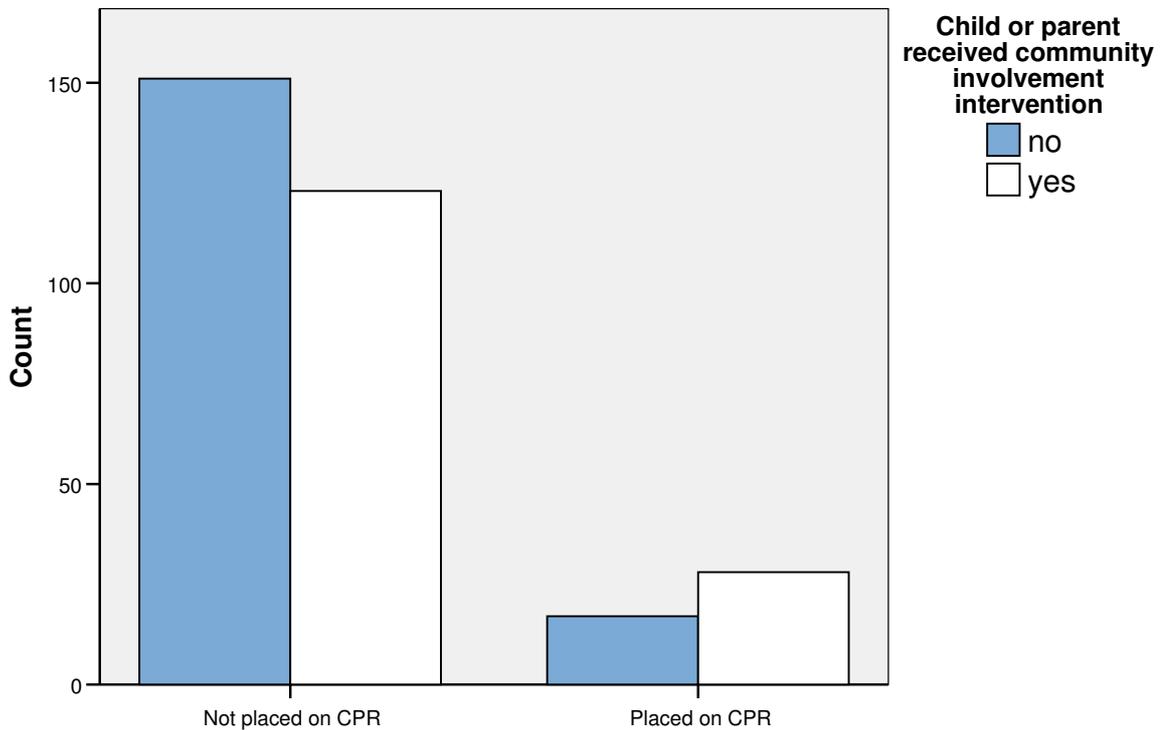


Figure 2.20. Number of children placed on the CPR and provision of Sure Start community involvement services

2.4.5.4.2. Referral subsequently closed / referral not subsequently closed

As the table below shows, there is a relationship between Sure Start community involvement and subsequent referral closure. When Sure Start has been involved on a community involvement basis less referrals have been subsequently closed. A chi-square analysis showed a significant effect, $\chi^2(1, N=319) = 5.48, p < 0.05$.

Table 2.14

Referral Subsequently Closed * Child or parent received community involvement intervention Crosstabulation

			Child or parent received community involvement intervention		Total
			no	yes	
Referral Subsequently Closed	No	Count	38	52	90
		% of Total	11.9%	16.3%	28.2%
	Yes	Count	130	99	229
		% of Total	40.8%	31.0%	71.8%
Total	Count	168	151	319	
	% of Total	52.7%	47.3%	100.0%	

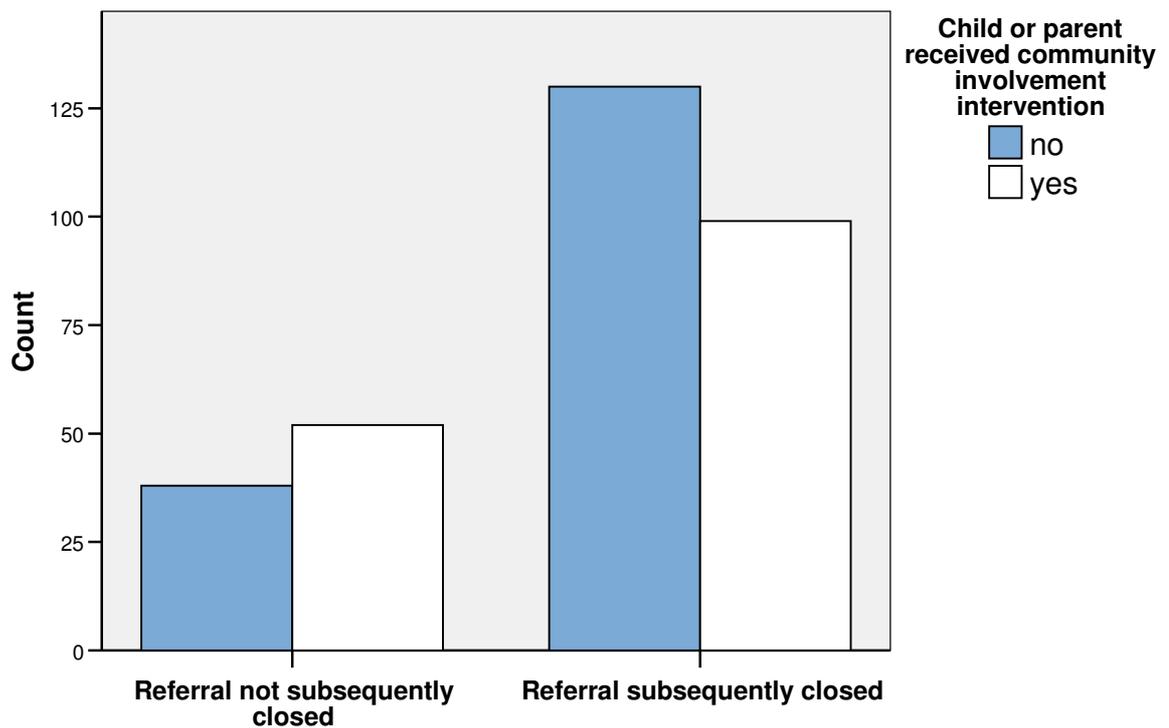


Figure 2.21. Number of cases where referrals were subsequently closed and provision of Sure Start community involvement services

2.5. Discussion

Sure Start was involved with just over half of the cohort of children referred to Children's Social Care between 1st April 2004 and 31st March 2005. This suggests that Sure Start is failing to reach almost 50% of the most vulnerable children in any SSLP area.

Given the categorical nature of the data and the number of possible extraneous variables that could be impacting on outcomes, interpretation of the results of the chi-square analyses is limited to speculation about causal affects, based on the researcher's personal experience. Analysis of combined data for all seven SSLPs showed that children who were re-referred to Social Care were more likely to have received Sure Start services and this was still the case when this analysis was narrowed down to the five most established SSLPs. Given that Sure Start involvement is likely to lead to increased contact with families, it might be expected that this in turn, would lead to identification of further need and concern, especially where the families in question, by virtue of having been referred already, have been identified as vulnerable and having complex needs.

Analysis undertaken in respect of data relating to individual SSLPs highlighted the fact that in the Boston, Grantham, and Lincoln Central, SSLP areas, less referrals to Children's Social Care had been subsequently closed where Sure Start was involved. No obvious link between these SSLPs could be identified to assist in interpreting this result; it is therefore necessary to treat any inferences that might be drawn with caution. However, it is possible that following referral, involvement by Sure Start in these areas led to identification of needs and concerns that warranted continued involvement by Social Care. Additionally, more referrals in these areas may have been made later in the time frame (April 2004 – March 2005) meaning that, whilst Sure Start was involved, there was less time available for the provision of services to support closure of the referral before the end date (31/03/06).

Whilst similar numbers of children (or their parents or both) had received Sure Start services on an individual basis to those who had received group intervention, slightly less had received the latter and less again had received services delivered in both ways.

Results of the chi-square analyses relating to mode of delivery of Sure Start services showed that referrals were subsequently more likely to be closed where services were delivered on an individual basis or through a combination of individual and group intervention. Given that Children's Social Care services are also delivered on an individual basis, it is possible that where similar support is in place from Sure Start there is less need for Social Care to remain involved. Additionally, support packages combining individual support, delivered via home visiting, with parent education and attendance at a parent support group have proved effective in improving interactions between parents and infants (Howe, 2005). The combination of individual and group support from Sure Start could be having a positive effect in Lincolnshire, hence the impact on referral closure.

Results of a chi-square analysis showed a relationship between delivery of Sure Start on both an individual and group basis and registration on the CPR. These results could be interpreted as suggesting that where Sure Start is involved in this way children are unlikely to be placed on the CPR. However, as mentioned in 2.3 above, data concerning child protection registration caused problems in terms of analysis, as very few children were registered on the CPR. Where analysis of this data was valid in terms of the required expected values, meaningful interpretation of the results was still restricted as there was a huge difference between the statistically generated expected values and actual data for the 'on CPR' yes/no category alone. Here the difference between the minimal number of children registered on the CPR and the comparatively huge number that were not, could in itself result in a significant effect, regardless of the data concerning the mode of delivery, thus limiting any interpretation placed upon the results.

Where Sure Start was involved with families, the majority of children (or parents or both) had received health (82.45%), play and learning (76.18%) and family support (69.91%) interventions, whereas less than half had accessed services focusing on community involvement (47.34%).

The fact that the results of chi-square analyses relating to the provision of family support services showed that the majority of children registered on the CPR, and those who became Looked After, had received this type of Sure Start service is unsurprising. Vulnerable families with complex needs are more likely to be those requiring individual support, such as that provided by Sure Start family support services, but the children of these families are also more likely to require protection or, where family problems are entrenched, placement away from their family of origin. Results also showed that referrals were more likely to be subsequently closed when Sure Start family support services had been provided. This could be attributable to the fact that these services are provided on an individual basis and, as mentioned earlier, the fact that Children's Social Care services are also delivered in this way had lessened the need for Social Care to remain involved. Given the relationship between provision of Sure Start family support services and children becoming Looked After it could also be possible that some children were removed from parents where these services were in place, leading to closure of the referral.

In relation to community involvement the results of chi-square analyses showed that where there had been no provision of services focusing on community involvement children were less likely to be registered on the CPR. However, registration was also less likely where these services were provided. It might be argued that because the aim of community involvement is to empower parents, the children of those who had made progress via this involvement were less likely to meet the criteria for CP registration. However, as before, the difference between the low numbers of children registered on the CPR and the comparatively huge number that were not could in itself result in a significant effect, regardless of the distribution of the other data, thus limiting any interpretation placed upon the results. Results also showed that where Sure Start services focusing on community involvement were provided referrals were less likely to be subsequently closed. It is possible that provision of this type of support from Sure Start

is not sufficient to impact on the closure of a referral to Children's Social Care. However, as it was not statistically appropriate, the data was not narrowed down to identify the number of cases where only this type of service was provided. As a consequence, it is not possible to identify whether this is a reasonable assumption.

Part 3

The Preventative Role of Sure Start Services and their Impact on Outcomes for Children referred to Children's Social Care

3.1. Introduction

This section of the report describes the role played by preventative services, including those identified specifically as being provided by Sure Start, and their impact on outcomes for children as perceived by their parents and front line staff involved, in five cases referred to Children's Social Care. It goes on to discuss the views of participants as to any additional services or changes in practice that might have prevented the need for Children's Social Care services to be involved and the principal themes emerging overall.

Whilst Sure Start funding is allocated to a range of projects providing preventative services across the County, the workers employed to deliver them are not all immediately identifiable as having any connection with Sure Start. It was therefore important, in designing this aspect of the study, to ensure that the role and impact of these services was not overlooked. This was achieved by focusing, in the interviews, on the whole range of services provided to the family rather than just those identified as emanating from Sure Start.

Due to time constraints a decision was made by the Project Steering Group to limit the case studies to one in each of the five most established SSLPs: Lincoln Birchwood; Boston; East Lindsey Coastal Ribbon; Gainsborough and Lincoln North. Cases were selected from those identified within the cohort (see Part 2) as having received Sure Start services. In the hope of gaining insight into the broadest range of circumstances possible, each case was randomly selected from a sample in each area narrowed down according to a different set of criteria, in terms of progress through the social care system following referral (up to 31/03/06). This resulted in selection of three cases where children had not been registered on the CPR, one of which had been re-referred and one in which the child had become Looked After, and two cases where children had been registered on the CPR, one of which had been de-registered.

The parents in each of the five cases were approached by Sure Start to seek their agreement to take part in an interview with the researcher and their permission for front line staff, who had provided support to the family following referral to Children's Social Care services, to be approached for interview. Individual interviews were undertaken using a semi-structured approach designed to ensure that the aims of the study were addressed.

A pictorial guide to the Government's five Every Child Matters (ECM) Outcomes (2003) was used as an aide-memoir to assist participants when discussing these. Not all cases were known to participants at the time of referral to Children's Social Care services and some of the cases remained open at the time of the interviews, so participants were asked to use their knowledge of the children's circumstances since the referrals were made and describe any changes in the extent to which they considered children were meeting the Outcomes.

A total of 30 interviews were carried out as follows:

Parents	4
Sure Start workers	7
Children's Social Care workers	7
Health workers	5
Workers from educational settings	4
Workers from voluntary organisations	3

SSLP area 1	Parent; SS, FSW; Social Care, FSW & SW; School, Head Teacher; Nursery, Manager.
SSLP area 2	Parent; SS, FRW & EYPS; Social Care, SW; Health Visitor; Nursery worker; Home-Start organiser.
SSLP area 3	Parent; SS, Nursery Nurse; Social Care, SW; Health, Health Visitor (& Nursery Nurse)* & School Nurse; Rainer worker; Women's Aid worker.
SSLP area 4	SS, Health Visitor; Social Care, Practice Manager & FSW; Health Visitor.
SSLP area 5	Parent; SS, Health Visitor & Speech Therapist; Social Care, CFO; Health Visitor; School, Teaching Assistant.

*Health Visitor & Nursery Nurse interviewed jointly

Key

SS = Sure Start

FSW = Family Support Worker

FRW = Family Resource Worker

EYPS = Early Years Play Specialist

SW = Social Worker

CFO = Children & Families Officer

Though agreement was obtained in all 5 SSLP areas, parents were successfully interviewed in only four. Workers identified here as Sure Start workers are based in Sure Start buildings and bear a title that clearly identifies them as such. Home-Start, Rainer and Women's Aid are all voluntary organisations which provide a national identity to projects operating independently, and responsible for their own fundraising, at a local level. Home-Start offers support, friendship and practical help to families with at least one child under five. Rainer Lincolnshire provides floating support to help young people in the community to obtain or sustain their housing tenancies. Women's Aid provides advice and support for women and children experiencing or fleeing domestic violence.

An outline of each of the case studies is provided, as described by participants. These include details of the extent to which front line workers and other members of their agencies or organisations were involved, the presenting problems identified in respect of children and their parents and the progress of the case following referral to Children's Social Care. Fictitious names are used in the interests of confidentiality.

Findings are presented in six key sections. The first explores the involvement of Children's Social Care services in terms of perceptions around the need for and impact of this. Conversely the impact of preventative services on the need for involvement by Children's Social Care services is explored. Identified need and how this was met through provision of services is then reported, along with perceptions around the benefits of Sure Start support. The next section deals with findings relating to outcomes and support that is viewed as having been most helpful. This is followed by a section focusing on access to services, including how they were accessed, what services were not accessed and participants views on why. The penultimate section considers relationships, including the positives identified in these, difficulties experienced in working relationships between parents and professionals and issues around values. Finally views are reported on what additional services or changes in practice, including the Common Assessment Framework (CAF) (DFES, 2005), which is due to be implemented across the County over the next year or so, might have made a difference in each of the cases.

3.2. Case Study 1

Data provided by Children's Services Directorate showed that Sara was two years old when her name was registered on the CPR (date of referral to Children's Social Care not provided). This was not the first time a referral had been made. Sara was subsequently looked after and remained on the CPR. At 31/03/06 she had not been de-registered.

By the time the SW became the key worker the children had been placed in foster care and care proceedings had been initiated. The FSW worker employed by Social Care became involved when contact was taking place between the children and their mother at the Family Centre. The Nursery manager's knowledge of the case was limited to the period prior to the children being discharged from foster care.

There was consensus amongst participants that a number of agencies had expressed concerns to Children's Social Care and that this resulted in a CP conference and registration. Front line workers recalled that Sara's mother, Sue, was drinking too much and this was impacting on her ability to parent Sara and her older sibling, who was being treated more as a friend than a daughter by her mother and was taking on responsibility for assisting her and caring for Sara. This was acknowledged by Sue, who explained that she was feeling guilty following her eldest child's disclosure of sexual abuse. She also concurred with the view expressed by workers that she was in denial of her alcohol problem at the time.

Sue explained that at the time that Children's Social Care became involved she had recently moved to the area away from extended family and didn't know anybody; she said that she felt really isolated. The SW and FSW described Sue's relationship with her mother as unstable and insecure and several workers referred to her poor mental health which they considered to be linked to unresolved issues from her past.

Workers described signs of neglect in the children at this time, including poor appearance, hygiene issues and head lice. Sara's speech was described as poor, leading to difficulty with communication and thus in her ability to express herself. Both children were described as withdrawn. Sue said that she was not 'there' for her children and admitted putting Sara to bed early and not cuddling her.

Following a subsequent incident in which Sue turned up to nursery in drink and was considered unfit to take the children home, they were removed to foster care and care proceedings were initiated by the Local Authority. Sue recalled thinking "they were having a great time [on holiday] and they didn't want to talk to me and the way I was feeling it was like they're better off with her because she can give them this and this"

Perhaps unsurprisingly, there were some relapses in Sue's drinking whilst the children were in foster care. She and the children attended a Residential Assessment Centre however, as part of the care proceedings, and the children were subsequently returned home with an intensive package of daily support provided jointly by Children's Social Care via the Family Centre and the SW, Sure Start, the SW from the substance misuse team, the school and maternal grandparents.

At the time of the interview Sue described major improvements in the situation. She said that she now responds to the children more; she is able to listen to her oldest child when she wants to talk about her abuse without "reaching for something else" and reassure and settle her, she cuddles Sara more, is more interactive in her play with the children and more able to impose boundaries. She also said that she knows that support is available if she needs it. The SS worker commented on the positive contribution Sue is now making to the community and how this had improved her self-esteem. The Head Teacher explained that Sue is now training to be a teaching assistant and supporting children at the school to gain experience.

3.3. Case Study 2

Data provided by Children's Services Directorate showed that Scott was one month old when he was referred to Children's Social Care. This was the first time a referral had been made. He was not subsequently registered on the CPR or Looked After prior to 31/03/06 and the case was closed prior to this date.

None of the front line workers interviewed were involved at the time of the referral. The Health Visitor had been involved for approximately two years at the time of interview and the SW had been allocated the case following the most recent referral to Children's Social Care (after 31/03/06). Jane, Scott's mother, told me that the first referral was made by the hospital when the family attended due to one of Scott's older sibling's being scalded at the family home. The SW confirmed from records that the staff nurse made the referral due to concern that the injury might be non-accidental. The injured child moved to reside with maternal grandmother pending the outcome of a Child Protection

conference. The children were not registered on the CPR and the case remained open as Child in Need. Jane said that, at the time, she was tired following Scott's birth and there were arguments between herself and her partner. She said that there was some domestic violence though this was less severe than it had been during her pregnancy. There was also tension between Jane and her partner's mother who was interfering in the care of Scott and this was, in Jane's view, preventing the bonding process between herself and Scott. This, along with the loss of her uncle and grandmother, led to Jane becoming stressed and depressed. Jane explained that the children were craving her attention at the time, but she was unable to give this because of the domestic violence and her depression.

The SW said that the records showed that the case was closed to Children's Social Care services approximately 17 months after the referral, during which time, concerns around Scott's oldest sibling's school attendance and presentation were noted. SS workers, the Home-Start organiser and the Nursery worker became involved later, whilst Mum was pregnant with her youngest child. There were numerous problems for Jane and the children at that point according to front line workers. Jane's physical health was up and down throughout the pregnancy, her mood was low and she was described as anxious. The relationship with her partner broke down around this time but, prior to this breakdown, workers noted the partner's controlling nature and Jane's difficulty in leaving the house, as well as the impact on Jane's self-esteem through feelings of worthlessness. There was reference to there being lots of arguing whilst the partner remained in the home and both he and Jane were prescribed medication for depression, which one SS worker linked, in Jane's case, to unresolved issues from her childhood.

Jane concurred with the view expressed by workers that she was struggling with the care of her children following the departure of her partner. Workers viewed lack of motivation, a symptom of her low mood and self-esteem, to be at the root of poor home conditions and lack of supervision of the children. As a result there were concerns around Jane's lack of control of the situation, especially around safety, and a lack of routines, guidance and boundaries.

Scott's behaviour and that of his older siblings was described as becoming challenging at this time. The oldest child was running off and Scott was found with him on at least one occasion. There was consensus around the suggestion that the oldest child was taking on inappropriate responsibility for assisting Jane in parenting his younger siblings.

Following the birth of her baby Jane struggled, without transport, to get Scott to nursery. Whilst Jane described her wider family as supportive, this was questioned by some workers who identified the possibility of unresolved issues for Jane's mother which rendered her needy of Jane's support rather than being able to provide support to her daughter. In addition there had been conflict between Jane and her ex-partner since the breakdown of their relationship.

Three months after the case was closed to Children's Social Care concerns relating to Scott's oldest sibling were once again expressed by the school and this led to reallocation

of the case. All professionals involved were contacted and following this a decision was made that no further Social Care involvement was necessary, on the grounds that Jane was cooperating. Closure followed three months after the concerns were raised.

A further referral was made to Children's Social Care services three months later due to escalating concerns on the part of the SSFRW and the Health Visitor. This led to a Child Protection conference and registration of the children's names on the CPR (post 31/03/06). The SSFRW said that she had contacted Social Care with her concerns following closure of the case, but the view was that CP registration would not change anything, as many professionals were already involved. She spoke of trying to prevent the need for Social Care involvement but in her opinion the children were not being safeguarded without it, despite the level of professional involvement.

Following registration on the CPR contact between the oldest child and his father has been resumed, whereas this had been stopped by Jane's ex-partner. The Home-Start Organiser and SW identified the impact of this contact as an increase in support for Jane, who had a good relationship with the child's father, and a positive effect on the household in general with less arguments occurring in the family. They also described positive changes in Scott who was engaging with others more readily, relating to his siblings more and whose speech had improved. A massive improvement was also reported in Jane who was said to have worked hard and cooperated fully. She was now getting out and about and was more able to manage.

Supported by comments from other workers around the difficulty Jane continued to experience in keeping on top of housework and the fact that such difficulty might be expected to arise for any single parent with four children, a word of warning was expressed by the Home-Start organiser
“(there are) bound to be hiccoughs and there has been hiccoughs but you can't make it better overnight”

3.4. Case Study 3

Data provided by Children's Services Directorate showed that Charlotte was three years old when she was referred to Children's Social Care. This was not the first time a referral had been made. A further two referrals were made within the following three weeks and her name was registered on the CPR approximately three weeks later. Charlotte was deregistered from the CPR within seven months but was subsequently reregistered prior to 31/03/06 (no details were provided of the re-referral that culminated in re-registration).

The Health Visitor, Nursery Nurse and SS Nursery Nurse were not involved at the time of the referral. The School Nurse had been involved since the family moved to the area but her involvement was limited to Charlotte's sibling who was of school age at the time. The case was transferred to the SW following registration on the CPR after the referral. The Women's Aid worker first met Eleanor, Charlotte's mother, when working for SS but moved to work for Women's Aid and met her again when she accessed services there.

The Rainer worker did not become involved until after the second registration on the CPR.

Eleanor told me that the referral was made by the police following domestic violence incidents between herself and her ex-partner. The Women's Aid worker mentioned that Charlotte was physically assaulted by her father around this time and the SW explained that he was subsequently sent to prison for child cruelty. The School Nurse explained that there were also concerns about missed health appointments for Charlotte's older sibling and her failure to meet developmental milestones, as well as Eleanor's mental health. She said that following deregistration, it was difficult to retain the progress made in the family's circumstances. Several workers pointed out that Eleanor was a very young, vulnerable mother with four children, whose choice of partner continued to impact on her emotions, leading to a decline in her coping ability and thus to a need for re-referral to Children's Social Care services. Eleanor's view was that she began shouting at the children due to stress resulting from problems with debt and that this was related by the children at school, who made the referral.

There was a consensus amongst workers that Eleanor had suffered quite severe domestic violence at the hands of her ex-partner. Once he left the family home she struggled to cope, finding the children's behaviour difficult. She experienced difficulty with morning routines and the children would frequently be late to school and nursery. The family home was overcrowded and Eleanor experienced difficulty acquiring a larger property. At the time of the re-referral Eleanor was experiencing severe financial problems which, in the opinion of the Women's Aid worker, she was not acknowledging or able to trust anyone sufficiently to seek help with.

Workers pointed out that although Eleanor had family living locally her relationship with them was poor leaving her isolated when she first moved to the area. Reference was made to fact that her mental health fluctuates with the events in her life, impacting on her coping ability and care of the children to the extent that on a number of occasions they have been found wandering unsupervised in the street. Several workers commented on the impact of exposure to violence on the children and the School Nurse mentioned the fact that Charlotte and her older sibling suffer from low self-esteem.

At the time of the interviews the children had been de-registered from the CPR and the case remained open to Social Care on a Child in Need basis. The family had moved to a larger property and the SW reported an improvement as far as finances were concerned. He explained that domestic violence had been a feature of Eleanor's subsequent relationships, but that she had moved on quite considerably, apart from her choice in partners. The Health Visitor and Nursery Nurse reported improvement in the relationships between Eleanor and her children and described her as being better 'in herself' and at acknowledging when she is low. The children's lateness to school remained an issue for the health workers who considered Eleanor to be failing to take on board the impact this was likely to be having on the way the children felt about attending, though they acknowledged her difficulty as a single parent with four children. There had been some improvement in this area in the SW's opinion. In his view Eleanor had

managed to put routines and boundaries in place but these were being 'pushed' by the children, leading to further criticism of her parenting skills.

3.5. Case study 4

Data provided by Children's Services Directorate showed that a referral was made to Children's Social Care one month before Callum's birth, that he was not subsequently registered on the CPR but became Looked After and that the case was later closed. A further referral was made approximately thirteen months after the first (prior to 31/03/06).

The SS Health Visitor said that she had no knowledge of the family at the time of the first referral but a self-referral had been made to SS by Tanya, Callum's mother, three months earlier which identified her need for advice regarding domestic violence. This referral was not followed up for nine months due to there being a backlog. The SS Health Visitor was not aware of either of the referrals to Social Care.

The Health Visitor told me that she knew Tanya at the time of the first referral as she had an older child. She had originally been homeless and living in bed and breakfast where she began a relationship with a male who was living there. The couple moved out to share a property and the relationship was 'up and down'. Tanya then left the area to seek out her birth parents and met another male. She returned, having had no contact with her birth family. The Health Visitor received a referral from the midwife when Tanya was 37 weeks pregnant with Callum (the pregnancy had been concealed) advising that she intended to have her child adopted. The Health Visitor had no further involvement until Callum was returned to Tanya from foster care.

Both Social Workers who had held the case had left the team at the time of the interviews and I therefore spoke to the Practice Manager. He said that the first referral had been made by Tanya herself and the second was related to a fire at the family home in which Callum had been rescued from a bedroom by the Fire Service. The FSW employed by Social Care and based at the Family Centre became involved during an assessment of Tanya's parenting, undertaken following the fire.

The Practice Manager explained that, at the time of the first referral Tanya was saying that she didn't know how she was going to cope with two children. She had recently re-established her relationship with her adoptive mother and had returned to the area due to domestic violence. He described Tanya as a "lonely individual" who did not seem to expect that her family would be supportive. She didn't want them to know she was pregnant. The Health Visitor's view was that Tanya's reluctance to tell her family about the pregnancy might be linked to shame and fear of letting them down, given that this would be the second time she would give birth to a child outside a stable relationship. The Practice Manager said that Tanya remained adamant, after Callum's birth, that she wanted him adopted. She was told that Social care had a legal obligation to approach maternal grandparents and she then decided to inform them herself. When she did they

were keen to support her with Callum's care. The Health Visitor described Tanya as being very good with him when he was returned from foster care but pointed out that she had become involved with the male she had met at the bed and breakfast once again and that there was severe domestic violence until Tanya took out an injunction against him.

The SS Health Visitor visited the family home between the two referrals to Children's Social Care in response to the original referral to SS. She said that no concerns were identified on her visit and that the family background was good. Tanya told her that the domestic violence issues had been resolved and that her partner had left the household. She had no further contact with the family. Although it was mentioned by other workers, there was no evidence on SS records of attendance at SS mother and toddler group. In the Health Visitor's opinion Tanya's vulnerability and need to be part of a 'normal' family draws her into unreliable relationships which impact on her relationship with extended family. She said that between the two referrals to Social Care Tanya had closed down and disengaged from services and that at the time of the fire she was involved with a male who was drinking. There was domestic violence in the relationship, even though the couple were presenting as getting on well.

According to the Practice Manager there were concerns, at the time of the second referral, about Tanya's forgetfulness, an issue that had been raised by maternal grandparents. There had been a flood and a fire at the family home previously. He said that Tanya suffered with periods of depression and was struggling to cope with the children. He explained that she had a history of involvement with Children's Social Care herself and that her relationship with her adoptive father had been difficult. The Health Visitor spoke of Tanya's problem with her identity and her lack of confidence as a parent. She said that adoptive parents were supportive but were taking over and parenting the children instead of Tanya. The FSW said that Tanya had difficulty managing the children's behaviour, even though this was not concerning in the FSW's view. She was unable to provide appropriate guidance and impose boundaries and was reluctant to go out with the children as they would not cooperate with her and she would resort to shouting and swearing at them.

In the Practice Manager's view the fact that Callum spent the first seven weeks of his life in foster care was likely to impact on his relationship with Tanya. The FSW described the relationships between both children and their mother as poor at the time that she became involved. She said that a lack of eye contact with Tanya and a reluctance to approach her was observed. The children were fighting and their play skills were poor. Both the FSW and the Health Visitor referred to the fact that the oldest child had hearing problems. The Health Visitor also mentioned that his speech was poor and that this was related to his poor hearing. She wondered if this was affecting his relationship with Tanya and also with Callum, who he was observed to be rough with. She described him as uncooperative and 'stropy' and thought that this was perhaps related to frustration arising as a result of his hearing and communication difficulties. She also said that Callum became very precious to Tanya following the fire in her view, perhaps because she had rescued her oldest child but had not been able to rescue him. She said that she

observed a difference in the relationships between Tanya and the two children and that the oldest child appeared more distant from her than Callum.

At the time of the interview the Health Visitor had recently received a referral from the nursery attended by the oldest child regarding his behaviour. She had tried to contact Tanya to follow this up and had been unable to do so. Her observation was that when all was well Tanya would engage with support but that she had a tendency not to engage if there was something going on for her that she thought agencies wouldn't like. This was giving the Health Visitor cause for concern given her difficulty in making contact with Tanya.

3.6. Case study 5

Data provided by Children's Services Directorate showed that Nathan was almost two years old when he was referred to Children's Social Care. There had been no previous referrals. The case was subsequently closed. He was not subsequently registered on the CPR or Looked After prior to 31/03/06 but a further referral was made approximately thirteen months after the first.

The Health Visitor was working with the family at the time of the first referral. The SS Health Visitor did not take up her post until later. The SS Speech Therapist was not aware of the reason for referrals to Social Care but was aware of input by and was working with SS colleagues. The Teaching Assistant had no knowledge of the family prior to Nathan's attendance at nursery at the age of three, when she became aware of the involvement of Speech and Language Therapy (SALT) and Social Care.

The CFO told me that the first referral was made by maternal grandfather; this was reiterated by Nathan's mother, Marie. She said that Social Care thought everything was "OK" at this point and "didn't push it any further". The second referral was made by the Health Visitor and the SS Health Visitor. The SS Health Visitor said that she had been working with Marie on a weekly basis for quite a long period of time but the situation had not moved on. The Health Visitor explained that concerns were escalating as things were deteriorating rather than improving and that Nathan was obviously a Child in Need.

Workers described Marie's difficulty in caring for Nathan and she told me herself that she just couldn't cope

"I just didn't want Nathan around me. That's how bad I got; I just didn't want him near me."

There was concern at the lack of interaction between Marie and Nathan and Marie told workers that she was unable to play with him. The CFO and the Health Visitor explained that Marie was not picking up on, or had no understanding of, Nathan's needs. She was focusing on her own instead and her lifestyle was inappropriate, given her responsibilities as a parent. Workers referred to the fact that Marie had been identified as having mild learning disabilities when she was at school. Her pregnancy with Nathan had been unplanned and she needed extra input as a teenage parent with an image problem and low

self esteem. She was also depressed but resistant to accessing health services to address this, including medication. There had been some historical issues regarding her relationship with her mother and abuse in the family, which the SS Health Visitor considered to be unresolved, and her relationship with her father was 'up and down'. Marie told me that she did not want to take pills for her depression.

The CFO said that, in her view, Marie had unmet needs due to her childhood experiences. She was isolated as she was staying in the house a lot with Nathan. She was expressing a wish to socialise and some resentment of the fact that she was missing out on being a young woman due to being a parent. The Health Visitor and SS Health Visitor described deterioration in home conditions following the breakdown of Marie's relationship with her partner. They also said that Marie was in debt. The CFO said that Marie subsequently introduced a new partner to Nathan with very little knowledge of his background.

Nathan was described as failing to reach his potential and developmentally delayed with poor speech. He had not attended SALT appointments. Workers' assessment of Nathan's difficulties was that they were the result of Marie's inability to stimulate him. Concerns were expressed about Marie's neglect of Nathan generally: her physical care of him, which deteriorated after her partner left; the fact that there was no progress regarding toilet training; his diet; her high expectations of him; lack of emotional warmth and rejection. The CFO and SS Speech Therapist both spoke of poor attachment between Nathan and his mother: the fact that he would not seek Marie out for support; his craving for attention from other adults and the fact that his play skills were delayed. Though Marie was shown how to play with him she was apparently unwilling or unable to put this advice into practice.

Marie told me that about five months after the second referral the CFO 'phoned her to say that she thought it would be best if Nathan went to stay with maternal grandfather for a while and that this led to an application to the Court, on her father's part, for parental responsibility and a Residence Order. The CFO said that she closed the case after the Residence Order was made, having undertaken a core assessment and a parenting assessment (worked jointly with a FSW from the Family Centre) with the family. At the time of the interviews there continued to be a shared care arrangement with Nathan having daily contact with Marie and spending every night in the care of maternal grandfather and his partner.

The SS Speech Therapist reported huge progress whilst Nathan was at nursery. She said that in the space of a year he had progressed from speaking only a few words to using phrases and was able to communicate verbally and engage with others. There had been some improvement in his attention span but he was still a year behind developmentally. She had visited him at his grandparents' home and described it as catering for his needs and enhancing his development.

3.7. The Involvement of Children’s Social Care Services

3.7.1. The Need for and Impact of Involvement

The referrals to Children’s Social Care were seen as appropriate by workers in Case Studies 1, 2, 3 and 5. There was no comment on this in Case Study 4. None of the parents interviewed disagreed entirely with the need for Social care involvement but there was some resistance to the idea for the most part. Sue (Case Study 1) was in total agreement in hindsight and Jane (Case Study 2) said that she agreed with and was pleased about the decision to re-refer.

Three key advantages of Social Care involvement were identified by workers:

- i) Formalisation of support leading to: raised awareness of the situation by everyone involved; a holistic overview of the family, gained through more in depth enquiry and information gathering, and a focus on the child’s needs.
- ii) Quicker access to more support, specifically focused on areas of need for parents and children, which cannot be accessed without Social Care involvement. Facilitation of this as a package with identified roles for individual workers.
- iii) Coercion to achieve cooperation and increased motivation on the part of the parent and open their eyes to the need to address issues of concern; and the authority to take action to safeguard children (for example facilitating Nathan’s (Case Study 5) move to grandparents or Sara’s (Case Study 1) removal to foster care) – this was expressed in terms of the difference between SS, for example, which is accessed by choice and the statutory role played by Social Care, which gives the agency more “clout”.

Two parents commented on the impact of Social Care involvement. Eleanor (Case Study 3) saw it as providing no more help, though she acknowledged the fact that it meant that this was available more quickly. In her view it brought more stress. Jane (Case Study 2) said that Social Care involvement had helped her a lot following the second referral. She said that she had gained clarity around what the issues were and that Social Care had more control over the situation. They had provided her with help and advice over contact and other legal issues. The impact of this was reiterated by workers who said that, prior to the Initial CP conference, reinstatement of the contact between Jane’s oldest son and his father had not been achieved.

3.7.2. The Impact of Services on Social Care Involvement

Sure Start Support – In Case Studies 2, 3 and 5 workers considered that though the provision of SS services had not prevented the need for a referral to Children’s Social Care it had delayed and reduced the intensity and extent of that involvement and the stigma that this brings. The possibility that problems may not have been picked up until much later without Sure Start involvement was also raised as was the likelihood that, because this then means that more people are aware of the situations children are in, more

referrals to Social Care will be generated as a result. The Health Visitor in Case Study 5 highlighted the potential of SS to improve the situation to prevent the need for Social Care involvement but acknowledged that this did not happen in Nathan's case. She pointed out, however, that the ground work had been done by the time the second referral was made, making it easier to demonstrate concerns, which she believed were then taken seriously.

Two workers in Case Study 1 highlighted the value of SS in providing the family with a link to the community through access to support in that setting. The view was that this encouraged Sue to go out and access her own support following rehabilitation of the children back home.

In Case Study 4 the SS Health Visitor described Sure Start's impact on the referral to Social care as "non-existent" because they were unaware of the situation.

Support in General – There was a general consensus amongst workers in all five Case Studies that, despite the provision of support outside of Children's Social Care and its impact on the nature of that involvement, the circumstances of each case rendered the need for a referral unavoidable.

The Nursery Manager in Case Study 1 pointed out that Sue was unable to care for her children and had no family support network – there was no option but to make a referral. In Case Study 2 workers referred to historical problems in the family and the fact that the situation had got to a low point at which the multi-agency package of support in place "just didn't seem good enough".

All workers in Case Study 3 mentioned that incidents still happen even when support is in place, regardless of the level of that support. The School Nurse said that Eleanor's parenting had improved for a time but that her choice of partner tended to impact on the progress made. The Women's Aid worker warned that there is "no quick fix".

The SS Speech Therapist in Case Study 5 viewed the impact of support to be linked to Marie's response to it, pointing out that if she chose not to take the advice on offer, the situation was bound to escalate, leaving agencies no alternative but to refer to Social Care.

In Case Study 4 support was limited to statutory agencies. The Practice Manager and the Health Visitor saw the support provided by Tanya's family as key to the outcome for Callum and the length of time that Social Care needed to be involved. However, the Health Visitor did question why Tanya would pursue adoption for Callum if she felt well supported by her family.

3.8. Meeting Need

3.8.1. Identified Need

Parents were asked what they saw as their needs and those of their children, at the time that referrals were made to Children's Social Care. They identified two main areas of need for themselves; practical help and emotional support.

Sue (Case Study 1) said she wanted to keep busy and "to know there is somebody there if we need it".

Jane (Case Study 2) acknowledged her need for practical support as well as counselling. Eleanor (Case Study 3) told me that she wanted help to establish routines and with housing and debt. She also said she needed help regarding domestic violence and what she described as counselling, from the Women's Aid worker.

These needs were reiterated by workers in all five case studies.

Sue had spoken to the Nursery Manager about her need for someone to talk to. Workers identified her need for help with her alcohol problem, to talk about it and recognise triggers and concerns.

Jane had told workers that she wanted practical help to get on top of things in the house and sort the garden out to provide a safe place for the children to play. Workers also considered that she needed someone to confide in and get things off her chest. It was pointed out that she needed to be encouraged and motivated and that she would need long term support to maintain the progress she had made.

Eleanor had expressed her need for practical help to some workers in Case Study 3 and there was general consensus around this, as well as her need for support on an emotional level. The Women's Aid worker explained her role as providing someone for Eleanor to "bounce off" to clarify her understanding of her problems and make it clearer to her that the relationship she was in was not right.

In Case Study 4 the Practice Manager's view was that Tanya wanted somebody to go to the family home and care for the children and he and the FSW identified the need for hands on practical support with parenting. Tanya herself had identified her need for advice on teething and support regarding domestic violence in her self referral to Sure Start.

Marie (Case Study 5) had not identified any needs for herself to workers, other than a wish to get out of the house with Nathan. Workers considered it difficult for Marie to express her needs due to her learning difficulties and low self esteem. She had, however made it clear that she needed someone to talk to.

The needs for parents to get out of the house more was also identified in Case Studies 1, 2, 3 and 4 as was the need to build self esteem and confidence. The need to improve her social networks due to lack of support from extended family was identified for Sue, along with the need for skills to move on and make decisions for herself. Jane was said to struggle to attend activities outside of the home and needed to build her self esteem and confidence as did Eleanor and also Tanya, who had spoken to workers about a wish to attend groups and access education.

The need for more support from extended family, or an alternative to this, was raised by workers in Case Studies 1, 3 and 5. Sue had said that she wanted more support from her mother; Marie's Health Visitor believed she needed mothering. Marie had told her "I haven't been mothered so I don't know how to mother". This comment was echoed by Health workers in Case Study 3 who agreed that Eleanor "could do with a bit of mothering – an adoptive mother" as she needed looking after. The Social Worker identified the need for more support for Eleanor from extended family.

Workers in Case Studies 1 and 4 spoke of parents' desire for normality. Sue was described as wanting to be seen as a good mum and Tanya as wanting to be part of a 'normal' family of her own.

Far fewer general needs were identified by parents or workers which specifically related to children; these were linked on the whole to individual need.

Marie had asked for help with Nathan's development and this was reiterated by the SS Speech Therapist who considered he needed to be on the Special Needs Register in order to access more support at nursery. Jane wanted contact with his father for her oldest child, which was viewed as important by workers, and support to provide him with 'quality time'. The SS FRW identified a need for more stimulation for Scott.

Two parents highlighted the impact of their own problems on their children. Sue said that Sara needed her mum to 'be there' for her and recognised that she wasn't. Eleanor identified the fact that she needed help not only for herself when she was down but for her children and with her children too. The Social Worker in Case Study 2 linked Jane's needs to those of her children, describing the knock on effect of these.

3.8.2. Sure Start Services

A range of services specifically identified as emanating from Sure Start was identified as having been accessed across the five case studies:

i) Subsidised Child Care

This was accessed in Case Studies 1, 2, 3, and 4.

ii) 1:1 Support for Parent

This was provided in all Case Studies but was limited to a visit to follow up the self referral by Tanya in Case Study 4. Regular home visiting was a feature in Case Studies 1, 2, 3 and 5 focusing on a range of issues including solution-focused work and parenting skills such as play, routines and boundaries.

iii) Counselling and Emotional Support for Parent

This was provided to Jane (Case Study 2) and Marie (Case Study 5) by SS workers on both a formal and informal basis

iv) 1:1 Support for Child

In Case Study 2 the FRW undertook work with Scott and his siblings and introduced the oldest child to activities outside the family home. The EYPS undertook behaviour management work with the children. In Case Study 5 the Speech Therapist carried out work with Nathan at the nursery.

v) Group Support for Parent

This was accessed by parents in Case Studies 1, 3 and 5. Sue (Case Study 1) attended a group for parents and their children and assisted in the running of this. Eleanor (Case Study 3) attended two groups, one for parents and one for parents and children, both providing practical and emotional support and aimed at building confidence. Marie

attended a young parents group and a parent and toddler group. The Health Visitor in Case Study 4 suggested that Tanya also attended a parent and toddler group though there was no record of this at Sure Start.

vi) Crèche

This was used by Eleanor to provide child care whilst she attended the parents' group. Records suggested that Tanya (Case Study 4) also accessed this service.

vii) Training for Parent

Parents attended some form of training in Case Studies 1, 2, 3 and 4. Sue and Eleanor attended parenting courses. Sue said that she "didn't last long on it" whereas Eleanor said she went despite not wanting to. Records suggested that Tanya attended volunteer support training; Marie attended a basic food hygiene course.

viii) Group Support for Child

A referral was made to Sure Start in Case Study 1 in relation to Sara's speech and she attended a social skills group. Children attended groups with their parents as detailed above.

ix) Transport

Transport was provided for Eleanor to attend the parents' group and to help get Jane's children to nursery and school.

x) Practical Support

Sue said that she obtained a pram and carpets through Sure Start. Intensive practical support was provided in Case Study 2 particularly when Jane was ill. She was given 'hands on' help to tidy and sort out the house, provided with safety equipment and helped with practical parenting. She was also taken to Citizen's Advice Bureau (CAB) for advice regarding debts, as was Marie.

xi) Community Involvement

Sue told me that she joined the committee for the parents' group she attended.

3.8.3. Focus of Sure Start Support

Sure Start support in Case Studies 1, 2, 3, and 5 was described as focusing on the individual needs of parents in particular. The need for Sue to develop her social network in the absence of support from her parents was highlighted by the Social Worker in Case Study 1. Practical help aimed at motivating and empowering Jane and assisting her with sorting out environmental factors; improving routines and work on parent child relationships were seen by Sure Start workers as key elements of the support offered to Jane in Case Study 2. Looking at the past and at feelings, emotions, relationships and her strengths and weaknesses in the parents group, in order to build confidence and self esteem was described by the SS Nursery Nurse as the focus of support offered to Eleanor in Case Study 3, whereas in Case Study 5 the SS workers said that they focused on

anything that could be done to engage Marie and meet her needs in an attempt to help her to meet Nathan's.

3.8.4. Why Use Sure Start Services?

Only Marie (Case Study 5) commented on her reasons for accessing Sure Start services which she cited as “something to do” because she and Nathan were bored at home. Workers identified Marie's lack of engagement with mainstream services and their lack of time to provide additional support, as well as the groups that were on offer, as reasons for making a referral. The Health Visitor said that the home visits from Sure Start provided Marie with a familiar face, popping in to encourage her to attend groups. She acknowledged how difficult it is for anyone to attend a group for the first time and suggested that most vulnerable families would need home visits as part of the support provided.

In Case Study 1 workers viewed Sue's isolation in the community and concerns regarding Sara's speech as reasons to access services and described the benefits these brought for Sue as choice, support in the community, improved networks including new friends, a sense of worth and confidence to make decisions. The SSFSW pointed out that families can contact Sure Start workers to offload when they are ready to do so, even if the case has been closed to them; if they have no support from extended family this acts as a replacement. This notion was supported by the FSW from the Family Centre who described Sure Start as providing someone to guide and advise.

The SSFRW in Case Study 2 said that a referral for services was initially made because of Jane's pregnancy and the fact that she was ill. 'Being there' for Jane was also seen as important

“It can't be done overnight and will take a bit of time, but we are there if things do slip”
(SS Early Years Play Specialist)

Other workers were complimentary about the quality of Sure Start support in Case Study 2, which was described as helping Jane 100%. The Health Visitor described this as fantastic adding

“Had this family not lived where they do in a Sure Start area it may well have been a completely different story”.

3.8.5. Other Support

A range of support, other than that specifically identified as emanating from Sure Start, and including that provided by Children's Social Care Services, was identified as having been accessed across the five case studies:

Case Study 1

- Addaction - substance misuse service
- Social Care Family Centre – contact between Sue and her children whilst they were in foster care; assessment; parenting advice; emotional support
- School – 13 week parenting course with crèche; ad hoc advice and emotional support

- Nursery and crèche for children

Case Study 2

Following 1st referral – statutory agencies (i.e. Health and Social Care) and support from extended family.

Following 2nd referral:

- Home-Start – weekly home visits; practical support; respite for Jane; transport to nursery for child; emotional support
- Solicitor – legal advice
- Police domestic violence service – assistance with domestic violence issues
- School – general support
- Health visitor – approached Housing regarding garden fencing
- Family Welfare Association (FWA) – 1:1 work with oldest child
- Nursery for Scott
- Support from extended family

Case Study 3

- Nursery Nurse (mainstream Health Visiting team) – weekly visits to provide parenting support ; emotional support
- Health Visitor – advice on routines; emotional support
- Women’s Aid – budgeting and support to attend CAB for advice on debts; practical support including some help with driving lessons; confidence building; emotional support
- CAB – advice regarding debts
- Housing association – to acquire larger accommodation
- Rainer (Support for Young Parents) – practical support regarding finances and housing, though these issues had already been addressed by the time the organisation became involved.
- Pre-school breakfast club and school lunches for Charlotte and her sibling

Case Study 4

Following 1st referral:

- Health Visitor – parenting support and regular monitoring
- Support from extended family

Following 2nd referral

- Social Care Family Centre – twice weekly parenting support; assessment
- Health Visitor – parenting support and regular monitoring
- Support from extended family

Case Study 5

Following 2nd referral

- Children’s Social Care – advice on diet and nutrition; support with cooking; accompanying Marie to the G.P.; assessment by Family centre focusing on play skills
- Nursery – offered advice to Marie on toilet training and interaction with Nathan
- Support from extended family

3.8.6. Focus of Other Support

The focus of support, as described by workers, in Case Studies 2, 3 and 4 was empowerment, encouragement and motivation of parents by providing them with strategies to assist them to move on. The Home-Start Organiser in Case Study 2 explained that the aim of input by her organisation was to use this approach to ease Jane’s stress levels and enable her to cope
 “The whole point is to make ourselves redundant”

3.9. What Works

3.9.1. The Five ECM Outcomes

3.9.1.1. Be Healthy

Case Study 1 – At the time of the referral Sara was described as poorly presented and having head lice. The Nursery Manager said that her presentation varied with Sue’s use of alcohol. At the time of the interview Sue told me that Sara’s diet was now healthier, that there were routines in place for her and she was getting more fresh air. She described this Outcome as 200% better. Workers reiterated what Sue said, referring in addition to an improvement in Sara’s speech, appropriate growth and the fact that health appointments were now kept. Improvements were considered to be linked to Children’s Social Care involvement which led to services working together.

Case Study 2 – Jane said that she used to give the children fatty foods all the time whereas she was now preparing healthier meals due to input by Sure Start and her Health Visitor. Workers concurred with this view though they considered there was still room for some improvement, particularly around the provision of appropriate drinks. Scott was now getting hot lunches at nursery and his speech had improved since he started to attend.

Case Study 3 – Eleanor told me that her children had always been healthy, but said that she was now providing them with a better diet by cooking nutritious meals. A similar view was echoed by workers and there was a suggestion that Eleanor had used knowledge gained in Sure Start groups to achieve this. The Women’s Aid worker pointed out that missed health appointments had been a concern. The consensus amongst workers was that this had been addressed and that there was an improvement in the children’s growth and development. There had been general improvement in the children’s appearance, routines and the environment in the Social Worker’s opinion but

some workers pointed out that Eleanor still needed prompting from time to time to maintain progress.

Case Study 4 – Workers had noted no issues relating to the children’s health or development.

Case Study 5 – In Marie’s view there had been no change for Nathan as regards this Outcome as he had always been healthy and had a good diet. This contrasted sharply with the opinions of workers, who said that prior to the second referral Nathan was pale and thin with sparse hair. He appeared hungry and dirty, lacked stimulation and was developmentally delayed. Health appointments were missed if Marie was not reminded and she lacked knowledge around appropriate diet and routines. Following placement with his maternal grandparents his speech improved, he was attending health checks, receiving a healthy adequate diet, had soon been toilet trained and was always clean and well presented.

3.9.1.2. Stay Safe

Case Study 1 – Sue said that at the time of the referral to Children’s Social care her children were not safe. She said that she wouldn’t have noticed if they had run out of the door. The School and Nursery agreed that, at that time, she was not fit to care for the children. Sue told me that her doors were now locked and she was more aware of practical safety issues. Workers described an improvement in her ability to protect the children, at the time of the interviews, due to having become more alert, aware and child focused.

Case Study 2 – Workers described the existence of risks to the safety of the children, prior to the second referral to Children’s Social Care, due to the house being cluttered and lack of supervision and safety equipment. They reported a general improvement at the time of the interviews. Jane was using safety equipment, was more aware of safety issues and strategies were being devised to address these. Hazards had been removed and the oldest child was no longer wandering off. Jane considered the improvements to be due to the support she had received from Sure Start.

Case Study 3 – Eleanor expressed risk to the children’s safety at the time of the referral to Children’s Social Care in terms of physical harm from her ex-partner. In her view they were now safer as this risk had been removed. Workers were divided in their opinions regarding improvement in respect of this Outcome. Whilst Eleanor was said to be more aware of practical safety issues within the home, some expressed concern that issues remained around supervision, as Charlotte had recently been seen out alone and unsupervised on her way home from school. Mainstream Health workers referred to the children being safer by virtue of being older, and this was reflected in Eleanor’s view that being in school most of the day was a form of protection. The Women’s Aid worker was of the opinion that Eleanor was now able to recognise negative aspects of her parenting and that, along with the absence of domestic violence, this rendered the children safer. Though concern was expressed by some workers that Eleanor was still vulnerable to

domestic violence in relationships the Rainer worker was confident in her determination not to become a victim of this in the future.

Case Study 4 – The Health Visitor identified safety as a big issue in this case given the fire that prompted the second referral to Children’s Social Care. In her view this was likely to have been caused by smoking as, though Tanya was inclined to ‘go to ground’ when she became involved with a man, she had always been mindful of practical safety issues. The Practice Manager was hopeful that Tanya would have become more aware of these, following input by the Family Centre. The FSW based there considered lack of supervision to have been an issue when she first became involved with the family, but believed Tanya had become more motivated and capable of reinforcing boundaries for her children by the end of her involvement.

Case Study 5 – In response to my prompt around this Outcome Marie said “I just didn’t care.....some days I just didn’t you know”. The Health Visitors view was that Marie’s learning difficulties were responsible for her lack of awareness around safety. Poor home conditions, lack of supervision and the presence of strangers in the home were identified as risks by other workers. Marie said that Nathan was safe now that he was living with her father, though she also pointed out that her own home was tidier and there was less risk of him hurting himself there than there had previously been. Workers had also noted some improvement; the Teaching Assistant said that Marie always held Nathan’s hand when she brought him and picked him up from school for example, but the majority of progress made was considered to be down to placement with maternal grandparents.

3.9.1.3. Enjoy and Achieve

Case Study 1 – Workers said that, at the time of the referral to Children’s Social Care, Sue’s use of alcohol and self absorption in her own emotions was impacting on her interaction with the children and they had become closed and withdrawn, though the Head Teacher said that she had always been supportive of her children’s learning. Sue said that she now plays with her children and workers described her as more available and attentive. Following intervention by Social Care and continued attendance at nursery Sara’s speech improved and she became less withdrawn. The SSFSW’s view was the children were now being allowed to ‘blossom’.

Case Study 2 – Jane told me that whilst she was living with her ex-partner he was demanding of her attention. Workers reported lack of stimulation of Scott, despite there being appropriate toys in the home, and little interaction between him and his mother, prior to the second referral to Children’s Social Care. Jane was described as low in mood, lethargic and lacking motivation. Jane told me that she was still finding it hard to divide her time between her four children but that she was spending more time with them now. Workers were sympathetic with Jane’s difficulty but agreed that, whilst there was a suggestion that there was still work to do, there had been some improvement in that she was more focused on the children; playing with them, reading and talking to them more than before and providing them with access to appropriate toys, books and TV programmes. The children’s self esteem had improved in the opinion of the SSEYPS.

Regular attendance at playgroup, nursery and school was considered to have assisted the children as far as this Outcome was concerned, supported by the provision of transport. For the oldest child, reinstatement of contact with his father was also seen to have contributed to progress in this area.

Case Study 3 – Eleanor told me that Charlotte’s older sibling had missed some school when her relationship with her ex-partner broke down. The Social Worker said that, though she would buy toys for the children, Eleanor did not engage in play with them when he first became involved. Workers reported progress in this area stating that Eleanor was now playing with the children more, they had friends to play at the family home and were engaging in activities. Eleanor considered her oldest child to have benefited from attendance at pre and after school clubs. The benefit of parent and toddler group was pointed out by the SSNN. Charlotte’s social skills had improved in the opinion of the Women’s Aid worker. Whilst the School Nurse acknowledged some improvement in this Outcome due to improved school attendance, there was room for more in her view.

Case Study 4 - There was a marked contrast between the observations of the SSHV and those of the Children’s Social Care workers in this case. Based on her visit to the family home prior to the second referral to Social Care the SSHV described good rapport and bonding between Tanya and her children. This was not the view of the Practice Manager, who described Tanya’s difficulty in managing the children’s behaviour, or the FSW based at the Family centre, who saw this as Tanya’s weakest area. She said that when she first met the family Tanya appeared to find it difficult being around other people and was not playing or interacting with the children. Both workers reported an improvement following provision of support, when Tanya was noted to give more praise and more eye contact and closer proximity were observed between her and the children. At the end of Social Care involvement the children were said to have calmed down and be attending parent and toddler group and nursery.

Case Study 5 – Marie acknowledged concerns for Nathan when responding to the aide-memoir for this Outcome

“When he was living with me I just didn’t do any of that, I just weren’t interested in anything, so before he weren’t getting the satisfaction that he needed.”

The SSHV translated this as a resistance to the parenting role on Marie’s part, which along with lack of access to appropriate toys was described by the SS Speech Therapist as having an impact on Nathan’s ability to play. Whilst some progress had been noted following access to Sure Start services, a huge change in Nathan was reported after he was placed with maternal grandparents. The vast improvement in Nathan’s play and social skills was considered to be the result of input by grandparents and the nursery. Marie told me “I do interact more and read stories with him and I sing and I play with him”. Her view was that Nathan was now getting what he needed in this area from herself and her father. The SSHV supported this view stating that, in her opinion, Marie was now able to enjoy being a parent, feeling more supported and “able to go out and be herself”.

3.9.1.4. Make a Positive Contribution

Case Study 1 – The Head Teacher commented on the impact of Sue’s alcohol use and her problems on the school’s ability to accept her offers of a contribution to school life. The FSW from the Family Centre said that Sue’s needs came first at this time and the Nursery Manager pointed out that Sara was unable to make a positive contribution at nursery when she was withdrawn, though this improved when she moved to foster care and was more able to verbalise her needs. Sue said that there had been very little in the garden at the family home for the children to play with but that there was now outdoor play equipment, the children’s friends came round to play and they were “interacting” a lot more. This progress was acknowledged by workers who described Sara as speaking positively of school and friends and being more sociable. The improvement in Sue’s well being and positive contribution to the community were viewed as providing a role model for the children, which was bound to impact positively on this Outcome in the future.

Case Study 2 – Jane identified the difficulties she had been experiencing in trying to make the garden at the family home safe for the children to play in as impacting negatively on this Outcome. The Health Visitor explained that she was still working to achieve this. The Home-Start Organiser highlighted school attendance issues prior to the second referral to Children’s Social Care as having had an impact in this area, but workers considered there had been considerable improvement since. Scott had become more confident and was attending nursery regularly where he was said to be integrating well with his peers. His older siblings were described as being happier at school and the oldest child had begun to play regularly in the school football team and was being supported to attend other activities by FWA.

Case Study 3 – The Women’s Aid worker pointed out that progress in respect of this Outcome would have been very different if the situation had remained unresolved where domestic violence was concerned. Other workers considered there to have been little change in this area which was seen as having always been positive for the children. Eleanor was described as having made a positive contribution through peer education and groups and was reported to be helping to change the community’s perceptions of teenage parents. This role modelling was viewed as having a positive impact on the children.

Case Study 4 – Tanya was described by the Health Visitor to be trying to promote positive parenting. Attendance at crèche, whilst she attended Volunteer Support training, and regular visits to maternal grandparents, following improvement in her relationships with extended family, were identified by workers as positives for the children in relation to this Outcome, though the FSW from the Family Centre considered there to be a lot further to go in this area.

Case Study 5 – Workers described a huge improvement in this Outcome for Nathan when comparing the situation at the end of Children’s Social Care involvement with that which had prevailed prior to the second referral. Nathan was described as being unable to contribute due to lack of speech whereas he was later able to communicate and join in with activities. He was said to have been isolated, without support to make sense of the

world, but his functioning in relationships was seen to improve following his attendance at nursery and placement with maternal grandparents. Whereas Marie had also been isolated, negative and focused on her own needs both were subsequently considered to be making a positive contribution both to one another and individually, Nathan through nursery and Marie through attendance at college and groups and an increase in social activity generally.

3.9.1.5. Economic Well Being

Case Study 1 – Sue said that in the past she was always criticised for the state of the family home and this was confirmed by workers who said that home conditions were poor and inconsistent, fluctuating with Sue’s mood and use of alcohol. The Head teacher and Nursery Manager questioned the impact of the cost of alcohol on family finances whilst Sue was still drinking. Sue told me that her standards had since improved and that the children were now given pocket money and treats. The Social Worker identified the Residential Assessment as the point at which this change had occurred. The SSFSW predicted further improvements in this Outcome over time, believing changes to be triggered by an increase in Sue’s self worth

“Just that one person needs to trigger.....for someone to say to you “You’re worthy of something and you’re clever at that”. For people who haven’t had positive regard in their childhood to get positive regard like that is everything really.”

Case Study 2 – Jane said that home conditions and finances had been a problem when she was living with her ex-partner. The impact of clutter in the home on the availability of space for play was highlighted by the SSEYPS. Jane described an improvement in home conditions, which was seen by workers to have been achieved with support provided by Sure Start and Home-Start. There was some consensus that these were always likely to fluctuate. Jane also referred to an improvement in her budgeting which workers acknowledged, explaining that this had been assisted by advice from CAB.

Case Study 3 – Eleanor described overcrowding as having been an issue for her in the past, with four children sharing a bedroom. She described bedtime routines as a “nightmare” in these circumstances. This issue was acknowledged by workers who also identified finances as a problem. The School Nurse pointed out the impact of Eleanor’s child care responsibilities on her ability to seek work outside the home. Eleanor told me that her finances had since improved and agreements were in place regarding payments to her debtors. The family had also moved to a larger house. These improvements were seen by workers to have been achieved through input by Women’s Aid and Rainer. The Women’s Aid worker described Eleanor as having different goals in life now than she had previously, which the worker believed would reflect positively on the children in relation to this Outcome.

Case Study 4 – Though the house fire which prompted the second referral to Children’s Social Care Services created problems as far as home conditions were concerned, none had previously been identified in relation to this Outcome. Extended family were

subsequently said to have assisted with decorating to address the damage caused by the fire.

Case Study 5 – Marie was said to be struggling with finances and disorganised where home conditions were concerned, prior to the second referral to Children’s Social Care Services. She told me that she was now managing her finances better and the Health Visitor referred to support provided by Sure Start in this area. Progress for Nathan in relation to this Outcome had been achieved, in the opinion of workers, as a result of his placement with maternal grandparents, where conditions were said to be cleaner and he had more clothes and his own bedroom. Marie spoke of additional improvements for Nathan in her own home, however, stating that she was now looking after it a lot better and keeping it cleaner and tidier, so that there was more space for him to run around. She also explained that she was accessing training via the local Job Centre and was currently studying on an Open Door course. She told me she was studying child development and gave her reason
“I just want to understand me own kid”

3.9.2. Outcomes achieved with Sure Start Support

From Groups - Parents

Case Study 1

Sue suggested and developed a ‘Story Corner’ and related activities and had input on the Committee. She was described by workers as having a positive influence on other members.

Related outcomes identified by workers:

- Increase in confidence
- Improved self esteem
- Sense of purpose
- More empowered
- Able to make choices
- Access to training and work experience
- A different person
- Met friends

Case Study 3

Eleanor was described as becoming a “sort of leader” whilst attending groups.

Related outcomes identified by workers:

- More empowered
- Able to make choices
- More responsive to children’s needs
- A different person

Related outcomes identified by Eleanor:

- Met friends
- Going to college – “I wouldn’t have known where to start with going to courses and whatnot”

Case Study 5

Marie attended a young parents group on a reasonably regular basis.

Related outcomes identified by workers:

- More responsive to child's needs
- Going to college
- Able to make choices
- A different person

From Groups – Child

Case Study 5 – The SS Speech Therapist said that, whilst attendance was limited, play in a group setting was observed to produce an increase in interaction between Marie and Nathan.

From Other Sure Start Support – Parent

Case Study 2 – Jane described an improvement in her parenting as a result of support provided by Sure Start and other agencies and organisations. The Health Visitor considered Sure Start to have made a difference to the outcome of the case to date.

From Other Sure Start Support – Child

Case Study 2 – Scott's attendance at nursery, subsidised by Sure Start, was considered by workers to be bringing him on developmentally.

3.9.3. Outcomes Achieved with Support in General

Parents

Case Study 1

“A year ago I couldn't even accept praise or a compliment or anything and now I'm the first one to give it out”

Sue thus described changes in herself following the referral to Children's Social Care. Workers confirmed that she would put herself down and fail to acknowledge her success, but her self esteem had now improved and she was more honest, trusting and ready to accept help. Sue's parenting was described as more consistent and the Head Teacher identified the fact that she had learned new parenting skills during the Residential Assessment.

Case Study 2

“I've got stronger in myself because I was ever so weak. My partner pulled me that far down; no self esteem no nothing”

Jane explained that as well as seeing herself as a stronger person she had been told that she looked happier and more bubbly. She told me she had also learned new parenting skills. The Nursery worker described her as more focused and relaxed and the Home-Start Organiser said she would now ask for help when she needed it.

Case Study 3

“I wouldn’t be where I am now, I could be locked up or something and me kids would be in care type thing, so they have helped me loads.”

Eleanor was speaking about the package of support she had received following disclosure of significant debt. She went on to explain that she had no support from family “so like Social Services and counsellors and that have been in and out of my life that much they have, they are like my family type thing”. She referred to a significant increase in the level of support on offer at times when Children’s Social Care had been involved with the family.

The Health Visitor and mainstream Nursery Nurse described an improvement in Eleanor’s functioning as a result of the high level of support put in place whilst her children were registered on the CPR. The Rainer worker believed she had learned new parenting skills and noted a big change in her self esteem; both he and the Women’s Aid worker referred to her recognition of what is acceptable in relationships. The Women’s Aid worker believed there had been an improvement in Eleanor’s ability to manage these, as well as an increase in her readiness to accept help.

Case Study 5

The Teaching Assistant described Marie as happier at the time of the interview than she had been when they first met.

Children

Case Study 1

In the Social Worker’s view, the children’s needs had been met as a result of the support provided to meet those of their mother. The Head Teacher believed the outcome of this for Sara’s older sibling was that she was able to be a child again.

Case Study 2

Both Jane and the Nursery worker described Scott as a happier child as a result of improvements in the situation overall. Workers attributed the fact that his oldest sibling was no longer running away to the reinstatement of contact with his father.

Case Study 3

The Rainer worker identified improvements in school attendance as having been achieved through provision of support.

Case Study 4

The FSW from the Family Centre had observed a positive response from the children to parenting support provided to Tanya. She believed that Tanya had recognised the impact of this on the children’s play.

Case Study 5

Placement with maternal grandparents was seen as key to improvement in Nathan’s speech and overall development. The Teaching Assistant had also noted more interaction between Nathan and his mother since she had first met them.

3.9.4. Most Helpful Support

For Parents

Case Study 1

- **Children’s Social Care Involvement**
Sue said that this made her realise where she was going wrong and that support was available. The Nursery Manager also commented on this.
- **Residential Assessment**
Sue identified being with her children in the Residential Assessment Centre as the key to changes in her behaviour and perspective and said she learned a lot there. The Residential Assessment was also seen as key by workers. They highlighted in particular the 24 hour support provided, which meant that Sue always had someone she could talk to.
- **Parenting Support**
Sue referred to the 13 week parenting course she had undertaken at the school, which she had found helpful in relation to learning, meeting new people and keeping busy.
- **Counselling**
Sue described the counsellor at the Residential Assessment Centre as “pretty good” even though she had made her question what had gone on in her past and face up to issues she had not wanted to.
- **Emotional Support**
Sue spoke of encouragement from the Social Worker and the fact that the Head Teacher always took time out to talk to her as well as the support she received regarding her alcohol use. The Head Teacher also believed the support Sue had received from the school had been helpful
- **Raising Self Esteem**
The SSFSW considered identification of Sue’s strengths and skill, which led to her taking on a specific role in a Sure Start group, had raised her self esteem and given her a sense of purpose. The FSW from the Family Centre considered her attendance at college and work experience at the school to have had the same effect.
- **Being Part of the Community**
Sue’s integration into the local community was identified as having been helpful by the Head Teacher and the SSFSW.
- **Consistent Workers**
The need for Sue to tell her story only once was seen as helpful by the FSW from the Family Centre.

Case Study 2

- **Parenting Support**
This was identified by Jane and workers as having been helpful, particularly in relation to the routines that had been put in place for the family.

- **Practical Help**
Jane spoke of the helpfulness of the practical support she had received to sort out the house, which was also identified by workers. The Health Visitor linked this to “the practical things that a friend or family would do; Jane doesn’t have that support.”
- **Subsidised Child Care**
The children’s attendance at playgroup and nursery was identified by Jane and workers as providing her with respite.
- **Counselling**
Jane described the counselling she had received from Sure Start as helpful, as did workers
- **Emotional Support**
In the SSFRW’s opinion “having someone she can off load to really and someone to be there at the end of the ‘phone if she’s having a problem” was what was helpful to Jane. This view was supported by other workers.
- **Support from Extended Family**
Jane identified support she had received from her family as having been helpful. In the opinion of the Social Worker support received from the father of Jane’s oldest child, following the reinstatement of contact between them, had been most helpful.
- **Raising self esteem**
Jane referred to the improvement in her self esteem, which she saw as one outcome of the support she had received. The SSEYPS considered this to have been helpful in empowering Jane to take control of the situation.

Case Study 3

- **Multi-agency Support**
The School Nurse considered the combination of support provided to Eleanor and her family to have been helpful. The Women’s Aid worker described Sure Start as having been a helpful way in for other agencies, highlighting the lack of stigma around it as compared with Children’s Social Care and the advantage of this in building a relationship with Eleanor.
- **Parenting Support**
Eleanor spoke about the helpfulness of work undertaken by the Sure Start FSW, out of hours, in helping her to put advice given by the mainstream Nursery Nurse into practice. Workers also identified this as helpful noting that it had provided Eleanor with direction and, ultimately, some respite. The Social Worker identified the parent education aspect of the Sure Start groups that Eleanor had attended as having been helpful.
- **Practical Help**
The Social Worker identified support from CAB regarding Eleanor’s finances and support received regarding housing as helpful.
- **Subsidised Child Care**
The Women’s Aid worker described the Sure Start crèche as having been helpful in providing Eleanor with ‘space’ for herself.

- **Counselling**
Though Eleanor described the support she had received from the Women's Aid worker as counselling it was clear that she was describing emotional support, rather than counselling in the formal sense.
- **Emotional Support**
Eleanor explained what she had meant by counselling: "just somebody to talk to and somebody to like be there for me." She described the Women's Aid worker as a "real diamond" and explained how the support she had given had been helpful
"When I first split up with the children's dad, because it was a nasty relationship and I didn't have like a lot of friends or anything, so I didn't have friends I could talk to or anything so she was like me only friend at that time."
- **Raising Self Esteem**
Workers considered Eleanor's attendance at the Sure Start parent's group to have been a key factor in raising her self esteem which, along with an improvement in her mood, was seen to have been helpful in achieving progress.
- **Being Part of the Community**
Eleanor explained that she achieved this through the young parent's group
"My friends that I've got now I met them all on that course.....I would say that was the best thing."
This was reiterated by workers who considered the group to have played a huge role in getting Eleanor out of the house and 'moving her on'.

Case study 4

- **Parenting Support**
The FSW from the Family Centre considered the support she had given to Tanya had been helpful in assisting her to understand her children's behaviour.
- **Practical Help**
The Practice Manager identified the practical help the Family Centre had provided in the home, at key times of the day, as being most helpful to Tanya.
- **Support from Extended Family**
The Health Visitor described the practical help provided by Tanya's extended family after the fire at the family home as helpful.
- **Raising Self Esteem**
The FSW from the Family Centre referred to the helpfulness of the confidence building aspect of the work she had undertaken with Tanya in assisting the raising of her self esteem.
- **Consistent Worker**
The consistent support provided to Tanya by herself and colleagues over time was considered helpful by the Health Visitor.

Case Study 5

- **Counselling**
Marie identified the counsellor she accessed at Sure Start as helpful, explaining that she felt "comfortable around her" as she did around Sure Start staff in

- general. The Health Visitor and the CFO considered counselling to have been helpful in addressing issues from Marie's childhood.
- **Emotional Support**
Marie spoke of the helpfulness of Sure Start staff being there to talk when she needed to off load and said that if she felt upset they would try and advise her "I suppose they have been a big help so if I didn't come here then I don't know where I'd be now"
She said that she didn't want to take pills from her GP
"It just helps to talk.....to a counsellor, to people, my friends and get it off my chest. That's how I got through it."
 - **Raising Self Esteem**
The SS and mainstream Health Visitors believed that attendance at the Sure Start parent's group had assisted in raising Marie's self esteem, which had been helpful to her overall progress.
 - **Being Part of the Community**
The SS Speech Therapist identified attendance at the parent's group as helpful in getting Marie out of the house, thereby reducing her frustration with Nathan.
 - **Consistent Worker**
The SS Health Visitor considered the consistency of Marie's contact with Sure Start, achieved via regular home visits, to have been helpful in building up a relationship with her and encouraging her to attend the parent's group.

For Children

Case Study 1

- **Partnership Working**
The Social Worker and the Nursery Manager spoke of the helpfulness of partnership working in picking up issues for the children quickly.
- **Residential Assessment**
The Social Worker described placement at the Residential Assessment as having been helpful in providing stability for the children.
- **Subsidised Child Care**
The SSFSW, FSW from the Family Centre and the Nursery Manager identified attendance at nursery as having been most helpful to Sara.
- **Emotional Support**
Sue referred to emotional support provided to her children as helpful in assisting them to deal with their feelings. The Nursery Manager considered support provided by foster carers to have been helpful in this regard.

Case Study 2

- **Support from Sure Start**
Jane identified the support she had received from Sure Start as more helpful to her children than any other. This view was echoed by the Health Visitor.
- **Parenting Support**

- The SSEYPS and the Nursery worker considered the routines that had been put in place in the family home, through parenting support, to have directly benefited the children.
- **Practical Help**
Workers described the practical help provided to Jane as having been helpful to the children, in particular help in the family home that had created more space for them to play and transport to nursery.
 - **Subsidised Child Care**
Jane pointed out the helpfulness of playgroup and nursery. This was also highlighted by workers who referred to the impact of this on the development of Scott's speech and the fact that it provided him with routine and a well balanced meal.
 - **Emotional Support**
The Health Visitor identified 1:1 work carried out with the oldest child by FWA as having been helpful.
 - **Support from Extended Family**
Jane described her oldest child's renewed contact with his father as being helpful to him. Workers pointed out that this had come about through the parent's attendance at the initial CP conference and agreed that it had been hugely helpful. Jane also said that extended family had been helpful in providing support to her middle child, in the absence of contact with his father.
 - **Being Part of the Community**
Jane considered the introduction of her oldest child to activities outside the home to have been helpful to him.

Case Study 3

- **Multi-agency Support**
The Women's Aid worker described the support that Eleanor had received in general terms as having benefited her children.
- **Parenting Support**
The SS Nursery Nurse pointed out the knock on effect of the practical parenting support provided by the SSFSW as having been helpful to the children.
- **Practical Help**
Eleanor considered the support she had received from the Women's Aid worker to prevent bailiffs from coming to the house to remove the family's belongings had been most helpful to her children. The Social Worker commented on the helpfulness of support with re-housing.
- **Subsidised Child Care**
The Women's Aid worker identified the children's attendance at the Sure Start crèche as helpful to them.
- **Emotional Support**
The SS Nursery Nurse believed the emotional support that Eleanor had received from Women's Aid had indirectly benefited the children. The Social Worker identified work he had undertaken with the children around contact with their father as helpful.
- **Being Part of the Community**

The SS Nursery Nurse pointed out the indirect benefits the children had received from their mother's attendance at the young parent's group. She explained that this had improved their support network, providing them with babysitters and opportunities for play with their peers. The Social Worker described attendance at pre-school club and getting to school on time as helpful for the children.

Case Study 4

- **Parenting Support**

The FSW from the Family Centre considered the work she had undertaken around their relationships with their mother had been helpful to the children.

Case Study 5

- **Children's Social Care Involvement**

The SS and mainstream Health Visitors both identified the second referral to Social Care as having been helpful to Nathan, in that it led to everyone involved becoming aware of the situation and ensured that he was accessing health appointments and other services. It was also seen as having coerced Marie into taking action and attending Sure Start, where he had access to opportunities for stimulation, play and socialisation which were regarded as helpful to him.

- **Subsidised Child Care**

Marie described Nathan's attendance at nursery as helpful because it taught him how to interact with other children. The Health Visitor and SS Speech and Language Therapist reiterated the benefit of nursery in relation to Nathan's social skills, as well as pointing out the helpfulness of the routine and opportunities for play and stimulation it provided. The Teaching Assistant identified the additional benefit of support provided to Nathan by the SS Speech and Language Therapist in the nursery setting.

- **Support from Extended Family**

Workers considered Nathan's placement with maternal grandparents to have been helpful to him. The CFO also referred to the helpfulness of their earlier support.

3.9.5. Partnership and Communication

Case Study 1

Workers were in agreement about the value of joint working in bringing services together and the benefit of this for the family. The Social Worker acknowledged the fact that a lot of work had been put in by a lot of agencies to achieve a positive outcome and pointed out that one person could not have met all the family's needs: "as a Social Worker I couldn't have done all those things".

Case Study 2

The SSFRW explained that initially the agencies and organisations involved were not meeting as a group

"I just felt it was all my problem but actually when I sat down and looked I thought actually it's not because we're all working together here."

The Home-Start Organiser said that she and the SSFRW began working together very closely to “see where the gaps were and if we could work together to cover it all”. The Health Visitor referred to the fact that once information began to be shared it became evident that others also had concerns. The advantages of partnership working were described by the Home-Start Organiser

“I think everybody has been working very hard; it has worked and the situation has been improving.....with all of us working together on different areas hopefully to cover what’s needed.....we liaise quite closely; we have regular meetings, core group meetings, planning meetings, and we can pick up the phone to each other which is something we didn’t used to do.”

She went on to speak of the need to break confidentiality when this is in the children’s interests. She said that, in her opinion, providing parents are aware of it, it is to their advantage and works much better.

Case Study 3

The mainstream Nursery Nurse and the Health Visitor were of the opinion that Eleanor’s parenting became more positive, as a result of the package of support the family received, because agencies and organisations were “all going in the same direction” and there was good communication making sure that everyone was working towards the same goal. They considered a “well co-ordinated package” to have been the recipe for success. The Women’s Aid worker said that, though the Social Worker had played a co-ordinating role, there was a ‘team’ of workers behind him able to communicate and access inter-agency help for the family.

Case Study 5

The SS Health Visitor viewed joint working as a fair way of dividing the work load generated by this family. The mainstream Health Visitor also referred to the benefits of co-working, describing this, alongside liaison and communication as providing a better picture of the circumstances, given that “everybody has a little bit more of the jigsaw”. The SS Speech and Language Therapist explained how she had checked with colleagues that the work she was doing or proposed to do with the family would fit in with theirs, in order to obtain feedback from them to inform her role and avoid excess pressure on Marie. The CFO said that regular liaison had taken place between herself and other workers involved, with regular meetings, in which Marie was included, taking place at the school; “so we all knew what we were trying to achieve”.

3.10. Access to Services

3.10.1. How Services Were Accessed

Case Study 1

Sue told me that initially, when care proceedings were initiated by Children’s Social Care services, she hated and was angry at the ‘system’; whereas later she came to be grateful to it and welcomed the Supervision Order made by the Court because she wanted to know there was somebody there if she and her children needed help. Workers described

Sue's attitude to support services in similar terms, explaining that she attended Sure Start when asked, rather than by choice, because she wanted her children back and was willing to do anything to achieve this. The Head Teacher pointed out, however, that Sue had always wanted to get involved at school and be involved in her children's school life. The FSW from the Family Centre said that once they were involved Sue would contact the Centre voluntarily for advice.

Case Study 2

All workers commented on Jane's willingness to ask for help when she needed it and the fact that she appeared to feel comfortable doing this. She was described as very cooperative and easy to work with, as well as grateful for the help she received. She had consented to the second referral being made to Children's Social Care.

Case Study 3

Eleanor told me that she had accessed services by "mutual agreement" explaining that workers already involved would suggest additional services to her and she would say "Oh yeah, I didn't think of that". She said that when she had problems she would seek out support from whoever she considered relevant. These comments were reflected in those of the Social Worker, who said that Eleanor would access services more when she was down and depressed, and the Rainer Worker

"I think in her case if it was something she needed or thought would help her she was fine."

Workers agreed that sources of support had been suggested to Eleanor but it was pointed out that she had been "quite heavily reminded". The Women's Aid worker explained that, at the time when domestic violence had been an issue, it was once services were able to get into the family that Eleanor began to access them voluntarily and was receptive to what workers had to say. The Social Worker's view was that Eleanor was willing to access voluntary organisations and Sure Start but was more resistant to imposed support; meetings led by Social Care and the pre-school club for the older children for example. In the Rainer worker's opinion this was because she felt she was being told what to do, which he believed was likely to impact on her motivation, especially as she was feeling heavily criticised:

"if you've got people telling you what to do and you don't agree with it you'd be fairly reluctant."

Case Study 4

The SS Health Visitor pointed out the fact that Tanya had accessed Sure Start herself and that no communication had been received from the mainstream Health Visitor or Children's Social Care regarding any concerns. She said that there had been no reason to unduly encourage Tanya, as the family had not been identified as being in need:

"This was an intelligent, well functioning mum with plenty of support networks around her."

The mainstream Health Visitor said that Tanya had worked very well with the FSW from the Family Centre, as she did when she was engaged by services, but "if it's something she thinks we won't like she has a tendency not to engage".

Case Study 5

The CFO explained that Marie had not wanted to work with Sure Start and that there had been some coercion involved in getting her to engage. The fact that “the message had been sold to her quite strongly” was echoed by other workers, but the view was that once she did access services Marie remained engaged. She was said to have shown some motivation to accessing counselling and address issues such as debt, though her link with CAB was not sustained.

3.10.2. What Sure Start Services Were Not Accessed and Why?

Case Study 1

Sue did not access Sure Start services initially and three possible reasons for this were identified by workers:

- i) Sue was new to the area, didn't know anyone at Sure Start and was lacking in knowledge about the services on offer.
- ii) Sue was fearful of accessing Sure Start wondering if it was part of Children's Social Care.
- iii) Access to services would depend on how Sue was feeling; she was hiding the situation and not recognising the problems.

Case Study 2

Jane said that she had not taken up services when her ex-partner was in the family home because he was so controlling. She was scared and unable to go anywhere alone. Though she had subsequently received a great deal of support from Sure Start she had not accessed groups, including parent and toddler group. Workers believed this was possibly due to:

- i) Jane's need for a familiar face due to understandable anxiety around meeting new people: the SSFRW believed she “would prefer someone to hand hold her there to support her”.
- ii) Time available, especially given her commitments around children's attendance at nursery, and lack of motivation.

Case Study 3

Eleanor was described as having been resistant to accessing Sure Start services initially. Workers suggested the following reasons for this:

- i) Eleanor was likely to have been prevented from accessing services, when domestic violence was an issue, due to the controlling nature of the relationship with her ex-partner.
- ii) Like many others in the community, Eleanor may have seen Sure Start as a threat. The SS Nursery Nurse explained “I think a lot of people were frightened to death of Sure Start and didn't know what it was all about.....[people] bring friends now and they tell them that it's not scary and we're not going to take the children away from them, because I think there's still that perception that professionals are going to take the children away.”

- iii) Eleanor's mental health was likely to have impacted on her ability to access services.
- iv) Mainstream agencies had been less likely to make referrals to Sure Start in the past, until they began to see the benefits of the support on offer.

Case Study 4

Though Tanya had made a self referral to Sure Start she had not subsequently accessed many of the services on offer, including transport to take her to a group that she had told the FSW from the Family Centre she wished to attend. Workers considered possible reasons for this might be:

- i) Tanya didn't know anyone at Sure Start and was lacking in knowledge about the services on offer.
- ii) Tanya lacked the confidence needed to go into a group situation. As the Practice Manager pointed out: "going to a group or being involved in a group is a quite difficult".
- iii) Tanya had clear ideas about what she did and didn't want and was unlikely to respond to encouragement or coercion. She possibly didn't think she needed the support that Sure Start was offering.
- iv) Tanya simply didn't want to attend Sure Start.
- v) The needs of the family were not highlighted to Sure Start by other agencies.

Case Study 5

Although Marie accessed some of the services on offer at Sure Start, there were a number that workers had hoped she would engage with that she did not. She did not always access the pre-school nursery group; refused a group in which she could have engaged Nathan in play with support and did not take up courses focusing on speech and language development and positive parenting. Worker's views as to why this might be were:

- i) Lack of self esteem on Marie's part and the difficulties she experienced in functioning in relationships. She was described as struggling to mix with other people, particularly those older than herself, despite support. It was suggested that she was perhaps embarrassed and fearful of feeling stupid (she had said she was unable to play with Nathan), or worried that others would make her feel worse because they were more motivated than she was.
- ii) Marie's learning difficulty.
- iii) Marie's mental health was likely to have impacted on her ability to access services.
- iv) Marie was failing to recognise or acknowledge that there were problems.
- v) The logistics of accessing services and lack of motivation.

3.10.3. What Other Services Were Not Accessed and Why?

Case Study 1

Sue said that she had been resistant to support from Children's Social Care services initially because of the attitude of the social worker who had originally been allocated the case. She admitted that much of this was down to where she "was at" at the time. Workers considered Sue to have been resistant to support in general initially, identifying

school activities and therapy as examples of this. They suggested that this was possibly due to:

- i) Sue being new to the area and possibly lacking knowledge about the services available.
- ii) Sue being fearful of accessing services.
- iii) Sue was in denial regarding her alcohol problem; was hiding the situation and not recognising the extent of the problems. The Head Teacher pointed out that it is hard for people to admit they are not coping.
- iv) The effect of alcohol on Sue's thinking; access to services would also depend on how she was feeling.

Case Study 2

Jane did not access services generally, initially. She told me that this was because she was scared, as her ex-partner had been so controlling and manipulative. She had not accessed support from Women's Aid at the time or subsequently, though this was seen as potentially beneficial by workers. She said that she already had support on offer from her family and other agencies and organisations and therefore thought that she didn't need it. Workers were of a similar view but pointed out Jane's anxiety problems and low self-esteem as additional reasons which may have prevented her from accessing services.

Case Study 3

Eleanor was reluctant to access support in general whilst living with her ex-partner, including that on offer from Women's Aid and Home-Start. Two reasons were identified by workers as to why this might have been:

- i) Eleanor was likely to have been prevented from accessing services due to the controlling nature of the relationship with her ex-partner.
- ii) Eleanor was concerned as to how any request for help might be interpreted: she needed to be seen as a good mum.

Case Study 4

Tanya had expressed a wish to attend a young women's group run by a voluntary organisation but did not do so. A number of possible reasons why were put forward by workers:

- i) Tanya was influenced by the attitude to support of the male with whom she was having a relationship.
- ii) Tanya lacked the confidence needed to go into a group situation and was anxious and uncertain about accessing new services.
- iii) She didn't think she needed the support on offer.
- iv) Tanya changed her mind or lacked motivation to attend.
- v) She already had support on offer from her extended family, which masked the need for additional services.

Case Study 5

The CFO referred to Marie's failure to go her G.P. to access anti-depressants and considered this to be simply a case of her not wanting to take medication. The Teaching Assistant pointed out the fact that Marie had not taken parenting advice offered by the

nursery. In her opinion this was partly because she was shy, but also due to lack of confidence and self esteem leading to a fear of being seen as silly. Marie had said that she was unable to interact with Nathan and the Teaching Assistant believed this was the case rather than Marie being unwilling to do so.

3.11. Relationships

Case Study 1

Positives

- Sue said that she found the current Social Worker more approachable than the first.
- She had been able to relate more easily to the second set of foster carers with whom her children had been placed, as they had been “chatty” and kept her informed.
- She had “hated” the counsellor at the Residential Assessment Centre at first but had gradually been more able to talk to her.
- The most significant relationship Sue had formed with a worker was with the FSW at the Family Centre:
“I think we’ve got a pretty good working relationship you know, I can talk to her, I know I can if I need to.....knowing that if we did need the help I could pick up the phone and say take that back, I need someone to talk to.”
The FSW explained that a lot of time had been spent, at the beginning of her intervention, building a positive working relationship. She believed this made Sue more likely to work with her rendering her input more beneficial to the family.
- The SSFSW believed Sue knew that support would always be available to her from Sure Start: “she knows she’s got somebody in the local community she can pop down and go “aagh” to and they’ll go “Yes, okay””.

Difficulties

- Sue said that she had had some difficulty with the attitude of the first social worker who had been allocated following the referral to Children’s Social Care: “If I knew she was coming I’d have at least three drinks before she got here because I couldn’t talk to her.....that was how she made me feel”
She had not listened to her views or taken account of her wishes. Sue also identified some difficulty in relating to the foster carers with whom the children were initially placed on being Looked After by the Local Authority.
- Sue described a breach in confidentiality on the part of a worker, although wholly unintended and satisfactorily addressed, to have affected her trust of the person concerned.
- Sue explained that her Health Visitor had picked up on her problem with alcohol and had tried to help. She admitted her response had probably been influenced by the fact that she had been in denial. This was seen by workers as a major barrier to working relationships

“[It is] very difficult to be open and honest with people that are alcoholics because they don’t want to hear it; it’s the last thing they want to hear thank you very much.”

The Social Worker described Sue as defensive when she first met her. Sue’s fierce independence, high levels of anxiety and stress and her inability to talk about her problems and acknowledge the need for support were all identified by workers as difficulties experienced in working with her.

- The SSFRW pointed out the number of workers involved with the family and the difficulty this presented to Sue as regards knowing who to contact.

Values

Openness and honesty in working with the family were considered vital by workers, who made a number of comments in relation to this:

- Being direct, open and honest is appreciated by parents generally as they know where they stand.
- The FSW from the Family Centre was good at this; nothing was covered up.
- It is difficult to do as it may offend but families usually come back and thank you.
- “Honesty and bluntness yes, but it has to come with the support and give them a way forward.”

Sue was quite clear about what was important to her:

“Having somebody I could work with who I don’t feel is against us”

Case Study 2

Positives

- The Home-Start Organiser explained that Jane had been reassured that workers were available and happy to be approached, which was very important in her view. She said that Jane was able to talk to workers openly and honestly as “she’s been made comfortable and reassured enough to speak openly, because it’s only then we can help her”.

Difficulties

- Workers commented on the difficulty they had experienced in engaging Jane whilst her ex-partner was still in the family home.
- The SSFRW said that Jane had been concerned that a referral being made to Children’s Social Care would mean that the children would be placed with her ex-partner.
- The SSFRW said that Jane had missed a number of appointments with the SSEYPS.
- One of the Home-Start volunteers had experienced difficulty in engaging Jane due to the number of other people who were in the house on the occasions she visited.
- The SSEYPS pointed out the number of workers involved with the family and the difficulty this presented to Jane as regards knowing who to contact.

Values

The SSEYPS identified the need for workers to appreciate the culture of the community in which the family lived and its norms (e.g. young children being allowed to play on the street), without losing sight of what was acceptable in terms of risk.

Case Study 3

Positives

- Eleanor identified her relationship with the Women's Aid worker in extremely positive terms:
"It weren't like counselling it was just somebody to talk to and somebody to like be there for me.....I can trust her and rely on her....she's like a mother to me...I know she's there if I need her, I can leave a message and she'll give me a ring to see what's wrong. None of them, it's [her] I'd keep"
The worker concerned said she had met Eleanor when she worked for Sure Start, prior to Women's Aid becoming involved with the family. She said it had taken a long time to build up a relationship with her "for her to trust and be able to say what was actually happening" as she was very mistrusting of everybody. She would now make contact both at times of crisis and to report the positives that were happening in her life. This was illustrated by worker's descriptions of Eleanor's response at the time when her financial problems had become serious; in that she had gone to those workers she had built relationships with for advice. The need to maintain these relationships was identified, the view being that Eleanor would be "scared" if she thought support was no longer available.
- The mainstream Nursery Nurse and the Health Visitor highlighted the importance of advance introductions to the person running groups. This had been the practice where the groups Eleanor had attended were concerned, with the worker subsequently maintaining contact via text messages.
- Workers reported positive relationships between Eleanor and the mainstream Nursery Nurse and Health Visitor. The Nursery Nurse was able to talk to her about parenting on her own level with positive effect.

Difficulties

- Workers identified secrecy around domestic violence, whilst Eleanor's ex-partner was still in the home, as a barrier to them becoming involved with the family.
- The Social Worker referred to the fact that workers had no control over Eleanor's choices around relationships, despite support being in place, leading to difficulty in preventing concerns arising.
- The SS Nursery Nurse believed Eleanor had not always been aware and understanding of the reasons why Children's Social Care was involved or why the children were on the CP register.
- The Rainer worker said that his perception was that the support imposed following the second CP registration had created more pressure for Eleanor and the process had left her feeling unfairly treated and heavily criticised because, in her view, whatever she did was seen as not good enough.

Values

- The Rainer worker highlighted the differing views amongst workers regarding what was acceptable in the home and the need to acknowledge the difficulties Eleanor faced as a single parent trying to get four children ready for school. In his view there was bound to be some chaos in these circumstances.

Case Study 4

Positives

- Workers were of the opinion that the relationships between Tanya and both the Health Visitor and the worker from the Family Centre were positive.

Values

- The SS Health Visitor had linked Tanya's presentation as an articulate, intelligent, pleasant young woman and her "good family background" with an absence of need for input by support services. A similar observation was made by the mainstream Health Visitor.

Case Study 5

Positives

- Marie described Sure Start workers as really friendly and 'there' for her if she needed to talk to them.
- The SS Speech Therapist believed that, having met her a few times at play sessions, Marie developed "a little trust" in her and engaged with her relatively well.
- The Teaching Assistant said that a good relationship had existed between Marie and the nursery.

Difficulties

- Marie did not consider Children's Social Care services to have been supportive. She said there had been a lack of information and openness and she "didn't want them in my house, I didn't like them there. They made me feel so uncomfortable and so small.....just the way they looked down at me and that 'cos I'm young". The CFO believed Marie saw Social Care support and intervention as interfering. The SS Speech Therapist's observation was that Marie found review meetings, held at the school, difficult. She would become upset and rejecting of the nursery staff.
- Workers spoke of the difficulty they had experienced, in general, in engaging Marie and the fact that she had kept them at arm's length, despite home visits by the SS Health Visitor. This had a direct impact on Nathan's development in the SS Speech Therapist's opinion; because no progress was achieved in developing Marie's parenting skills.

- The Health Visitor identified female teenage parents, including Marie, as a difficult group to work with. The SS Health Visitor echoed this view, stating that they tended to change their minds frequently about what they wanted.

Values

- The SS Speech Therapist was concerned that Marie had been ‘labelled’ in relation to her learning difficulties, on the basis of past experience of her as an ex-pupil of the school attended by Nathan. She considered her to have been “written off” as a parent as a result and that she should have been given the opportunity to be helped rather than condemned.

3.12. What Else Might Work?

Case Study 1

i) **Local access to services** – Sue believed things would have been different if she had known about alcohol support services earlier. She said that, knowing how well she had got on with the specialist social worker when she did meet her, she might have engaged with the service if she had been introduced to her casually, despite having been in denial regarding her alcohol problem. Workers identified the need for these services to be provided locally.

ii) **Access to therapeutic services** – Workers suggested that, had Sue been supported to talk more openly about the issues that were impacting upon her life; the situation might have panned out differently:

“I think she would have benefited from having a free counselling service. Had her past problems been able to come out before, we may not have had the alcohol problems.”
(Nursery Manager)

The Social Worker identified the need for “therapeutic services for women with childhood experiences of abuse that are impacting on their parenting ability”.

iii) **Emotional Support** – The SSFSW believed that having “someone to just constantly, constantly be with Sue that’s the steady force that will, no matter what you say to her, will still come back”, would have made a difference to the situation. She also considered more time spent checking out the children’s feelings about their situation would have been helpful.

iv) **Support from Extended Family** – Workers suggested that the situation might have been better if Sue’s mother had been more supportive.

v) **Solution –focused approach** - In the SSFSW’s view, “earlier identification of parents’ difficulties and what they want in their life could possibly turn things around a bit quicker”. She went on to explain that supporting parents to identify their own solutions and helping them to develop these into action plans was her favoured approach.

vi) **Practical Help and Support** – The SSFSW pointed out the possibility that an early offer of simple practical hands on support for Sue might have made a difference.

vii) **Flexible Access to Resources** – The Social Worker was concerned that it had not been possible to increase the level of support provided to the family by the Family Centre, once it had been reduced, when a crisis situation developed due to bereavement. The Head Teacher was concerned that, once it was in place, support should continue to be available to the family.

viii) **Joined up Services** – There was consensus amongst workers that networking and working together at an earlier stage might have made a difference to what happened in this case. It would have also meant that a key person was identified for Sue to contact. The Head Teacher pointed out that past referrals had not been taken up by Children’s Social Care; she also referred to the need for continued information sharing despite the fact that a positive outcome had been achieved for the family.

ix) **Early Identification of Need** – Workers agreed that support had come too late for this family. The SSFSW suggested that once early signs of a problem had been picked up by the school and support from Children’s Social Care Services had not been forthcoming to address these, a local response by a ‘team’ of people offering immediate support might have made a difference:

“As soon as you notice something to address it straight away.....sit them down and be very supportive and say when did it happen, what went on and what do you think we should do about it now?”

She viewed offering choice in this way to be important and thought that use of this approach by Social Care might remove some of the fear associated with their involvement. She also pointed out how useful it would have been if Children’s Social Care had made referrals to local services at a much earlier stage; that they should have been approaching Sue saying “We can’t help you, but who do you think can help you? Is there anything local you can access or we can refer you on to?”

x) **Openness and Honesty** – The FSW from the Family Centre believed that more openness and honesty with Sue on the part of Social Workers, at the time of the children’s removal to foster care, would have been helpful to the situation.

xi) **Consistent Workers** – The fact that three different social workers had been allocated to the family was seen as unhelpful by the FSW from the Family Centre, who had previously pointed out the value of Sue having had a consistent worker at the Family Centre so that she only needed to tell her story once.

Case Study 2

i) **Access to therapeutic services** – The Health Visitor referred to the need for counselling to be available when the need for this is identified; if Jane had been referred to Mental Health Services she would have been waiting for about a year. The Social

Worker said that Jane would have preferred to have seen the counsellor in the family home but this service was not offered.

ii) **Support from Extended Family** – The SSFRW believed that earlier involvement on the part of the oldest child’s father would have made a difference to the way the case progressed and may have prevented the need for a CP Conference.

iii) **Practical Help and Support** – Workers had experienced difficulty in accessing help from the Housing Authority for Jane to make the garden safe for the children to play in. Finance and planning consent were needed for fencing but it was difficult to identify whose remit this was. Access to this support plus help to clear the garden would have, in their opinion, improved the outcomes for the children. The Home-Start Organiser referred to a lack of stability in the support provided to the family by her organisation, because of difficulty she had experienced in identifying a suitable volunteer with access to transport:

“We’re not professionals; we’re there to offer emotional and practical support and friendship and try and help”

She highlighted the need to match the right volunteer with the family and said that, in her view, the right person would be mature and flexible; a good listener with experience of dealing with a group of children and able to offer practical support.

iv) **Flexible Access to Resources** – The Health Visitor was concerned that 1:1 support provided to the oldest child by FWA was limited. In her view he would have benefited from further work but this was not available.

v) **Early Identification of Need** – Things “wouldn’t have got to this”, in Jane’s view, had she not been living with her ex-partner, or if she had had the support she received later at an earlier stage. She referred to an incident of domestic violence that occurred whilst she was pregnant with Scott, which “should be on record” and said she believed this could have been addressed by Children’s Social Care being involved at that time: “They could’ve stepped in and said look, right, you know.....because that’s what they’re there for and you know I’ve tried....it’s hard when you can’t get out of the house and he’s at home 24/7, you’re not even allowed to fetch the kids on your own so I couldn’t go shopping you know.”

The SSEYPS believed that more assessment at the time of the first referral to Social Care, to find out what was going on in the family, would have been helpful. Identification of need was required at a far earlier stage altogether, in the Social Worker’s opinion:

“not when someone’s had two or four kids, right from the beginning.....I think when people stop going into the house and stop seeing what’s happening, so for a service like Sure Start to be involved very early to draw people into their activities and groups.....they can highlight the ones they think will have some problems.”

She also pointed out the importance of teaching people parenting skills at an earlier stage.

Case Study 3

i) **Support from Extended Family** – The Health Visitor and mainstream Nursery Nurse referred to a lack of respite or support for Eleanor from extended family and the fact that, in their view, issues within the family were having a negative impact on the situation.

ii) **Practical Help and Support** – More ‘hands on’ help for Eleanor would have been useful in the opinion of the Health Visitor and mainstream Nursery Nurse. They agreed that the logistics of having somebody in the family home working alongside Eleanor, as might have been available had she been able to call on extended family to assist, were difficult, but that more of this kind of support might have been helpful. The Rainer worker highlighted the difficulty Eleanor experienced in acquiring larger accommodation and said that easier access to this would have made a difference.

iii) **Flexible Access to Resources** – Workers identified Eleanor’s ongoing need for support due to fluctuating mental health (arising as the result of poor upbringing, experience of domestic violence and depression) and vulnerability to domestic violence in the future.

iv) **Early Identification of Need** – Earlier involvement by Sure Start could, in the SS Nursery Nurse’s view, have prevented the need for Children’s Social Care to be involved. The Rainer worker suggested that more assessment at an earlier stage, once Social Care became involved, might have prevented re-registration on the CPR. The Social Worker pointed out that an assessment of Eleanor’s parenting capacity was still outstanding.

Case Study 4

i) **Additional Sure Start Services** – The SS Health Visitor pointed out that there was now a SS Midwife in post, but this service had not been available at the time of the first referral to Children’s Social Care.

ii) **Emotional Support** – The FSW from the Family Centre believed that availability of emotional support for Tanya may have had a significant impact on what happened in this case:

“I think if she knew somebody would be there for her, to support her he [Callum] wouldn’t necessarily have been accommodated.there was nothing to support the way she was feeling.”

She highlighted the likely benefit of 1:1 support “with someone she could talk to about her feelings, along the lines of a befriender” to assist her with the decision regarding Callum’s future. The Practice Manager suggested that support from an adult befriender might have been helpful to Tanya to help build her confidence or to attend a group. This was echoed by the FSW:

“My experience is that people that I’ve worked with, that initial first walking into a room is really scary, you don’t know the environment, the people, the workers, and why should they want to put themselves through that when they’re already feeling low?”

iii) **Support from Extended Family** – The Practice Manager pointed out that Tanya’s relationship with her adoptive mother had only recently been re-established and that Tanya was therefore isolated.

iv) **Practical Help and Support** – The Practice Manager believed more assistance to Tanya, by way of regular support in the family home at key times of the day, might have been beneficial:

“Support needs to be available early morning until bedtime seven days a week. People still have problems at weekends.”

v) **Information** – The FSW from the Family Centre considered it would have been helpful if information had been more widely available to parents and workers as to what support was on offer in the community.

vi) **Joined up Services** – In the opinion of the SS Health Visitor there had been some problems with communication in this case; she thought that information about the family should have been shared. She pointed out that Sure Start had no knowledge, in general terms, of children being on the CPR or any involvement by Children’s Social Care, unless SS workers had been involved in highlighting concerns or workers from other agencies (or parents themselves) chose to let them know. She considered this to be “really dangerous”. She said that few referrals were being received from mainstream Health Visitors, though this was improving, and highlighted the fact that this meant that families’ access to Sure Start services was very “hit and miss”. The FSW from the Family Centre also identified communication as an issue, explaining that her co-worker had left messages for Sure Start to contact her about the family, but had had no response. From a Social Care perspective, the case had been closed before she and her colleague had finished their work and had the opportunity to make any recommendations, which meant there was no forum for this process to take place.

vii) **Early Identification of Need** – All workers referred to the possibility that, had the family’s needs been identified at a much earlier stage and services been put in place, the circumstances of this case might have been different:

“If she [Tanya] hadn’t been left on her own trying to solve things it would never have got to that pitch.” (SS Health Visitor)

“If she [Tanya] had the support when she came out of hospital, even if it was long term, I don’t think it would have been necessary for all that to happen. I really feel that the fire wouldn’t have happened either because if she felt confident in herself and felt she was doing the right thing and more motivated and been given the support then I don’t think any of the problems would’ve come about.” (Family Centre worker)

The SS Health Visitor also pointed out that early involvement by Sure Start at the point of both referrals to Children’s Social Care would have resulted in provision of a package of support for the family. At the time of the first referral some respite care could have been provided for Callum, by way of a childminder, plus regular support for Tanya, ensuring she had someone to talk to. At the time of the second referral support could have been offered by way of nursery or playgroup places, respite care and signposting to other services such as groups and activities for the whole family.

The Health Visitor believed that Tanya's concealment of her pregnancy meant that it had not been possible to prevent Callum being accommodated. Had Tanya been in the area throughout her pregnancy and presented sooner to midwifery services, support would have been available to help her. As far as the second referral was concerned, the Health Visitor considered this to be due to smoking and questioned whether the fire could have been prevented, given Tanya's lack of response to input around smoking cessation.

Case Study 5

i) **Local access to services** – The Health Visitor suggested that an early assessment of Marie's mental health might have been made a difference to the outcome of this case. It would be useful, in her view, if a community psychiatric nurse were attached to Sure Start, as people with mental health problems are unlikely to seek out help for themselves. She also considered there was a need for more SS Speech and Language provision as this was currently limited.

ii) **Support from Extended Family** – Marie told me on two occasions during the interview that she would have liked to have had her father's support. She considered she had never had this.

iii) **Engagement by Parent** – The CFO and the Teaching Assistant both referred to lack of engagement on Marie's part, which prevented workers from being able to make a difference to the situation for Nathan, despite their efforts to do so. The Teaching Assistant suggested that this problem might be addressed by some sort of incentive, such as music, to appeal to parents and encourage them to become involved in Sure Start.

iv) **Joined up Services** - The Teaching Assistant said it would have been useful for the nursery to have been made aware of any play work being undertaken with Nathan by Sure Start workers, as Marie had gone into the nursery regularly to speak to staff and talking to her about links with other aspects of support could have been used as an opportunity to engage her for Nathan's benefit. This observation was echoed by the SS Speech Therapist:

“If we had a common framework up and running now it would be much easier for everybody to have information about what everybody else is doing with the family and have a process to share the information with each other and the family....to have the family in the middle”

v) **Early Identification of Need** – The Teaching Assistant expressed a clear opinion about the possibility that referrals to Children's Social Care could have been prevented in this case:

“Maybe when she'd first had Nathan if there had been a support group, how to look after your baby, how to wash, cook, clean etc.; also if health visitors noticed the diet wasn't healthy they could've said something to Sure Start and maybe someone could've gone in to do some cooking and cleaning. I think anyone involved earlier could've stopped it going to Social Services.....anyone who has contact with the mother before school age.”

3.13. The Likely Impact of CAF

Case Study 1

The Head Teacher's view was that a multi-agency meeting at an earlier stage would have brought issues to the fore. She said that such meetings could be effective but that this depended on the extent of the problems and where 'on the line' these were. The Nursery Manager expressed a similar view:

"I think we could have got in quicker having Child in Need meetings because there would have been more agencies together a bit more quickly to respond quicker for Sue and the children."

Case Study 2

The SSFRW thought that earlier meetings of the agencies and organisations involved and having a formal plan might have made a difference, but pointed out that Jane hadn't seemed to understand the severity of the situation and didn't appear to share the concerns of workers. The Home-Start Organiser had had some experience of other cases where multi-agency meetings had taken place outside of Social Care involvement and had been successful.

Case Study 3

The Rainer worker questioned whether the CAF process would have made a difference, given the family history prior to involvement by Children's Social Care services. The Women's Aid worker's view was that, had there been a multi-agency discussion prior to the second period of registration on the CPR, the situation might have been viewed slightly differently. She also identified the danger following de-registration that Eleanor would have felt that those providing support were "pulling away" from her and there was potential for the situation to spiral down as a result.

Case Study 4

The SS Health Visitor wondered if Sure Start would have been taken seriously if the CAF process had been in place. She said that though the situation was improving she thought a lot of agencies saw Sure Start services as "just icing on the cake". The FSW from the Family Centre was unsure whether the CAF process would have made a difference as this case "kept dropping through the loop".

Case Study 5

The SS Speech Therapist believed that if a 'process' had been in place for Nathan from an early age there would have been more communication between agencies about concerns that needed to be dealt with.

In General

There was general consensus amongst workers about the positive impact the CAF process was likely to have on outcomes for families:

"I think things will improve dramatically with partnership working and people talking to each other. Previously there just seemed to be agencies going in not knowing whether

other agencies were there, crossing over sometimes...” (Home-Start Organiser, Case Study 2)

“I think it’s really good to get all the agencies together and sharing responsibility....more preventative work can be done and not have to go down the CP route. The whole process is really positive and I like the fact that parents will get involved, telling them what is available and asking what they need to help them and not this is what we’re going to do to you.....they can ask for help in certain areas and identify their own needs, setting their own targets.” (Rainer worker, Case Study 3)

“I suppose what might happen is that parents would be made aware, I think the problem is sometimes that parents think – I’m talking about health visitors – that we’re just these interfering people and, you know, why don’t you leave us alone and I think sometimes for some parents where if you have Child in Need meetings and you see all those people coming together that they are sharing the concerns I think that might help the parents think...” (SS Health Visitor, Case Study 5)

“Presently we are messing about with information someone knows and others don’t. I think it can’t come soon enough.....I would hope also from a parent’s point of view that they don’t have to repeat their story to everybody separately.” (SS Speech Therapist, Case Study 5)

“That’s a good idea; at least everyone will be talking and will know what everyone is doing to help the family.” (Teaching Assistant, Case Study 5)

3.14. Themes

Given that the five case studies were randomly selected from a total of 319 children who met the criteria for Sure Start involvement in Part 2, the fact that poor mental health and unresolved issues from the past were identified as difficulties experienced by all five parents involved is remarkable. Issues with extended family, in that they were either unavailable to provide support or the relationships between parents and extended family were problematic, were also identified in all five and domestic violence featured in three. Isolation, low self- esteem and problems with coping all featured strongly as difficulties for parents. Emotional support and practical help were identified as key areas of parental need.

Relationship issues between parent and child and lack of routines and boundaries were the most prominent problems identified for children, but neglect issues; lack of supervision; behavioural problems and developmental delay also featured strongly. Needs identified for children tended to be quite specific; to be placed on the Special Needs Register or to have contact with a parent for example, though a need for more stimulation was mentioned in three of the five cases.

A range of Sure Start services was accessed by parents and children: subsidised child care and crèche; 1:1 support for children and parents, groups for children and parents; counselling and emotional support for parents; training for parents; transport and practical help. Additional support was provided by statutory services i.e. health, social care and schools; nurseries; voluntary organisations and specialist services focusing on specific issues such as substance misuse or domestic violence.

The referrals to Children's Social Care services were considered appropriate in those cases where these had been made by other agencies or organisations. The advantages of Social Care involvement were identified as: more formalised support providing a holistic overview, focus on identified need and clearly identified roles; quicker access to some sources of support and the potential for coercion of parents arising from the statutory nature of the Social care role. Whilst support provided by Sure Start and other agencies and organisations had not prevented the need for referral to Social Care, it was said to have delayed this and the 'groundwork' undertaken with families to have created more clarity around identified concerns. There was also frequent mention of a reduction in the extent to which Social Care services needed to be involved and the intensity of this involvement, once a referral had been made, as well as in the associated stigma for the families concerned.

Raising their self esteem was seen as having been helpful to parents in all five cases; whilst emotional support and parenting support were identified as helpful in most. The helpfulness of counselling, practical help, being part of the community and having consistent workers was also frequently reported. Subsidised child care was reported as having been helpful to children in most cases. Emotional support provided to children directly, or the impact of that provided to their parents, and the 'knock on' effect of parenting support were also frequently cited as helpful.

The majority of positive outcomes identified in respect of parents were considered to have been achieved with Sure Start support. Whilst in some cases there was a view that there was 'still some way to go'; where concerns had been identified regarding the extent to which children had been meeting the five ECM outcomes at the time of referral to Children's Social Care, subsequent improvements had been noted. These improvements were attributed to a combination of support provided by the various services accessed, including Sure Start; that originating from extended family and the impact of improvement in maternal well being. Support provided by Sure Start, Children's Social Care and extended family was identified as having contributed to improvements in all five outcomes. Educational settings were seen as the principle source of support in achieving improvement where Enjoying and Achieving was concerned, whereas support provided by voluntary organisations was seen to have contributed, on the whole, to improvement in Economic Well Being. Improvement in maternal well being was also considered to have impacted positively on this outcome as well as on children's ability to Make a Positive Contribution.

Whilst initial resistance to accessing services was a common theme, the fact that parents had accessed support more readily once services were involved was frequently

highlighted. Three out of five parents had accessed services by choice, in line with need they had identified for themselves. Whilst all five parents had accessed some Sure Start services it had either taken some time to engage them; they had not accessed some services seen as potentially beneficial or both. Newness to the area or the fact that they knew nobody at Sure Start; denial or failure to acknowledge their difficulties and lack of time or motivation were most frequently cited as possible reasons for this. Lack of confidence; low self esteem; anxiety and the controlling nature of a relationship featuring domestic violence were seen as the most likely reasons for parent's initial resistance to accessing services in general.

Earlier identification of need was referred to as something that would have had a positive impact on what happened in all five cases and could have prevented referral to Children's Social Care. Extended family support was also identified as key to the possibility of a different outcome in every case. More practical help was seen as something that would have been useful in most cases. A joined up approach to the provision of support, providing parents with a key person to contact, was frequently mentioned as something that would have worked better, as was flexible and local access to services. Counselling (including provision of this in the home); community psychiatric nursing; midwifery and substance misuse services, for parents, and speech and language therapy for children were all identified as services that could have made a difference had they been available (or more available) locally.

Relationships between parents and workers were identified throughout as being hugely relevant to the progress and outcome of most of the cases; with the knowledge that support was readily available from workers being seen as the key positive for parents. Frequent mention was also made of the positive impact of both significant relationships parents had developed with workers and feeling comfortable in relationships with workers in general. Difficulties identified by workers in their relationships with parents were generally related to barriers created by lack of engagement; parent's defensiveness or the presence of domestic violence. The time taken to build a trusting relationship was highlighted as was the difficulty created by the number of workers involved.

The attitude of some workers was identified by three of the four parents interviewed as having had a negative impact on relationships with them and the way they felt about themselves. The impact of values on relationships, and to some extent on the way the cases were managed, was seen as relevant by workers, who identified the need to be open, honest and non-judgemental, the latter being linked to the dangers of lack of understanding of community culture and variance in thresholds around 'good enough' parenting as well as labelling, stereotyping and assumptions.

Workers often referred to the value of joint working, in providing a package of support for families, improved communication and a clearer picture of needs and concerns. They were asked what difference they thought the forthcoming CAF process might make in similar circumstances to those prevailing in the case studies. The extent to which the process was likely to be helpful was seen to depend, in the main, on the extent of the families' problems; parent's acknowledgement of these and willingness to engage. A

number of likely advantages were identified however; the most frequently mentioned being improved communication and formal identification of need and concern. It was considered likely that, on attending a meeting where all the workers involved with a family were expressing concern, parents would be more inclined to acknowledge the need for intervention and change.

Part 4

Conclusions and Recommendations for Future Service Development and Practice

Whilst results from Part 1 of this study show that referral rates to Children's Social Care had dropped in three of the four SSLPs for which data was available, the fact that the data available from the Local Authority was limited to that required by NESS precludes any conclusions being drawn from this. In addition, examination of data over a longer period of years might have been more helpful in detecting trends, as suggested in the study undertaken by Carpenter, Griffin and Brown (2005). Differences and similarities between countywide and individual SSLP data are nevertheless noteworthy and *we would suggest that data gathering processes are put in place by the Local Authority to facilitate further investigation in this area. The absence of any link between the Social Care and Sure Start databases also needs addressing*, though it is assumed that the difficulties this creates will be remedied by the introduction of a shared database to underpin the CAF process.

Carpenter, Griffin and Brown reported difficulty in drawing any inference from data relating to CPR activity because of the low numbers of children registered. The same may also be said of numbers of children Looked After. This was an issue here in both Part 1 and Part 2 and results relating to this data may not therefore be relied on.

Results in Part 2 which showed that children who were re-referred to Children's Social Care were more likely to have received Sure Start services reflect the findings of a local evaluation cited in the background to this study, where an increase in the number of re-referrals was noted in a SSLP area. These findings reinforce the notion that there is "no quick fix". All five parents featured in Part 3 of this study were struggling with mental health problems and unresolved issues from the past. Relationship problems between parents and their children and with extended family members were also identified in all five cases and domestic violence was an issue in three. Problems like these are complex and take time and expertise to unravel. They are likely to require more help than Sure Start alone can offer. However, the forthcoming implementation of the CAF process should facilitate earlier identification of need and improve communication, as suggested by the workers taking part in the study. It will hopefully also bring more formalised support; a holistic overview; focus on need and provide clarity in respect of individual roles, all seen as advantages of Social care involvement. In the longer term this should lead to referrals and re-referrals to Social Care being limited to those cases where their involvement, as a statutory agency, is truly required.

Where Sure Start services were delivered on an individual, or both an individual and group, basis referrals to Children's Social Care were more likely, subsequently, to be closed. This was also the case where Sure Start family support services were provided, though these had been provided less frequently than health and play and learning

interventions. These results suggest that where support mirroring that provided by Social Care, i.e. that delivered to families on an individual basis, is in place, continued involvement by Social care is less likely following a referral. A link may be made here with the view expressed in Part 3 of the study that, despite being unable to prevent the need for a referral to Social Care, Sure Start and other agencies and organisations had been able to reduce the extent to which they needed to be involved and the intensity of that involvement. ***There is a strong case here for an increase in services providing family support on an individual basis.***

Sure Start was seen, in Part 3 of the study, to have been instrumental in the positive outcomes achieved by parents, whereas improvement in ECM outcomes for children was attributed to a combination of support from the various services accessed, as well as to extended family support and improved maternal well being. This suggests that Sure Start is best placed to assist parents in achieving positive outcomes that will in turn benefit their children. ***Consideration should therefore be given to increasing provision, in the future, of services identified here as helpful to parents; namely those that assist in raising self esteem; emotional support including counselling; parenting support; practical help and support to integrate them into the community. Much of this support was considered to have a 'knock on' effect on outcomes for children, but subsidised child care provided by Sure Start was believed to have helped them directly and identified as having impacted positively on ECM outcomes. Increased provision of this type of support should therefore also be considered.***

Whilst the study identified the positive impact of Sure Start services, results in Part 2 showed that Sure Start was not involved with almost 50% of a cohort of 586 children under 4 who had been referred to Children's Social Care. This highlights access to Sure Start services for vulnerable families as an issue. Part 3 of the study revealed that despite initial resistance, parents accessed support more readily once services were involved. ***Work needs to be undertaken to identify ways of engaging parents in vulnerable families, taking into account reasons identified here for their failure to access services; i.e. lack of confidence; low self esteem; denial of or failure to acknowledge difficulties and the controlling nature of relationships featuring domestic violence.***

Difficulties surrounding access to services might be alleviated by a number of measures. The nature of the relationship between parent and worker was seen as highly relevant to the progress and outcome of most cases in Part 3 of the study. The knowledge that support was readily available from workers was seen as a key positive for parents, as was the quality of their relationships with those providing support. ***Flexible access to services provided by those with whom they had forged trusting relationships over time was seen as something that might have made a difference in some cases and as required to sustain progress in others. Local access to services providing counselling and mental health support; help with substance misuse; midwifery and speech and language therapy was suggested as something which might assist in addressing difficulty experienced in engaging vulnerable families. These issues should be taken into account in developing services for the future.***

Whilst extended family relationships were seen as problematic in all five cases in Part 3 of the study, more support from extended family was also identified as key to the possibility of a different outcome in every case. This highlights both the value of utilising extended family support where this is available and the need for caution where relationships have the potential for impacting negatively rather than positively on the situation. ***Increased use of family group conferences should assist in maximising the use of extended family support where this is likely to be beneficial. Where it is not available because families are isolated or extended family relationships are poor, consideration should be given to developing support that mirrors that usually provided by extended family, given the emphasis placed here on the positive impact of significant relationships developed between parents and workers.***

This study demonstrates that parents in vulnerable families with complex needs require flexibly available support delivered in a way that mirrors what might otherwise have been provided by their extended family. It shows that improved self esteem in parents has a 'knock on' effect on positive outcomes for children. Unsurprisingly, these are the ingredients of four approaches which seek to increase security of attachment between infants and parents in order to improve children's socio-emotional development through: changing parents' behaviour in interaction with their children; changing parents' internal working model of self and others; providing increased social support and improving maternal mental health and well-being (Howe, 2005). Development of services and practice in line with the recommendations of this study would be in keeping with the focus of these interventions and Sure Start's aims to promote physical, intellectual, social and emotional development in working with children, and their parents, at the pre-school stage of life.

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