Llywodraeth Cynulliad Cymru
Welsh Assembly Government

Evaluation of “Option 2”

Final report

Final Report

on the Evaluation of “Option 2”

Prepared for the Welsh Assembly Government

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SUMMARY

Introduction

- "Option 2" is a service funded by the Welsh Assembly that works with families in which parents have drug or alcohol problems and there are children at risk of harm. A particular focus of the service is reducing the need for children to come into public care. It has a Cardiff and a Vale of Glamorgan service.

- The intervention is short (4 to 6 weeks) and intensive (workers are available 24 hours a day). Workers use a combination of Motivational Interviewing and Solution-Focussed counselling styles, as well as a range of other therapeutic and practical interventions.

- Option 2 is a service of particular interest because there is limited evidence on how to prevent high risk children from entering care, and increasing concern about the number of children affected by parental drug or alcohol misuse.

Structure of the evaluation

The evaluation had 4 main components:

1. a review of the literature on intensive family preservation services;
2. a quantitative follow-up of Option 2 children and a comparison group looking at the impact of the service on care entry and associated cost savings;
3. a qualitative study of the views of parents and children who used the service in 2006.
4. questionnaires to social workers in the local authorities.

An additional literature review on outcomes for children in the care system was carried out and is the subject of a separate report.

Review of the literature on services to prevent children entering care

- The literature review reported on in this report focuses on intensive family preservation (IFP) services for children at high risk of care. It summarises evidence from around 100 articles or books.

- Intensive interventions seem important because general services aimed at improving family welfare (such as Sure Start and Homestart) do not appear to have an impact on care entry rates. They also often fail to engage families with the most severe problems.

- Initial evaluations of IFPs suggested that 90% of children "at risk" of entering public care avoided doing so following an intervention.

- A series of more rigorous and large-scale evaluations of IFP involving control groups found that Family Preservation services *did not tend to have any impact on the likelihood of children entering public care and that as a result they did not tend to have any economic benefit*. Specifically they found:

- Placement rates of children into care — No differences
- Functioning of children and families — No differences
- Length and intensity of intervention — No differences

The main issues identified were:

1. The children referred to IFP services were not in fact at “high risk” of coming into care - most children in control groups did not enter care.

2. Few studies provide evidence on the services for the control groups.

3. IFP services are based on a “crisis intervention” model, yet the family problems generally appear to be chronic and long-term.

4. Many of the projects developed practices that differ from those on paper, such as keeping families on waiting lists.

5. It is often difficult to be certain what is being evaluated as the focus is on the structure not the process of the intervention.

6. Family Preservation should not be seen as a goal in its own right, as sometimes entering care is the right choice for children.

The research highlights the danger of over-enthusiasm about insufficiently tested models. There is no “magic bullet” that will prevent the need for children to enter public care. At best it may be possible to develop services that are able to stop *some* children from entering care by significantly improving their family situation. This process requires careful and ongoing evaluation.

The quantitative study comparing care entry outcomes

The quantitative study compared information on care entry and cost for 278 children referred and accepted by the Option 2 service between 2000 and 2006 (this includes 16% who did not receive the service) and 89 referred but not accepted as the service was full (the comparison group). Results are summarised in the table on the next page.

Impact of Option 2 on Care Entry

- Option 2 did not reduce the proportion of children who entered care;
- Option 2 significantly reduced the time children spent in care, because:
  - Option 2 children take longer to enter care;
  - If they do enter care, they tend to stay there for a shorter time;
  - A higher proportion of Option 2 children return home from care.

- As a result a quarter of Option 2 children were in care at the end of the study, compared to a third of children in the comparison group

Summary of Impact of Option 2 on Care Entry

	Option 2	Comparison	Statistically significant?
Did child enter care?	41%	40%	No
How many days did children spend in care?	766	958	**Yes** (p=0.038)
How many days was it from referral to care entry?	243	126	No
Was the child in care at 31.12.06?	24%	33%	**Yes** (p=0.025)
Was the child living at home at 31.12.06?	68%	56%	**Yes** (p=0.003)
Cost of care (Cardiff only) (£)	13558.36	16931.13	**Yes** (p=0.049)

Impact of Option 2 on the cost of placements
An attempt was made to measure the savings from reduced need for public care and "off-set" this against the cost of Option 2. This found:

- In the Vale, the figures on costs seemed unreliable (through no fault of the local authority). The Vale children were therefore excluded from the cost/off-set analysis.

- For Cardiff, the *cost of Option 2 was £2194.67* per child.

- *Option 2 on average saved £3372.77* per child in the cost of placements.

- Thus, on average **each appropriate referral saved the local authority £1178.10 per child**.

- The savings were probably considerably greater than this, as not all the costs of care were included, and the alternatives to Option 2 were not costed.

- It can be concluded that Option 2 in Cardiff provides significant cost savings to the care system and is therefore likely to be a cost-effective approach to reducing the need for public care.

Which types of family was Option 2 most effective with?

- Option 2 appeared particularly good at reducing the need for care when:

    - The referral specified a child being "at risk" of accommodation;
    - Parents misused alcohol;
    - Families had one parent.

- The only group in which Option 2 increased the likelihood of care entry were children referred as “at risk” of going on the child protection register.

The impact of Option 2 was particularly noteworthy because the study used a valid comparison group and the numbers are relatively large. However, the test of impact was particularly stringent because the evaluation involved:

- A comparatively long follow-up period (averaging 3.5 years);

- The full costs of care were not underestimated because the cost of continued social worker input or of finding placements were not included;

- Most importantly, information on other services received by the comparison group is not included. The cost of these is not included within the economic evaluation. More importantly, the presence of these other services mean that **the impact of Option 2 is in comparison to other services – not in comparison to receiving no service**. In effect, Option 2 is producing a greater impact in reducing the need for care than the combination of other services that families tend to be referred to.

What parents and children would most like to tell the Welsh Assembly Government about Option 2

- “without [Option 2 worker's] intervention… we would have split up as a family

- “without wanting to sound dramatic, [Option 2 worker] did save this family”.

- it’s “been brilliant for me and [daughter] for those 4 weeks”.

- It’s “good for our relationship between mum and daughter

- “when you can rely on somebody…that’s more than 101%…”.

- “I could have killed my [eldest son] by now” or put him in care if “I didn’t have someone like [Option 2 worker] to talk to”.

- “They’re very helpful”; “good listeners”. “Friendly”. “I wish I was still with them!”.

- “It’s good for alcohol help” and “alcohol is a drug”. “Thanks!”.

- [the interviewee] said that Option 2 was a “good service” and without it he didn’t know “where I would be concerning the children”.

- Option 2 is “really a big help”. They “should have all social workers working like them [Option 2]”

- “Don’t put a stop to Option 2, definitely” and “extend it as much as they can”.

The qualitative study of the experiences of service users

- All parents and children interviewed (n=18) were very positive about the service that they received.
- A particular feature was that Option 2 workers appeared able to engage with families that other professionals had found difficult to work with.
- The style of interaction of Option 2 workers was contrasted with the often unhelpful ways in which child and family social workers engaged with families.
- All the families talked about the changes that had occurred within families during their engagement with Option 2. For some families these had been permanent; for others the family had slipped back after Option 2.
- The tendency to return to previous levels of difficulty appeared more pronounced in families with complex and inter-linked difficulties.

The questionnaires to social workers

- Questionnaires were returned from 23 social workers in the Vale and Cardiff;
- Those who had referred to Option 2 were very positive about the professionalism of the response;
- In general respondents felt that Option 2 had had a positive impact, though a small number felt that it temporarily improved family functioning only for children to eventually enter care;
- Workers in the Vale had a closer relationship with Option 2; those in Cardiff often did not know much about the project.

Conclusions

A child entering care is a sign of social and familial breakdown of the most profound kind. It only happens when families have extremely severe difficulties. This explains both the comparative improvements that children exhibit in care (detailed in the report accompanying this one) and the repeated difficulty that services have in preventing the need for care.

In this context, the impact that Option 2 has is noteworthy. We believe that this is the first British evaluation with a robust methodology to show a reduction in the need for care from a support service for families. Indeed, the proven impact was noteworthy because it had a long follow-up and what appeared to be a valid comparison group. It is particularly important to stress that the comparison group will have received a variety of other services – including some intensive and/or long term services. The impact of Option 2 is therefore compared to a variety of other services – not compared to receiving no service.

As a result of these considerations our central conclusion is that ***in Option 2, Wales appears to have a ground-breaking asset of national and potentially international significance.*** It has the potential to be developed and expanded to address the needs of some of the most vulnerable families in society. However, there are some important cautions that need to be sounded:

- We do not know the impact of Option 2 on child welfare. This is crucially important – because even an excellent service may inadvertently harm children if it prevents children who would benefit from care entering care. There is no evidence that Option 2 is doing this – but it remains an important gap in our current knowledge;

- Option 2 did not reduce the proportion of children who entered care. Why this was so requires further investigation;

- Option 2 often appears to produce change for a period of time but some families return to previous levels of difficulties.

The following questions seem relevant to these findings:

- Is the brief period of intervention appropriate for families with complex needs? Would longer periods or top-up interventions be helpful for some families?

- Do other services help to sustain the positive changes made by families? It is important that the impact of Option 2 is seen within the context of general service provision. Service users were very critical of normal social work, in particular.

The contrast between the success of Option 2 and the general failure of interventions based on the Homebuilders model is striking. It seems likely that this is related to the use of evidence-based interventions such as motivational interviewing and to the high quality of staff and management within the project.

Recommendations

Recommendations for Option 2

1. There seems to be limited evidence to support brief intervention based on a crisis intervention model as a way of preventing care entry – though it may be useful for families with less serious problems. Option 2 may wish to consider experimenting with:

    a) longer periods of intervention;

    b) more use of follow-up sessions and multiple re-referrals;

    c) flexible models of engagement negotiated with families.

2. Targeting more closely on children “at risk of accommodation” or “in care” might increase the success of the project at preventing care entry.

3. Variations of Option 2 could be adapted and tried out with non-substance misusing parents.

4. The service needs to be publicised within Cardiff.

Recommendations for other services involved with children and families

5. The potential impact of training child care professionals in motivational interviewing and solution-focussed approaches should be explored. It is particularly important that this training is followed-up with skilled clinical supervision of actual practice, as research indicates that training alone is rarely sufficient to achieve skilled practice in an evidence-based approach.

6. Training might usefully be provided for social workers within Cardiff and the Vale in motivational interviewing and other aspects of Option 2 ways of working, and an evaluation of the “added value” to the Option 2 intervention undertaken. This might reduce the perceived difference between Option 2 and standard services and reduce the rate of “relapse” to previous levels of difficulty.

Recommendations for further research

At a number of points the dangers of relying on an evaluation that does not consider child welfare have been highlighted. We would therefore recommend as a priority:

7. A research study following-up the impact on child, parent and family welfare outcomes and full costs of Option 2 compared to comparison group children.

8. Adaptations to the Option 2 model should be carefully evaluated to identify their impact on child and family welfare and care entry.

Recommendations for policy

- The focus of interventions in families should be *child welfare not preventing care* – care is the right option for some children. This is the philosophy of Option 2 and it needs to be replicated in any intervention aimed at reducing the need for children to enter care;

- We do not know what services or interventions are able to improve children’s welfare and reduce the need for care at present, and *policy should therefore actively explore and evaluate different approaches*;

- The evaluation suggests that Option 2 is a positive model for achieving some of these aims. It provides *an excellent starting point for exploring how we might improve outcomes* for these extremely vulnerable children and their families. Particular features of the service that appear important include:

    - Excellent communications skills in all the workers;
    - An ability to engage even very “difficult to engage” families;
    - The use of an evidence-based approach appropriate to the client group (namely, motivational interviewing);
    - A focus throughout the service on client-centred values;
    - Strong supervision and management that supports a collective vision of excellence.

- However, service development and evaluation should not focus solely on specialist services – it should also consider ways of improving general social work practice. The contrast between service users’ perception of Option 2 and their views of “normal” social work was striking and suggests important lessons about skilful ways of working need to be learnt for diffusion into general practice.

Option 2 is an example of excellence in working with vulnerable families in which parents misuse drugs or alcohol. There is evidence that it reduces the need for care for children in many of the families referred to it. We would recommend that the model be developed and expanded, and the implications of the success of Option 2 be considered for social services more generally.

CONTENTS

INTRODUCTION

The research study described in this report involved an evaluation of the "Option 2" project in Cardiff and the Vale of Glamorgan. Option 2 is an award-winning and highly regarded service that has been running in Wales since 2000. The service provides brief and intensive interventions for families in which social workers identify that there is a risk either that a child may enter care or that the child's name may be placed on the Child Protection Register. It is based on the Homebuilders model developed in the USA. An important difference is that the focus of Option 2 is on families in which there is parental substance misuse.

The National Assembly for Wales' (NAW) decision to commission research on Option 2 appears particularly timely and important. There is currently great interest at all levels of government in attempts to prevent children entering care. Success in this endeavour is seen to offer the possibility both of saving money and avoiding the poor outcomes for children associated with the care system. For instance, such considerations inform the Westminster government's *Care Matters* green paper. It is also particularly important in Wales, as there has been a significant increase in the proportion of children entering care in Wales compared to England in recent years.

Yet little is known about the effectiveness of attempts to reduce the number of children entering care. The substance misuse focus of Option 2 also appears particularly timely as there has been increased recognition of the high prevalence of this issue in children entering care in recent years.

This report gives an account of the evaluation in five main sections. These are:

1. A review of the literature on intensive services aimed at preventing children from coming into care;

2. A study comparing care entry and associated costs for children who received Option 2 and those referred but not provided a service because there was no space (the comparison group);

3. A qualitative study of the experiences and views of parents and children who used Option 2 in 2006 (the "qualitative study");

4. A study of the views of social workers who might make referrals to Option 2;

5. A discussion section outlining the key findings and their implications for policy, future research and practice.

1. LITERATURE REVIEW: INTENSIVE FAMILY PRESERVATION INTERVENTIONS

1.1 Introduction

Preventing children from coming into public care seems important for three reasons. First, in general families are considered the best place for children and this is recognised in the 1989 Children Act. Thus, if children can be kept in their birth family this should be done. Second, it appears to be a way of avoiding what are often perceived to be the poor outcomes for children who enter the care system. Third, it saves the cost to the public purse of children entering care.

As a result of these considerations there is currently great interest in developing interventions aimed at preventing children from coming into care. For instance, the Government "*Care Matters*" green paper devotes a chapter to the topic. They summarise the U.K. government's view thus:

> "We should concentrate our efforts on avoiding the need for care, except for those who truly need its support. We must identify problems earlier and respond quickly and effectively. And our responses must be driven by what we know are the key characteristics of effective interventions."
> (Department for Education and Skills, 2006, p 21)

Yet, what do we know about the key characteristics of effective interventions? Indeed, do we know what effective interventions exist? This literature review considers this area in some depth, in an attempt to answer these crucial questions.

A particular focus of interest is interventions for children whose parents misuse drugs or alcohol. Around a third of all social work cases involve parental substance misuse (PSM), with even higher proportions in families where concerns are greater. Forrester and Harwin (2006, 2007) carried out prospective research on the full range of children allocated a social worker where PSM was an issue. They found that two years post-referral around half of the children had been removed, with around a quarter living in the wider family and a quarter coming into the formal care system; 40% were subject to care proceedings at some point. Looked at another way, PSM is an issue for around 60% of children subject to care orders (Forrester and Harwin, 2006; Harwin et al, 2003). Indeed, increases in parental substance misuse – and in particular more problem drinking and drug-taking by mothers – have been identified as likely to be a key factor in the rise in the number of children subject to care proceedings since the inception of the 1989 Children Act in 1991 (Statham et al., 2002).

This review considers what we know and do not know about intensive services for families aimed at preventing children from coming into care. Based on our review of the evidence base we make recommendations in terms of investment of resources, supplementary training, ongoing process and outcome evaluation, and feedback to the Welsh Assembly to ensure best practices for children and their families. Findings relating to parental substance misuse are particularly highlighted due to their relevance for Option 2. The review starts with a brief section on the very limited British research on what works in preventing children entering care. The bulk of the review considers the extensive international research base, with most of the studies being from the USA. Evidence in relation to British interventions using intensive intervention is limited, but two relevant evaluations are discussed. Conclusions and implications for service

development generally, in relation to Option 2 specifically and for evaluations in this area are discussed in the final section.

The full methodology for the identification of literature is set out in Appendix A. The literature can be broken down into original research studies, reviews of a number of studies and theoretical pieces. As there are excellent reviews of the evidence base up to the mid-1990s we have drawn on the findings of these as appropriate. We have in addition attempted to include every study published between 1995 and 2005 and available in the United Kingdom (around 60 studies) plus a number of unpublished evaluation reports. In total the review is therefore summarizing a literature of in excess of 1000 studies in this area. We have summarized each piece of literature included in the review (see separate document).

1.2 Research on Interventions to Prevent Children Entering Public Care

The government's call in *Care Matters* for services specifically focussed on preventing the need for children to enter care has been presaged by developments in various local authorities. For instance, based on interviews with managers in local authorities who had reduced the number of children entering care, Held (2005) identified services proactively aimed at preventing the need for care as being important. There are also anecdotal descriptions of such services having an impact. However, there do not appear to be any published studies on the effectiveness of these services or changes in organisational approach.

In contrast, there have been studies of the impact of supportive services targeted at individuals or areas likely to be at risk of poor outcomes. However, the evaluations of these interventions are not encouraging. Homestart is one such intervention. It provides new mothers experiencing difficulties such as isolation, having twins or triplets or having had a recent bereavement, with a trained volunteer who visits regularly and provides practical and emotional support. The evaluation of Homestart included consideration of whether it had had an impact on the number of children coming into care. The researchers found that most mothers reported positively on the service, but that there were no measurable differences at follow-up between children or mothers who received Homestart and those who did not. As one might expect in light of this, it did not have an impact on the number of children who entered public care (McAuley et al., 2006).

The largest targeted intervention aimed at improving outcomes for disadvantaged children in recent years has been Sure Start. Sure Start involved £3.1 billion of investment by the government in areas with indicators of multiple deprivation. Local areas were allowed considerable latitude in developing services tailored for different communities. The evaluation attempted to identify both the overall impact and differences between areas implementing Sure Start in different ways (National Evaluation of Sure Start, 2005). Drawing on a very large sample it compared outcomes in areas with Sure Start with those for children in comparable areas without Sure Start.

Unfortunately, the outcomes of Sure Start have been somewhat disappointing. Outcomes for children in Sure Start areas improved in small ways in some areas of functioning; however, the outcomes for the most vulnerable families – such as those with no adult in employment, young mothers or lone parents – actually got worse. One possible factor explaining this unexpected finding was that the most vulnerable families were reported not to be successfully accessing Sure Start services, and this may have actually reduced the services they received when compared to similar families in non-

Sure Start areas. Entry into care was not specifically looked at in the study, but given that Sure Start had a small negative impact on the most vulnerable families it appears very unlikely to have reduced the number of children entering care (although this was not specifically reported on in the 5 year evaluation study).

In contrast to the generally gloomy picture for the outcomes of Sure Start overall there is some evidence of specific Sure Start initiatives that made a difference. For instance, Hutchings et al. (2007) report findings for a targeted parenting programme based on an intervention with a strong evidence based (the Webster-Stratton Incredible Years programme) delivered in North Wales. They compared outcomes for 116 children who participated in the programme with those on the waiting list. The programme had a positive impact on a range of outcomes for children at risk of developing conduct problems and the associated cost-benefit analysis suggested very significant cost savings.

While this study was not targeted at preventing children coming into care, its importance is in the contrast it provides to the lack of impact of Sure Start more generally. Unlike Sure Start, it was based on an evidence-based intervention and considerable attention was paid to ensuring that the intervention was delivered as intended. In addition, the intervention was targeted at an “at risk” group. There may be lessons here for the development of effective psycho-social interventions more generally.

Nonetheless, overall there appears to be comparatively little British literature to guide us. The only studies of some relevance look at comparatively widely targeted interventions. Thus far these interventions provide no indications that such approaches reduce the number of children coming into care. For both Homestart and Sure Start a key problem is that the most disadvantaged families do not appear to access services. In order to develop services more likely to reduce the number of children entering care it may therefore be more helpful to look at services targeted at children at high risk of such an outcome. In this respect the largely North American literature on Intensive Family Preservation services seems particularly important, and is reviewed next. Following this section two recent British evaluations of services based on a similar model are discussed.

While the evidence on interventions aimed at preventing children from entering care is limited, there is more research looking at improving outcomes for children in vulnerable families, particularly where the children are exhibiting difficult behaviour, and on interventions aimed at preventing child abuse and neglect. This evidence base is reviewed in the final section of this part of the report. Unlike the review of intensive family preservation services – which is a comprehensive review of the entire literature – the review of family support services is a more narrative description that identifies key lessons from the literature.

1.3 Review of the International Literature on Intensive Family Preservation

1.3.1 The service and policy context

Option 2 is based on the “Homebuilders” model from the USA. Key elements of the Homebuilders model include (Institute for Family Development, 2007):

- *Intervention at the crisis point.* Families are considered to be “in crisis” – with this crisis generally being linked to the possibility of their child entering public care. The response is broadly shaped by crisis intervention theory and focuses on immediate, intensive and short-lived intervention. Client families are seen within 24 hours of referral.
- *Treatment in the natural setting.* Services take place in the client's home or the community where the problems are occurring.
- *Accessibility and responsiveness.* Therapists are on call to their clients 24 hours a day, 7 days a week. Families are given as much time as they need, when they need it. This accessibility is intended both to be therapeutic and to allow close monitoring of potentially dangerous situations.
- *Intensity*. Services are time-limited and concentrated in a period targeted at 4 weeks. The service is designed to resolve the immediate crisis, and teach the skills necessary for the family to remain together. Each family receives an average of 40 to 50 hours of direct service.
- *Low caseloads.* Therapists carry only 2 to 3 cases at a time, sometimes only 1. This enables them to be accessible and provide intensive services. Low caseloads also allow therapists the time to work on specific psycho-educational interventions, as well as the basic service needs of the family.
- *Flexibility*. Services are provided when and where the clients wish. Therapists provide a wide range of services, from helping clients meet the basic needs of food, clothing, and shelter, to therapeutic techniques. For instance, therapists teach families basic skills such as budgeting. They also educate families in areas more commonly associated with counseling, such as child development, parenting skills, anger management, other mood management skills, communications, and assertiveness.

Indeed this very “flexibility” is an important issue in interpreting the evaluations of Homebuilders. Originally Homebuilders was primarily cognitive-behavioural in orientation. Subsequently services and individual therapists have been encouraged to use a range of interventions. These include those with a strong evidence base, such as Motivational Interviewing and structural family systems approaches, and those with limited evidence for their effectiveness, such as solution-focused, as well as unspecified approaches that appear to be good ideas but do not have a strong evidence base, such as skills-building interventions. This flexibility in the content of Homebuilders, as well as the still greater diversity in the range of practices used in Intensive Family Preservation Services generally, creates difficulties in interpreting the evaluations of the interventions, as discussed below.

It is important to note that Option 2 differs from the original Homebuilders model in important ways. Most obviously:

- All of the families have substance misuse problems;
- The service provides follow-up input sessions;
- The intervention within Option 2 is broadly based on Motivational Interviewing and Solution-Focussed approaches. These are used in some Homebuilders projects but many are not based on these approaches;

- The British service and welfare context is significantly different from the United States. For instance, Britain has a stronger welfare state and significantly fewer children per head of population are taken into public care.

The implications of these differences for interpreting the American research are discussed below.

1.3.2 The research base

Intensive in-home family interventions to reduce placements in public care were first developed in the mid- 1970s. “Homebuilders” was the first such intervention, and it remains the most widely used model and the most thoroughly evaluated. The bulk of the literature is from the USA, but research studies have also reported findings for IFP programmes in Australia, Canada and the Netherlands.

Homebuilders attracted considerable attention when initial evaluations suggested that 70, 80 or 90% of children “at risk” of entering public care avoided doing so following a Homebuilders intervention. Initial findings such as these contributed to considerable excitement about the potential Intensive Family Preservation (IFP) services had for reducing the need for public care. Projects based – to varying degrees – on the Homebuilders model began to compete with a model taking place over a longer time period of intensive in-home family preservation services which was based on structural family therapy approaches. Other types of IFP were also tried out, with local variations: some were more connected with mental health strategies, others were focused on delinquents and included drug screens, some were more systemic, others were more behavioural, some were based on building support networks for families, and others included supervised daily positive family activities which included one to one responsive play, family games, and positive problem solving talk. Most of these adaptations extended the time of treatment, and increased the case loads, which initially were restricted by Homebuilders.

The apogee of the IFP movement came in Clinton’s Family Preservation Bill of 1994. This set out Family Preservation as a central policy aim for children’s services and led to considerably increased funding for state child welfare budgets to do IFP. At the same time, the federal bill did not specify the nature of the interventions to be used, and let local counties make decisions about what exactly they would deliver.

Meanwhile, in the United States, there was an emerging commitment to rigorously evaluate social work practices. Because of the high profile of Intensive Family Preservation Services, which included Homebuilders and other practices, several large-scale randomized controlled trials were commissioned by state governments. A randomized controlled trial (RCT) is considered to be the most rigorous experimental evaluation strategy for measuring effectiveness in science, for example it is the approach used in the assessment of a medical drug intervention. An RCT has the following core components:

1. A target population is identified, which in this instance was children who were identified by social workers as being at risk for placement outside of the home usually for reasons of safety to the child’s physical and emotional well being;

2. A specified intervention is defined as being tested, which in this instance was IFPS;

3. Children are randomly assigned either to receive the intervention or not. Those receiving the service are termed the experimental group while those not receiving the service generally receive usual services and are called the control group. Crucially the decision about which group individuals enter must be random: the social worker is not supposed to take into consideration the specific circumstances of each child as this would make the groups different and difficult to compare;

4. Half of the children receive the intervention of interest (IFPS) and the other half (or at least a reasonable number) receive ongoing social services as they currently exist.

5. At follow-up – generally one year later - the proportion of children placed in care are compared across the two groups. The number of days in care and costs of the placements between the two groups can also be compared; so can the welfare of the child and their parents.

6. In addition, through this method the economic cost and savings of the intervention can be considered. As:

    a. the IFPS involves extra training for social workers and drastically reduced caseloads for social workers, which in turn increases the costs of social services for children,

    b. the hypothesis is that this will prove cost-effective through decreasing the costs of placements in residential and alternative care and foster care.

Through this process policy-makers can compare the cost of providing a specific intervention – such as IFPS – with both the economic savings and the impact on welfare.

From the late 1980s through 2002 a series of more rigorous and large-scale evaluations of IFP involving control groups were carried out. These included some of the largest and best designed evaluations of social work interventions to date. For this review we present the results of 5 reviews of the literature. We then consider all relevant studies between 1995 and 2007.

1.3.3 Meta-Reviews of the IFPS Research

Dagenais et al (2004) attempted to carry out a meta-analysis of studies published between 1980 and 1995. A meta-analysis involves selecting all of the randomized controlled trials published over a period of time, applying rigorous and explicit inclusion criteria, and then statistically aggregating the findings from the studies included. To be included in the review, studies had to include a control group, have information on placement rates of the child at risk, measures of family functioning, and sufficient quantitative data to be included in the analyses (e.g. standard deviations). Dagenais et al reviewed 224 studies, but most provided only descriptive information. Only 27 programs - provided for 10,296 children - met criteria for entry into the meta-analysis, and the outcome measures were so varied that the researchers abandoned an attempt to statistically synthesis findings and provided a more descriptive review of the research.

Dagenais et al discuss in detail the problems in drawing conclusions from this literature. In particular, different measures of outcome were used; they identified in total 235

outcome measures. Also, they criticized the studies for using a wide range of formats and methodologies and for not delineating the specifics of the interventions being evaluated. Furthermore, those which did specify the nature of the interventions suggested that they differed from one another in important ways. Nonetheless, Dagenais et al. were able to conclude that the only studies that showed a significant positive impact on prevention of placement were those in which the target clients were families referred to the programme because of behavioural problems or offending by adolescents within the family. IFP programmes had little or no impact on placement outcomes for families where younger children were at risk of care placement as a result of maltreatment. On the other hand, Dagenais et al suggest that a number of studies indicated some positive impacts on family functioning, at least in the short term. They conclude that better quality research is required to evaluate these promising findings for some IFP services. As will be seen below, this finding of no significant reduction of placement rates is repeated a number of times in the research literature.

For instance, Fraser et al.'s (1997) review of IFPS evaluations had a similar central finding. Fraser et al. reviewed evaluations of IFPS published between 1985 and 1996 that randomized IFPS with a control group receiving ongoing services. To qualify, the service needed to be intensive, short-term and provided in-home, however, they included studies from health, youth justice and social care and thus services aimed at prevention of placement in care, prevention of arrest or incarceration and prevention of hospital readmission. They found that IFPS was moderately effective at preventing the placement of children in early adolescence referred for truanting, oppositional or criminal behaviour. They did not find a reduction in placement for other groups. A key reason for this was that while comparatively few children who received IFPS entered care, this was also true for children in control groups. This low level of placement into care in both groups suggests either that children in both groups were not in fact at high risk of entering care or that those in the control group also received an effective intervention. This is a key issue, found in many studies in this area.

Issues such as those identified by Fraser et al. loom large in a comprehensive review of the methodological adequacy of evaluations of IFPS undertaken by Henegham et al. (1996). Henegham et al. reviewed studies published between 1977 and 1993. They identified 802 references relating to family preservation, however only 46 were rigorous evaluations of programmes, and of these only 10 met the criteria for inclusion in their review, namely that they included outcome data and had a control group. Henegham only rated 2 of the studies as having an acceptable methodology, four were adequate but had limitations and 4 were unacceptable. Shortcomings included poorly defined assessment of "risk" (e.g. how was high risk of coming into care defined), inadequate descriptions of the intervention and non-blinded determination of the outcome (i.e. the field social worker knew whether they had received IFP and this may have influenced their decision-making). Overall, there was very little difference between rates of placement for IFP and control children with only two of the ten studies showing any significant impact. The authors conclude that evaluations show no benefit of IFPS in reducing out-of-home care, and they highlight the challenges in evaluating such interventions.

Wells and Biegel's (1992) review sheds further light on the issue of the level of risk of out-of-home placement for children referred to IFPS. They reviewed studies which genuinely randomly assigned families to IFPS or control groups. Only 3 studies met this criterion. However, a particularly interesting feature of the Wells and Beigel review is that

it focuses on families with high levels of "risk" (based on factors identified at the time of the referral). Findings for IFPS were not particularly encouraging: for "high risk" children they found that IFPS did have an impact in delaying entry into care for around half of the children. This is interesting, but is not necessarily a positive result as delay in entry into the care system may actually result in worse outcomes for some children. Wells and Biegel draw two main conclusions. First, they suggest that the initial claims for the impact of brief interventions were unrealistic: the expected impact interventions might make and the length of time that such impacts might last needs to be clarified. Second, the social and economic context of the families and their material needs should to be taken into account. This includes the referring services, other services available as well as the social and economic situations of families. IFPS take place within a context that often includes a complex interplay of social deprivation and individual difficulties such as substance misuse or mental illness. Expecting long-lasting impacts from brief interventions in such situations may well be unrealistic and based on a misunderstanding of the nature of the issues within these families.

The review that includes the most recent research in this area, by Lindsey et al. (2002), reiterates many of the points made in the previous reviews about the limited success of IFP. Indeed, Lindsey et al entitle their article "the failure of intensive casework services to reduce foster care placements". Lindsey et al identified 36 studies between 1970 and 2000 that evaluated IFP aimed at preventing the need for foster care. They categorised studies into categories according to the rigour of their design, namely category A – classic experimental studies, with reasonable numbers and genuine control group; category B – experimental studies with small sample sizes or modifications that reduced their rigour; category C – major modification of classical experimental design; category D – no control group. Four studies qualified in category A, and in three of these the *control* group had fewer placements than the intervention group while for the fourth there was no significant difference. The remaining studies generally showed no difference between the groups and painted a discouraging picture of the ability of IFPS to prevent children from entering care. Lindsey et al. reiterate the point made by Wells and Biegel, namely that a brief and unspecified intervention in the context of multiple individual and social problems of a chronic nature is unlikely to achieve genuine and long-lasting change.

More recently the US government has carried out an extremely thorough evaluation of IFPS in four states, using randomized control groups (DHHS, 2002). This study had 756 families receiving IFP and 535 in control groups. Information was collected from multiple sources at start of service and 3 and 12-months after service entry. Child welfare, family functioning and out-of-home placements were examined. Families reported positively about the interventions and there were some positive changes in individual intervention sites. However, the overwhelming finding was of very few differences between the groups and no difference in out-of home placement. Any differences at the end of the intervention (3 months) had disappeared by the 12 month follow-up.

Overall, it can therefore be concluded that evaluations that used randomized controlled trials with a control group found that Family Preservation services – including Homebuilders – *did not tend to have any impact on the likelihood of children entering public care and that as a result they did not tend to have any economic benefit*. Specifically they found:

- Placement rates of children into care No differences

- o Functioning of children and families — No differences
- o Length and intensity of intervention — No differences

The exception to this generally negative picture was services targeted at young people with difficult or criminal behaviour (discussed further below).

1.3.4 Questions about IFPS and research showing lack of placement outcomes

The reviews discussed above – combined with the DHHS (2002) study - established a general consensus that, at least as practiced up to the mid-1990s, IFPS did not "work" and they raised serious questions about whether brief and unspecified interventions were likely to be effective with such chronically stressed and multiply disadvantaged families. This certainly appeared to be true for the need for children to enter care, but also seemed to apply to child welfare and family functioning outcomes.

As Selwyn and Sturgess (2000) concluded in reviewing approaches to the care system in the United States of America:

> "In the late 1990s, family preservation was increasingly questioned and seen as ineffective and unresponsive to the needs of families with chronic problems and children at risk of being looked after by the state. Research on outcomes for children showed that, particularly for families where maternal drug addiction was the cause of concern, family support services were not working. It should be noted that one model (Homebuilders) had come to dominate the family support offered and its failure to deliver should not be seen as a failure of the whole of family support services."
> Selwyn and Sturgess, 2000, pgs 2-3

In response to these problems a number of important issues have been identified in the literature about the effectiveness of IFP and of the research on IFP:

1. The children referred to IFP services were not in fact at "high risk" of coming into care.
While a high proportion of children receiving IFP services do not come into care, an equally high proportion of those in control groups not offered services do not. This suggests that in fact these children were not at high risk of entering care (Epstein, 1997; Gelles, 2000). This is a crucial issue influencing the findings, and is discussed further below.

2. Lack of information on interventions for control or comparison groups.
Few studies provide much evidence on the inputs for the control groups. Most will have received ongoing social work services, and in many instances these may have shared many of the characteristics of an IFP service. This is a major problem with the literature. It is possible that IFP does "work", but that other ongoing services offered also work.

3. Failure to specify the process of the intervention.
The specification of Homebuilders focuses on the structure of the service (i.e. brief and intensive) rather than on the process (i.e. the specific nature of the interactions). In practice IFP services provided in different projects or even by different social workers in one agency, vary considerably. What is often being evaluated is therefore a mixture of interventions, provided within a "crisis intervention" framework. This is a fundamental

problem of the outcome oriented research in this area. As a result it is difficult to be certain exactly *what* is being evaluated (Nelson, 1997).

Amazingly, none of the studies provide evidence on monitoring the program integrity of what is supposed to happen in the interaction between therapist and client. (This would now be an expectation of most RCTs). It is thus difficult to be sure what social workers are trying to do and whether they are doing it well. In some of the projects where there was training offered for therapists, it was very limited (e.g. 5 days) without ongoing supervision to support implementing new practices, without ongoing consultation for problem solving with real cases, and without site visits to directly observe and monitor the specific practices of the social workers. Thus, there must be some doubt about whether the "intervention" is being carried out skilfully.

In recent years different parts of the US government have compiled lists of interventions supported by a rigorous evidence base (e.g. Office of Juvenile Justice and Delinquency Prevention (OJJDP), 2007). Two IFPS are identified as evidence based, one based on functional family therapy and the other on multi-systemic family therapy. Both have had multiple randomized controlled trials which show that severely acting out, court involved adolescents can be deterred from "corrections" and prisons by IFPS. Interestingly, neither is either as intensive or as short-term as the "homebuilders" model. Recent publications of studies using these approaches have shown that even with extensive training and monitoring of the specifics of the implementation process, the replication sites are showing widely varying outcomes. By ongoing evaluation of the replication sites and feedback from those sites, the program developers are creating additional structures for training and monitoring to increase local impacts. Their published research details what happens during the intervention, and illustrates the importance of ongoing training, evaluation, feedback and monitoring to maintain the high levels of program impact for their versions of IFPS (see OJJDP, 2007).

Their ongoing research sheds new light on the 20 year old debate about what works within IFPS. The actual process of the intervention as delivered – often referred to as "the black box" as its contents are not explored - must be specified. In addition, direct observation, monitoring, training, and evaluation needs to be part of the system in order to achieve outcomes from evidence based social work.

4. Lack of fidelity to service definition.
A related issues is that many of the projects developed practices that differ from those on paper, such as keeping families on waiting lists. It is also possible that as the model was used more widely it was often watered-down, thus making any genuine impacts difficult to detect.

5. Mismatch of intensive intervention with chronic and multiple problems.
IFP services were originally developed more than 20 years ago, based on a "learning theory and crisis intervention" model. Since then the knowledge about effective practices has changed. Best practices for addressing specific presenting problems have evolved, including maternal depression, domestic violence, substance misuse and serious mental illness. At the same time the families being referred to IFPS are not the families for whom the Homebuilder intervention was developed. Most of those being referred appear to have chronic stresses and long-term challenges, rather than being in a crisis. Learning effective parenting strategies are important, however most of the families are experiencing significant social pressures, such as extreme poverty, which is

outside the domain of this intervention. In addition, complex personal difficulties, such as mental illness, depression, or domestic violence (Keegan-Eamon, 1994; Staudt and Drake, 2002) need evidence based interventions that are targeted towards those specific needs. The originator of Homebuilders, Haapla, has stated that there has been a move to provide the intervention to chronic problems – such as, he states, substance misuse – for which it was not originally designed.

6. Criticism of family preservation as a goal.
There has been increasing criticism of family preservation as a goal (e.g. Brydon, 2004; MacDonald, 1994). It is claimed that IFP has been associated in some cases with a failure to protect children from harm, and that a small number of children have died who would have been protected. It is now broadly agreed that the focus should be on child welfare. Family Preservation has a part to play in this, but should not be seen as a goal in its own right. Rates of entry into care are therefore not an adequate outcome measure. This important change in focus creates new challenges, discussed below.

1.3.5 Studies between 1995 and 2006

In light of these generally negative findings researchers continued to explore the reasons for the poor results of evaluations of IFPS. Furthermore, the proponents of IFPS developed and evaluated new types of services. We have identified 42 studies published between 1995 and 2005 providing empirical evidence in relation to IFPS, plus a further 10 theoretical articles.

In this section, we review the following areas:

a) The challenge of defining imminent risk of care and the timing of the referral process to IFPS;

b) Whether delays in placement are a good outcome;

c) The characteristics of successful or unsuccessful programmes;

d) Adaptations or new ways of doing IFPS that appear potentially successful;

e) Information relating to parental substance misuse.

a) The challenge of defining imminent risk of care and the timing of the referral process to IFPS

A key area of interest, given the low level of care entry amongst children in the “control” groups, is understanding the processes involved in making and receiving referrals. Denby and Curtis (2003) shed light on this through a survey of 500 randomly chosen family preservation workers and an analysis of policies and procedures for 368 programmes. They found that most programmes do not explicitly target special populations and that 93% of the workers had never refused a referral on the basis that it did not meet their eligibility criterion. This strongly suggests that most IFPS are accepting virtually all referrals they receive with little attempt to target children at high risk of care, or indeed those children whose families may appropriately benefit from a short term, intensive intervention.

A similar conclusion can be reached from the findings of a study by Hayward and Cameron (2002). Hayward and Cameron compared (through questionnaires to social workers) families in which workers had recently placed a child in care and those which they had referred to one of 4 IFPS programs. About 40% of the children who had been placed in care were rated as eligible for the IFP program by the social workers, while half of the children referred to IFPS were not rated as at short-term danger of having a child placed outside the home – despite the fact that they were all described in this way in the referral to the service. Furthermore, referrers were actively hostile to the idea of referring children at high risk to the IFPS if they believed a child should be placed in care – whatever official policy stated. There was also evidence of the services changing from their theoretical specifications, for instance some had started waiting lists. Children should not be placed on waiting lists if they are at imminent risk. Furthermore, waiting lists are not appropriate for crisis intervention services. In the Australian context Campbell (2002) reported similar difficulties in ensuring that both referrers and agency workers operated the referral processes specified.

b) Whether delays in placement are a good outcome

Kirk et al (2000) and Kirk and Griffith (2004) compared the risk profile of children receiving IFPS with very large samples of children within child welfare services generally. Kirk et al concluded that when risk factors were allowed for IFPS had a significant impact in preventing placement. This was interpreted as a positive outcome, however by 12 months after the service most of the positive difference had disappeared. Kirk et al argue that this suggests follow-up "booster" sessions might be appropriate. However, this also highlights a possible concern about IFPS: even if they are "effective" there is the possibility that IFP *delays* children coming into care rather than *preventing* it. For younger children, in particular, this might be a harmful outcome.

c) The characteristics of successful or unsuccessful programmes

The service provided on paper may vary from that which families actually experience for two main reasons. First, the service may say that it uses a particular model, such as Homebuilders, but has in fact developed significant variation from the Homebuilders model. Second, even where a service appears on paper to be consistent with a specific model, the actual service delivered to clients may differ in important ways from the theoretical specification. Much research has looked at whether variations between services are associated with different outcomes.

A research review by the Washington State Institute for Public Policy (Miller, 2006) provides empirical evidence on the issue of delivering the Homebuilder model with or without fidelity to the programme. This report is not published in an academic journal, and some aspects of the study design – such as the ways in which studies were identified for inclusion – are not made explicit, however the report states that only those using "rigorous experimental designs with control groups" were included. The authors review studies purporting to be based on the Homebuilders model and examines the relationship between outcomes and the extent to which studies meet 16 aspects of the definition of the Homebuilders model. Fourteen studies were identified. Four documented 13 or more of the Homebuilders characteristics while the remaining 10 documented no more than 5 characteristics of the model. Comparison of placement outcomes between those sites which implemented the model with program integrity contrasted significantly with those which did not. Their data suggested that Homebuilders interventions reduced out-of-home placement by 31% while non-Homebuilders had no impact.

Ten Brink et al. (2004) examined the issue of the relationship between the intervention in theory and in practice. They carried out research on a project called Families First (based on the Homebuilder's Model) intensive family intervention project in the Netherlands. The activities of workers were monitored through questionnaires completed after each contact with the family. Based on these they concluded that workers carried out the therapeutic aspects of the programme but did not provide the practical and material help set out in the theoretical model of practice. The reliance of this study on self-reported data is a clear limitation. Nonetheless it highlights that what happens in theory and in practice in an intervention may be very different. This adds a further layer of complexity to evaluating such interventions.

Even in services offering only one model – Homebuilders - and in projects supposed to be true to the original model, there is a lack of clarity about the nature of the intervention in practice. For instance, therapists are now allowed to use a range of methods in their work with families. These need to be specified and monitored as adaptations. This makes comparison of sites and rigorous evaluation difficult. A focus for a number of studies has been to try to identify the key elements of the programme that make a difference.

Bagdasaryan (2005) looked at 488 families that had received a service from the Los Angeles Family Preservation Program. This program was modelled on Homebuilders but the length of input was considerably longer, with families receiving intervention for an average of 3 to 6 months and some for much longer. Bagdasaryan was interested in what factors were associated with positive outcome (defined as completing programme and children remaining at home). Key factors associated with positive outcome were: two parents in family; having had a prior child in care; participating in counselling; not receiving mental health services. The frequency of worker visits was not significant, but the longer the period of work undertaken the greater the likelihood of a successful outcome. Berry et al. (2000) similarly found, in a single sample pre- and post-intervention design, that shorter duration of service was associated with poor outcomes.

In contrast, Littell (1997) looked at the impact of duration, intensity and range of services provided to 1911 families in IFPS. She found that duration and intensity had no impact on outcomes. She argued that the quality of the intervention was likely to be more important than these service characteristics. This is important because much of the definition of IFPS has focused on the duration and intensity rather than process within the client/worker interactions. Littell and Schuerman (2002) similarly found no characteristics of services or families that predicted outcomes.

Littell explored these issues further in an important later paper (Littell and Tajima, 2000) in which she looked at 2246 families who worked with 64 different IFP agencies and focused on factors associated with parental collaboration (their agreement with plans) and compliance (extent to which they kept appoints and completed tasks). Littell and Tajima found substance misuse, mental illness, neglect, inadequate housing, having had a child at a young age and being an ethnic minority were associated with reduced participation in treatment. Perhaps more interestingly, there were also aspects of services associated with greater compliance and collaboration, the most important of which were:

- strong supervision for workers,

- job clarity,
- worker autonomy

It is interesting to note that the factors associated with greater "compliance" in parents all related to the way in which the service was set-up and managed. In addition, workers with a "deficit orientation" obtained less collaboration. Littel's work points to an important finding in relation to IFPS. In essence the structure of the intervention may be less important than the quality of the relationship. Put another way, it would appear that "it ain't what you do, it's the way that you do it" that can make the difference between successful and unsuccessful IFPS interventions.

d) Adaptations or new ways of doing IFPS that appear potentially successful

In response to these findings some studies tried to focus more clearly on genuinely high risk cases. An important study of such a response was undertaken by Blythe and Jayaratne (1999). They evaluated a service targeted at children at imminent risk of care entry. Children were randomly assigned either into foster care or IFP following a decision by a court that foster care would be necessary if IFP was not provided. At 12 months 93% of the IFP children were living at home compared to 43% of those who received foster care. Even more importantly, indicators of school performance and contact with police indicated little difference between the groups, suggesting that children were maintained at home without obvious harm to their welfare.

Walton (1997) reported on a service in which IFP workers worked closely with child welfare social workers around assessing the family and helping in decision-making. She measured service outcomes for 69 families and a control group of 65 families. Families who received IFPS had fewer children in care and were more likely to have a case closed. This suggests some promise in combining assessment and intervention functions, though an important limitation in the study is that there was no direct measure of family welfare. There were however indications from interviews with parents and others that the IFP had had a positive impact.

Lewis (2005) did a randomized controlled trial for an IFPS aimed at offending adolescents. They found that there were significant improvements for the IFPS in child and family functioning, vs. the others. Lewis found an improvement in behavioural problems including offending behaviour and a significant positive impact on family functioning and child behaviour at 8 to 10 months. This contributes to a consistent body of work indicating that positive outcomes at both the level of child welfare and service outcome are considerably more likely with families in which a child has behavioural problems including offending behaviour.

e) Information relating to parental substance misuse

The outcomes of IFPS with families in which PSM is an issue are of particular significance for Option 2. A number of the studies above noted PSM as an issue associated with lower likelihood of positive outcomes, and this also arose as an issue in some other studies not explicitly discussed (Unrae, 1997). There were only four studies of an IFP project aimed specifically at families in which there was documented parental substance abuse, and these were primarily descriptive. None had a control group.

a) Dore et al., (1998) looked at the profile and outcomes in 138 families attending one service. The service was provided over an 8 month period, highlighting that it was working with a very different model to most of the IFP programmes. A striking feature of the sample for a British audience was that every single carer was African American, 77% were lone parents and 96% lived on public assistance. Families were referred for suspected abuse or risk of abuse rather than substantiated maltreatment – suggesting that the profile was predominantly "low risk". Only 44% of the sample completed treatment and remained sober for 12 months. The most important predictor of whether parents completed treatment and maintained sobriety was whether they had previously successfully undergone treatment. In addition, those who only misused alcohol and those whose substance misuse was more recent had more likelihood of completing treatment. However a range of other factors were better predictors of whether a child would enter care than whether the parent completed treatment. In particular, children were more likely to enter public care when the mother was younger, never married, living alone, the more children there were, when other children were in care and if the family had been known to child welfare services for more than 12 months.

b) Carten (1996) studied IFPS for mothers in recovery from addiction. She interviewed 20 mothers who had successfully completed a programme. The women supported the finding that the style of intervention was important. They found confrontative approaches unhelpful and noted that they increased feelings of guilt, low self esteem and shame. In contrast, they found the style of intervention in the programme had been helpful, with an emphasis on positive relationships and building strengths. The women reported that the threat of the child being removed provided the spur for them to successfully complete treatment.

c) Gruber et al (2001) studied a service offering a "blended" model of IFPS and "substance abuse recovery" work for families in which a child was at risk of removal and a parent had just completed intensive drug or alcohol treatment. They provided three case studies but little other empirical data. Gruber et al highlighted the lack of IFPS for families in which PSM was an issue and suggested that such families need long term support.

d) Brydon (2004) considered IFPS and characteristics of families for whom this was not an appropriate intervention, and concluded that among other chronic issues, parents with substance misuse may not match with a short term intensive approach.

1.3.6 Conclusions from more recent studies

IFP is effective in preventing adolescents with behavioural problems and/or "delinquency" from entering care. In the USA Federal review of early intervention and prevention programs to identify evidence based practices have been conducted in for the past ten years. In order to achieve the top level ranking, randomized controlled trials with one year follow-up are required. Two IFP approaches have achieved the top rankings: Multi-systemic family therapy and functional family therapy interventions appear effective with adolescents to keep them out of corrections. Several randomized controlled trials by Scott Henggeller et al and by Alexander have supported the use of systemically informed, family interventions to keep adolescents already involved in the court, out of the prison system. Cost effectiveness studies have been conducted on these approaches and found them to save money by avoiding very costly placements within the prison or "corrections" system. Because they were not focused on children identified as being abuse and neglected, they were not reviewed in detail in the present

context. However, lessons from these evidence-based IFP programs are that replication sites must invest heavily in:

- training,
- ongoing consultation and,
- ongoing evaluation,

To continue to produce positive impacts.

When young children are referred based on child abuse investigation as a direct alternative to entry into care (e.g. at the start of care proceedings or when referred to foster care) IFP *may* be able to demonstrate an ability to prevent the need for some of the children to enter care. However, for such a service to work relatively high risk children need to be kept in their family environment. This may contribute to the reluctance of social workers to refer such families. It certainly emphasises that the goal of such interventions should be child welfare; family preservation should only be one way of achieving this goal.

Considerable attention has been paid to the intensity and duration of the service. Findings in this regard are contradictory, with several studies finding no relationship between outcome and the length of the service or amount of contact. There are indications that more important than intensity or duration is the spirit of the service. Services with a collaborative approach, in which parents are involved in setting goals, appear to engage and retain parents better in the service and this is associated with better outcomes.

1.4 British interventions using an Intensive Family Preservation model

Following the positive early evaluations of IFPS in the US, interventions based to varying degrees on the "homebuilders" model have been tried in the UK. Option 2 is perhaps the first and best known of these, but evaluations of similar interventions in Lincolnshire and Tower Hamlets have also been carried out (Brandon and Connolly, 2006; Bifulco et al., 2002).

Brandon and Connolly (2006) report on an evaluation carried out of an IFPS service between 1998 and 2001. Brandon and Connolly compared 57 families who received the service with 29 who did not. The number of children is not noted. Families did not receive a service either because they did not wish to have the service (7), because they dropped out of the programme (8) or because the service was full (14).

Brandon and Connolly collected information through a combination of file information and interviews with "family members", project workers and some referrers at referral and one year after the intervention. They found that for families receiving the service there was an increase in the number of children entering care (22% had had children in care at the time of the referral compared to 35% one year later). This increase was similar to that for the "comparison" group (which went from 20% to 40%).

Brandon and Connolly themselves note that the families in the "comparison" group can not be considered a control group, though it would seem more true to say that they are not a valid comparison group. Families that dropped out of the programme and those that did not wish to use the service are likely to have very important differences to either those who received the service or the 14 who did not receive the service only because it

was full. This makes it virtually impossible to interpret the increase in the proportion of children entering care. One would expect some increase in care entry – as no service works for everybody. The challenge is to identify the relative impact of the service, and for this a valid comparison group is necessary. It is interesting to note, however, that Brandon and Connolly felt that when children entered care who had been through the service, the care entry was more likely to be planned and purposeful. This is only impressionistic evidence, but it does highlight that even similar levels of care entry may mask important differences between children.

Of more interest are Brandon and Connolly's qualitative findings on the impact of the service and its relationship to whether children entered care. They retrospectively divided families into those in which there was "lasting improvement", those which showed "initial improvement" but there continued to be concerns and a "no apparent change" group. Brandon and Connolly suggest that families in the latter two groups were often not in acute crisis at the time of referral. Qualitative data was very positive about the intervention itself, though both family members and professionals suggested that a longer period of involvement might have been helpful for some families.

Bifulco et al (2002) describe an intensive family preservation service aimed at adolescents. The programme varied from the strict Homebuilders model in important ways. Firstly, the service took on average 7 days to engage families and secondly, there were only 11 contacts on average in 6 weeks, so it was less intensive than most Homebuilders interventions. Bifulco et al followed-up 33 families and looked at their success in achieving the goals they had identified. There was no comparison group. A high proportion of goals identified by families themselves were achieved (92%) and families were generally positive in their feedback about the service. There was no information about the impact on care entry.

1.5 Lessons from the review of the evidence

1.5.1 Lessons for research and evaluations:

- Virtually no British studies use control or even comparison groups in evaluating social work interventions in children's services. The IFP literature illustrates clearly both the importance of control groups and the ethical and methodological difficulties of establishing genuine control groups in the real world.

- An understanding of the context within which interventions occur – including patterns of referral and informal processes – is crucial to effective evaluation of the service.

- Any study of IFP needs to describe in detail the nature of the intervention. In most of the older studies and too many of the recent studies this was left unexplored, and this makes drawing conclusions from findings difficult. Similarly studies should be able to provide information on services received by the control group. This is almost completely absent from the literature.

- Outcome measures of services aimed at preventing children entering care should focus, as much as is practicable, on child and family wellbeing using standardized instruments with established validity and reliability, not solely entry into care.

Recommended instruments for example, include the SDQ, Strengths and Difficulties Questionnaire, (Goodman, 1994) which is short (only 30 questions), available on the web, developed in Britain, and free.

- Full evaluation of even care entry as an outcome should be done with a long follow-up period. It is possible that IFP services *delay* entry into care. This may have a harmful effect for children and be costly in the long term.

1.5.2 Lessons for developing services to prevent children entering care (with a particular focus on Option 2):

- IFP services – such as Option 2 – should not be seen as "stand alone" services. To be effective they need to work closely with referrers to assure appropriate referrals are being made.

- IFP services –such as Option 2—should implement the core components which are determined by research to be evidence based, but not be rigid. Option 2 or any other IFP should not be a fixed model, which cannot adapt to new challenges and new research results, but neither should it be allowed to develop in an unexamined or unhelpful manner according to local custom and practice. Rather IFPS should be developed as "learning organisations". This involves:

    - Social worker and therapist concerns and ideas should be actively solicited,
    - Ongoing process and outcome evaluations should be conducted,
    - New developments should be encouraged and evaluated,
    - Quality assurance structures should include ongoing review and training
    - Feedback loops should include referrers and service users.

- A crucial element in doing this successfully is a common understanding between the service, social workers and social work managers about risk and risk management. Research suggests that social workers are reluctant to refer children at imminent risk of harm, yet to prevent children entering care these are the very children the service should be working with. There needs to be managerial recognition of and support for this from within children's services. The intensive service provided by services such as Option 2 is in part aimed at providing a method for managing high levels of risk; however, this needs to be understood and accepted by social workers and managers.

- Evidence on the optimum length of the intervention is contradictory. However, more important than the length or duration of the intervention is the spirit in which it is offered. Collaborative and respectful approaches appear to engage parents better and produce better outcomes. Such a philosophy is at the heart of the Option 2 intervention.

- The process of the intervention, that is what specifically is done by the practitioner, is the key to the effectiveness of psycho-social interventions. The exact methods used within the intensive intervention need to be specified and monitored to optimize outcomes. Research indicates that outcomes are related to the evidence base of the strategies used. The Option 2 use of Motivational Interviewing appears particularly

appropriate for this client group, and is an evidence-based therapeutic process. On the other hand the focus on substance misuse suggests that Option 2 may be working with an issue that IFPS have had low success with.

- Intensive family services aimed at teenagers with court involvement resulting from delinquent behaviour, using a multi-systemic family therapy approach have the best evidence base for reducing the need for public care in the USA. The research suggests the critical importance of ongoing training and clinical supervision.

1.6 Conclusion and Recommendations

The generally negative findings about IFPS do not mean that it is not possible to develop effective services to prevent children entering care. However, the research highlights the danger of over-enthusiasm about insufficiently tested models. There is no "magic bullet" that will prevent the need for children to enter public care. At best it may be possible to develop services that are able to stop some children from entering care by significantly improving their family situation. A good example of this is the more clearly specified area of families in which young people are repeatedly breaking the law. More recent randomized controlled trials of multi-systems intensive family approaches show positive outcomes with youth justice adolescent populations. This is important: the generally negative findings about IFPS do not contradict the evolution of the approach to specific populations with specific strategies to prevent children entering care.

It may therefore be most useful to develop and evaluate specified IFP interventions aimed at improving the welfare of children whose families are chronically experiencing difficulties, and thereby hoping to reduce the need for some to enter public care. A crucial part of such an approach is to move away from the overly simple question of whether an IFP service does or does not stop children from entering care. The following questions may be a more appropriate place to start:

- What is involved in this intervention? (In theory and in actual practice)
- Does it improve children's welfare and family functioning? How?
- Which children and families does it work best with?
- Which children and families does it work less well with?
- How can we improve the service using the above information?

Once we have answered these questions we can consider more usefully whether the intervention reduces the need for public care – or indeed whether it makes other savings, such as reduced costs to the education and criminal justice systems. It is precisely these types of questions that the current evaluation of Option 2 aims to answer. As such, we hope it will make a significant contribution to the development of services to prevent the need for some children to enter public care.

2. QUANTITATIVE ANALYSIS OF OUTCOMES

2.1 Method

2.1.1 Data

Option 2 staff provided the local authorities with lists of all children referred to the service between 2000 and September 2006. This included those who received a service and those who could not be provided with a service because there was no therapist available (the comparison group). The local authorities provided information on the dates of any placements in the care system for the children from their administrative records, plus information on the typical costs for different types of placements (Cardiff) or the actual costs of the particular placements (Vale). This information was then combined with some basic information from the Option 2 referral sheet on the type of substance misused and the nature of the crisis within the family. The information from the referral sheet included:

- Date of referral
- Number of children in family
- Age of child at referral
- Types of substances used (alcohol, heroin, amphetamine, other drugs)
- The nature of the "crisis" (i.e. possibility of the child protection register, possibility of accommodation or child in care)
- Whether child was on the Child Protection Register (CPR)
- Whether child was subject to interim care order
- Family structure (Both parents/Mother/Father/Other)

The data from the local authorities allows investigation of the impact of Option 2 on five outcome variables:

- Whether a child enters care
- Whether a child is in care at 31.12.06 (on average 3.5 years post-referral)
- Whether a child is at home on 31.12.06 (this differs from not being in care, because children leave care to be adopted, placed in the wider family or to live independently)
- The number of days from referral to care entry
- The number of days in care
- The average cost of placement in care for children in each group

For a small number of children a referral when there was "no space" (and therefore the child would enter the comparison group) had subsequently been followed by a referral in which there was Option 2 input. These children were excluded from the comparative analysis. Families receiving consultation were excluded. Two "doubles" identified through comparison of dates of birth, referral dates and other information were excluded.

2.1.2 Statistical analysis

In order to examine whether the outcomes in Option2 are significantly different from those of the Comparison group, we carried out our quantitative analysis in three stages. First, we ran frequency tables to see the patterns and distribution of the data. Second, chi square or t-tests were carried out to see whether these distributions were independent of whether the children were in the Option 2 or the comparison groups. The third step involved running a multivariate analysis of outcome variables controlling for

characteristics that were found to be significantly different in Option2 and No-space groups in earlier stages of the analysis. We used stepwise logistic regression for dichotomous variables (e.g. whether the child entered care) and stepwise linear regression for continuous data (e.g. costs). Where the distribution of a variable was not linear, the tests were conducted on transformed logarithmic scales. A non-parametric test (Mann-Whitney U-test) was also carried out to confirm the findings. Finally, we plotted costs, time to care and days in care against each other in each intervention type to see whether specific patterns emerged.

2.1.3 Limitations and methodological considerations

First, the cost comparisons have a number of limitations. One is that one local authority provided costing for each placement from their records, while the other could only provide average costs for the type of placement the child was in (e.g. if a child was in a local authority foster placement then the average cost for that type of placement was given). A second is that – in common with almost all local authorities – only the direct costs were provided i.e. the money paid to the providers of the placement. This excludes costs for finding and supporting placements for internal providers but includes such costs for external providers. Thus the full cost of internal placements tends to be underestimated. While both these sources of variance mean that that figures are not accurate in absolute terms, there is no reason to believe that they led to distortion between the Option 2 and comparison groups.

Second, the analysis is only of care data and the costs of care. This does not provide information on child welfare, family functioning or other important issues. It also does not include other costs, for instance related to crime or education or even the cost of future social work input.

Third, central to the validity of the analysis is that the Option 2 and comparison groups were comparable. This issue is explored empirically below, but it is worth emphasising that any formal or informal processes that led to differences would influence the whole comparison.

Fourth, the decision to place a child in care is not an objective measure of the risk to them. It is a complex social process mediated by a social worker and other professionals. Thus “care entry” might be influenced by whether children have been offered the Option 2 service. For instance, if at some point after Option 2 were involved there was a crisis the social worker might react differently than they would if the family had not received Option 2.

Fifth, it is important to emphasise that the Option 2 group included families assessed as inappropriate *who did not receive the service*. This is appropriate methodologically because we can not know which families in the comparison group were in fact not appropriate. However, this will reduce the impact of Option 2. In effect, 16% of the sample who did not receive the service are being included. (A method that assessed whether families were appropriate or not and *then* randomised them to receive the service or not would be better for evaluation, though ethically and practically difficult). This makes it harder to show an impact from Option 2.

Finally, it is important to bear in mind that the families in the comparison group will be receiving other services and interventions. This is discussed further in the section exploring the views of referring social workers. It means that this analysis is not of

"Option 2 compared to nothing" it is of "Option 2 compared to a range of other services". A number of these services provide input of equivalent or greater cost than Option 2. Again, this makes it harder for Option 2 to demonstrate a positive impact.

2.2 Findings

A total of 367 children were referred to Option 2 during the data collection period. Of these 278 (76%) received a service and 89 (24%) entered the comparison group. The average time between referral and the follow-up date was 3.5 years, however there was very wide variation (from 104 days to 6.5 years). There was no statistical difference between Option 2 and comparison children (1269 days vs. 1248).

2.2.1 Were the Option 2 and Comparison groups comparable?

The Option 2 and Comparison groups were compared on the variables identified in referrals (see Table 2.1). This was done both through bi-variate analysis (unadjusted) and multivariate analysis (i.e. taking account of inter-relationships between variables to provide the adjusted significance; non-significant variables are removed).

Table 2.1 Comparison of Option 2 and comparison groups at referral

		Comparison Group		Option 2		Unadjusted (bivariate) significance	Adjusted significance
		n	%	n	%		
	Cardiff	53	59%	187	67%	0.184	**<0.001**
	Vale	36	40%	91	33%		
Substance	Alcohol	45	51%	171	61%	.062	**.006**
	Amphetamine	9	10%	47	17%	**.042**	**.036**
	Heroin	31	34%	65	23%	.314	
	Other drug	6	7%	29	10%	**.050**	**.026**
Presenting crisis	CPR	32	36%	92	33%	**.042**	
	Accommodation possible	47	53%	177	64%		
	In care at referral	9	10%	9	3%		
On CPR	On CPR	26	29%	119	43%	**0.022**	
Family Structure	Two parents	39	43%	134	48%	n/a	
	Mother only	19	21%	109	39%	.085	
	Father only	31	35%	12	4%	<0.001	**<0.001**
	Other	0	0%	23	8%	n/a	
	Care Order	8	9%	35	13%	0.359	
	Child age	6.1 yrs		7.3 yrs		.319	
	Number of children	2.6		3.4		.133	

The analysis identified some significant bivariate differences, however the main differences between the groups were a tendency for all substances other than heroin to be more prevalent in the Option 2 group, a strongly significant relationship between "father only" families and the comparison group and a strong relationship between which local authority children were from and the comparison group. It is possible that the increased reporting of alcohol, amphetamine and other substances is related to recording issues rather than genuine between-group differences. There was a statistically significant tendency for more substances to be noted on Option 2 referrals. One might hypothesise that workers take more detailed information on referrals that they know they have space to work with. This would leave the over-representation of heroin misuse amongst the comparison group as a difference that requires explanation.The strong relationship between "father only" referrals and the comparison group requires further analysis.

The statistical significance of which local authority a child was from suggests that this factor has a major impact on the nature of the comparison group and its comparability with Option 2 children. This therefore needs to be explored further. This is particularly important because in the analysis of social workers' questionnaires (reported on in part 5) it became apparent that the respondents in the two local authorities appeared to have very different relationships with Option 2. The respondents in the Vale described a close and informal relationship, and mentioned discussing referrals prior to making them. Respondents in Cardiff generally had considerably less knowledge of Option 2 and did not mention discussing referrals informally. Whatever the strengths or weaknesses of these different relationships, from a research point of view they open up the possibility that the composition of the comparison group in the Vale may be influenced by these informal discussions. This could lead to it being non-comparable to the Option 2 group. When combined with the statistical impact of "local authority" on the findings, this makes an analysis of the composition of the comparison group for each local authority important. In tables 2.2 and 2.3 the analysis of factors that differentiate between Option 2 and comparison groups is carried out separately for each local authority.

The figures for Cardiff identify the distribution of alcohol, heroin or amphetamine use and lone father families as different between the two groups. It is only possible to speculate why these might be systematically different. The higher identification of alcohol use may be a recording issue (as discussed above). The pattern of referrals of lone father families is high, compared to what might be expected and to the Vale. It is possible that this may be related to the presence of a male worker, though it is not possible to identify why these referrals would be particularly likely to be in the comparison group. While amphetamine use and father only families are not evenly distributed between the groups in Cardiff, and they are therefore highly significantly related to whether children are in the comparison group or not, their impact on the overall comparability of the groups is limited by the fact that both are present for only about 15% of children.

In contrast, in the Vale there are fewer variables that have a significant difference between the two groups – but one of them (the nature of the crisis) is very important. Comparison children are more likely to have heroin misuse identified and to be younger, and they tend to present with a more serious "crisis". It is also noteworthy that every substance is more common in the comparison group. This suggests a pattern of referrals that are mediated by informal processes; specifically, it would appear to confirm the feedback from social workers that they tend to discuss cases informally before making referrals. The impact of this is that in effect "lower risk" cases, such as those that involve

less of a presenting crisis, may be "weeded out" through informal discussions when there is comparison. In contrast, an acute crisis may be referred without waiting for the opportunity for an informal discussion. As a result, the comparison group has fewer low risk or non-pressing cases; the Option 2 group includes a mix of high risk/pressing cases and less immediately concerning referrals agreed following informal discussions.

Table 2.2 Comparison of Option 2 and comparison groups at referral in Cardiff

		Comparison Group		Option 2		Unadjusted (bivariate) significance	Adjusted significance
		n	%	n	%		
Substance	Alcohol	28	53%	113	60%	.015	**.006**
	Amphetamine	1	2%	32	83%	.001	**<0.001**
	Heroin	20	38%	54	29%	.021	**.012**
	Other drug	3	6%	13	7%	.950	
Nature of crisis	CPR	19	36%	40	21%	.361	
	Accommodation possible	31	60%	144	77%		
	In care at referral	2	4%	3	2%		
On CPR	On CPR	20	38%	87	46%	.615	
Family Structure	Two parents	20	38%	97	52%	n/a	
	Mother only	5	9%	58	31%	.080	
	Father only	28	53%	11	6%	<0.001	**<0.001**
	Other	0	0%	21	11%	n/a	
	Care Order	4	7%	26	14%	.748	
	Child age	6.84		7.14		.599	
	Number of children	2.70		3.67		.663	

For the validity of the research these differences are crucial. In broad terms the similarities are greater than the differences between the groups. However, in examining the outcomes related to public care the variables identified as significant in the above tables are included in the statistical analysis. This allows differences between the Option 2 and comparison groups to be identified and allowed for to some degree. In addition, outcomes will be compared between the two local authorities. Finally, in considering the significance of the results the possibility that they are due to the nature of the comparison group is considered as appropriate.

Table 2.3 Comparison of Option 2 and comparison groups at referral in Vale of Glamorgan

		Comparison Group		Option 2		Unadjusted (bivariate) significance	Adjusted significance
		n	%	n	%		
Substance (yes/no)	**Alcohol**	19	53%	33	36%	.702	
	Amphetamine	8	22%	15	16%	.528	
	Heroin	11	31%	11	12%	.116	**.040**
	Other drug	3	8%	16	17%	.373	
Nature of crisis/threat	**CPR**	13	36%	53	58%	.007	**.006**
	Accommodation possible	16	44%	33	36%		
	In care at referral	7	19%	6	6%		
Family Structure	Two parents	19	53%	38	41%	n/a	
	Mother only	14	39%	51	55%	.258	
	Father only	3	8%	1	1%	.233	
	Other	0	0%	2	2%	n/a	
On CPR (yes/no)	**On CPR**	6	17%	32	35%	.208	
	Care Order	4	11%	9	10%	.537	
	Child age	5.06		7.56		.722	**.010**
	Number of children	2.56		2.80		.129	

2.2.2 What happened to the children overall?

Information on the outcome measures for the whole sample is set out in table 2.4. It can be seen that 4 in 10 children entered care, though only a quarter were in care at the end of the study. Just under two-thirds of children were at home at the end-point. On average by the end of the study the children who entered care had spent almost a year there (353 days). The average cost of care (including the 60% who did not enter care) was £13,802 per child; however there was a very large variation in average costs. For instance, 35 children cost more than £50,000 and four cost more than £100,000. These figures suggest some important issues in analysing the data. In particular, a small proportion of the children account for the bulk of the cost to the care system. This issue is returned to below.

2.2.3 Did Option 2 make a difference to the likelihood of care or its cost?

Table 2.5 compares the outcome measures for the Option 2 and comparison groups. It can be seen that there was virtually no difference in rates of care entry. An important point to note is that most of those who did not receive the Option 2 service remained at home. This suggests either that many of the referrals were not at high risk of care entry or that other effective services were put in place to prevent care entry (or a combination).

Table 2.4 Outcome variables overall

Variable	n	Mean or %	SD
Entered care?	149	41%	
In care at 31.12.06?	98	26%	
At home at 31.12.06?	239	65%	
Days in care		353	547
Days to care entry		213	354
Number of placements		1.5	2.5
Cost of placements (£)		13,802.95	33,618.79

To allow for potential differences between the groups at the point of referral, a multivariate analysis of outcome variables controlling for characteristics that were identified at the time of the referral was carried out (table 2.5). This found that there:

- *Was **no significant relationship** between the Option 2 intervention and:*
  - *the likelihood of children entering care;*
  - *the total cost of placements in care per child*;
  - *the time it took for children to enter care*.
- *There **was a significant relationship** between Option 2 and:*
  - *Children spending less time in care;*
  - *Children being less likely to be in care at the end date;*
  - *children being at home at the end date.*

Table 2.5 Outcome variables compared between Option 2 and Comparison groups

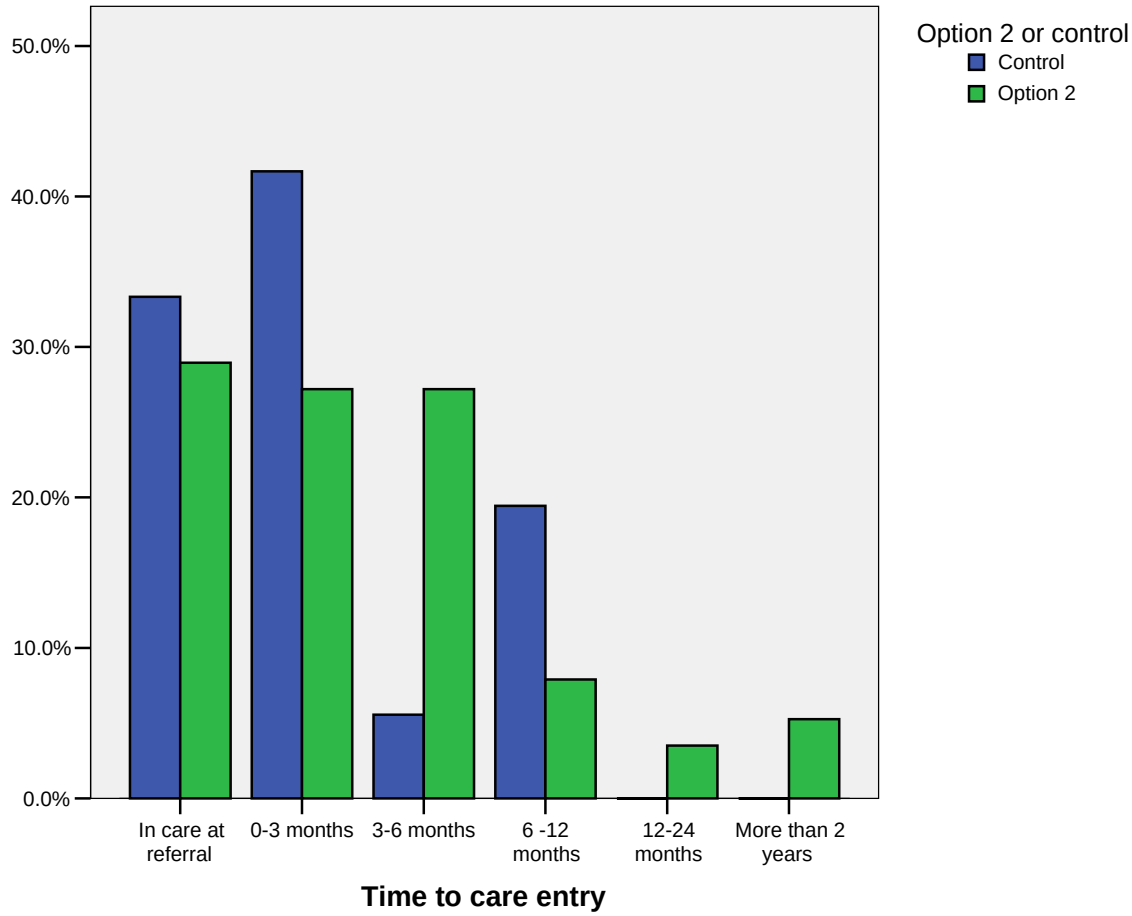
	Comparison	Option 2	Unadjusted significance	Adjusted significance
Entered care	36 (40%)	113 (41%)	0.926	-*
In care at 31.12.06?	29 (33%)	69 (24%)	0.098	**0.025**
At home at 31.12.06?	50 (56%)	189 (68%)	0.042	**0.003**
Days in care to 31.12.06 (if entered care)	958	766	0.993	**0.038**
Days to care entry	126	243	0.205	**-***
Number of placements	1.42	1.56	0.737	-*
Average cost for children entering care	11240.50	14518.13	0.690	-*

* The stepwise analysis removes non-significant variables and therefore significance

level can not be provided

These results are rather complicated. It would appear that Option 2 delays care entry and this accounts in part (but not entirely) for the lower number of days Option 2 children spend in care. The impact of the delay in care entry is particularly clear for children who took a long time to enter care (see chart 2.1). All of the 12 children who took more than 600 days to come into care were in the Option 2 group. Nonetheless, even if the difference in average time to care entry (117 days) is taken into account there remains a 75 day difference between Option 2 and comparison groups. Option 2 therefore appears to reduce the number of days in care independently and in addition to increasing the time to care entry. This is because once children enter care they are more likely to return home if they have had an Option 2 intervention – and this contributes to them spending a shorter period in care. Thus, 7% of the comparison children have been in care and then returned home, compared to 17% of the Option 2 children – and as a result 68% of Option 2 children are at home at the end of the study compared to 56% of comparison children. (For children who had entered care and then moved elsewhere, the end placements were virtually identical for Option 2 and comparison children apart from the increased likelihood of being at home).

Chart 2:1 Time to care entry for Option 2 and comparison children



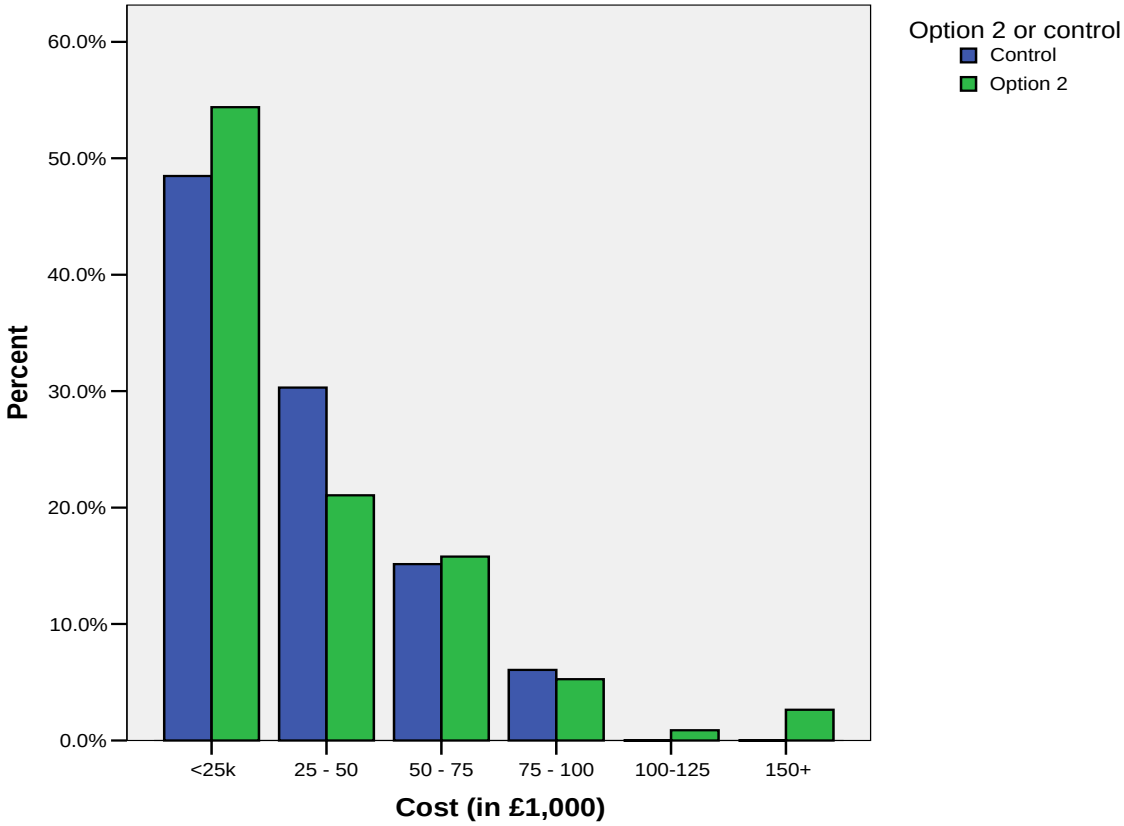
This is a broadly positive finding, in that it shows that Option 2 does significantly reduce the need for care (though the interpretation of this finding is discussed further below). However, despite the reduction in days in care achieved by Option 2, there was no reduction in costs. Indeed, on average Option 2 children cost somewhat more than those in the comparison group.

2.2.4 Why did care cost more for Option 2 children?

The higher cost for Option 2 children is on the face of it surprising, as they spent less time in care. It is explained by the fact that when they entered care Option 2 children tended to have more expensive placements. The average *daily* cost of placements for Option 2 children in care was £45.95 compared to £31.40 for comparison children.

This difference remained significant even when other factors were taken into account statistically. It was primarily due to a comparatively small number of very expensive children (of the 12 children who cost more than £75,000, 10 had had the Option 2 service) (see Chart 2.2). If these children are excluded from the analysis the average cost of care for Option 2 children who enter care (at £24,352) is virtually identical to that of the comparison group (at £25,997). This similarity in total costs exists because, even when the most expensive children are removed, Option 2 children's placements cost more per day in care (£36.11 compared to £30.56). This appears to be related to differences between the two local authorities (see table 2.7 and charts 2.3 and 2.4).

Chart 2.2 Cost of Care for Children in Option 2 and Comparison Groups



2.2.5 How did outcomes compare between the two local authorities?

A key issue emerging during the analysis was that there appeared to be very important differences in cost-related outcomes between the two different Option 2 areas. Some differences between the local authorities were evident at the point of referral as discussed above. There were also similarities and differences between the local authorities in the outcomes (see table 2.7). Children from the different local authorities were equally likely to enter care and similar proportions were in care at the end of the study. Children in the Vale came into care far quicker than those in Cardiff, however they spent less time in the care system. This is because those who entered and then left did so very quickly. The overall costs of the care system were broadly similar for children in the two areas, however the pattern of costs was very different in the Vale. Given the broad similarities between the local authorities, the differences in the impact of Option 2 are important.

Table 2.6 Comparison of outcome measures between Cardiff and Vale

	Cardiff	Vale
Entered care?	40%	42%
In care at end at 31.12.06	24%	29%
Average days in care to 31.12.06	380	304
Average days to care entry	269	116
Cost per child entering care (£)	35314	30717
Cost per day of placements (£)	43.83	40.29

Table 2.7 Care system outcomes by local authority and whether Option 2 or comparison group

	Cardiff		Vale	
	Comparison	Option 2	Comparison	Option 2
Entered care?	32 (40%)	76 (41%)	15 (42%)	38 (42%)
In care at 31.12.06?	14 (26%)	44 (23%)	15 (42%)	22 (24%)
At home at 31.12.06?	29 (55%)	127 (68%)	21 (58%)	62 (68%)
Average days to care entry	160	298	78	130
Average days in care to 31.12.06	405	372	362	281
Average cost per day in care (£)	43.05	44.02	17.41	49.31
Cost of care per child (all children) (£)	16931.13	13558.36	3649.10	16629.39

Chart 2.3 Cost of placements comparing Option 2 and comparison in Cardiff

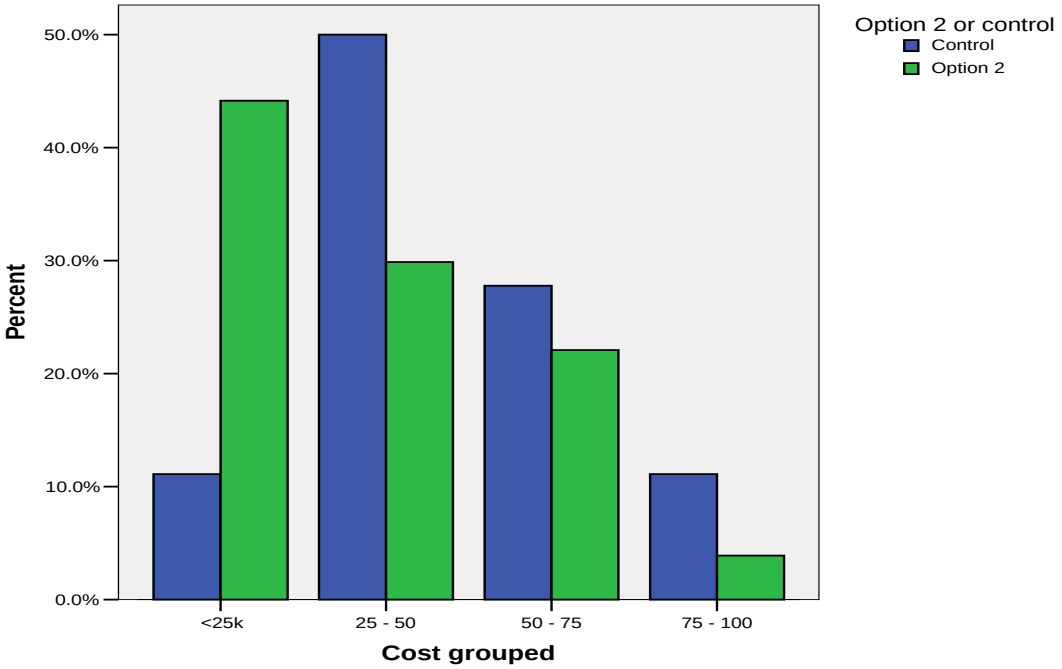
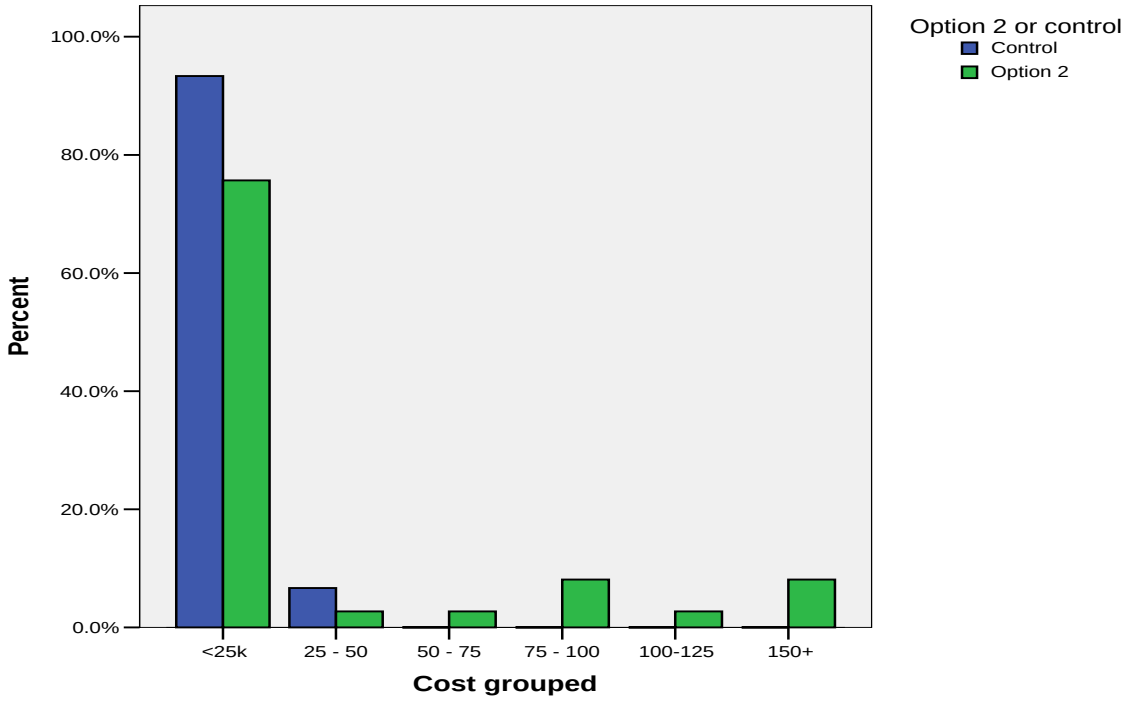


Chart 2.4 Cost of placements comparing Option 2 and comparison in Vale



Breaking down the analysis of outcomes relating to the care system for the Vale and Cardiff produces an interesting picture. The findings are crucial in making sense of the impact of Option 2 on care entry (see table 2.7). First, there are some broad similarities. In both locations Option 2 has no impact on whether children enter care overall, but children take longer to enter care if they have experienced Option 2 and they are more likely to return home after entering care if they have had an Option 2 intervention. As a result they spend on average less time in care. However, there are some important differences, particularly in the cost implications for the Vale children. Specifically, 15 of the comparison children in the Vale entered care comparatively quickly and remained in care throughout the follow-up period, yet cost far less per day and overall than children who received the service - or than either group in the Cardiff sample. Most of these children were placed swiftly in permanent kinship or adoptive placements, and these appeared to be very cheap placements. In contrast, 7 of the 12 children who cost more than £75,000 received the Option 2 service in the Vale. These children significantly distorted the cost profile in the Vale.

As a result of these variations, there are some significant variations in the cost implications of Option 2 in the two local authorities. However, there are reasons for believing that the Vale figures are misleading. Most importantly, the distribution of cost for both Option 2 and comparison children is very unusual – as can be seen in charts 2.3 and 2.4. In Cardiff, Option 2 clearly reduces the average cost of care, but for both Option 2 and comparison groups the numbers are distributed across the spectrum of cost. In the Vale, very few comparison children cost more than £25,000, while a number of Option 2 children are very expensive indeed.

2.2.6 What were the characteristics of "expensive" children in care

In order to shed more light on the contribution that the small group of 12 "expensive" children (each costing more than £75,000) made to these differences, both a numerical and a descriptive analysis were carried out. For the numerical analysis the characteristics of the expensive children and others are compared. It can be seen in table 2.8 that larger families and those where amphetamine was an issue were more likely to be expensive; those involving heroin, in care or subject to a care order at referral tended not to be expensive children.

The descriptive analysis involved Option 2 staff summarizing issues for the 12 "expensive" children (from 7 families) at the time of the referral based on case notes. In some cases, additional information on subsequent developments was added. It was difficult to draw any firm conclusions based on the limited information, the small numbers involved and the lack of a comparison group. Nonetheless, a couple of themes seemed significant.

Firstly, as identified in the statistical analysis, amphetamine use was an issue in a number of cases. It is difficult to know what to make of this factor, but it seems to have an association with expensive placements (in both local authorities).

Second, more striking was that while they were nominally in the "Option 2" group, 3 of the 4 Vale families with expensive children had received limited or no intervention from Option 2. Of the four families, one had been assessed as inappropriate for the service, a second was not worked with as the children almost immediately went into care, while in a third family Option 2 expressed concerns and the children entered care. These are

strong grounds for suggesting that Option 2 in itself was not producing increased costs for these children.

Table 2.8 Factors identified at referral for expensive children and all others

	Non-Expensive Children		Expensive children	
	n	% or mean	n	% or mean
Number of children		3.16		4.17
Child's Age		6.97		7.27
Alcohol	211	59%	5	42%
Amphetamine	49	14%	7	58%
Heroin	96	27%	0	0%
Otherdrug	34	10%	1	8%
Crisis Threat of CPR	115	32%	9	75%
Threat of accommodation	221	62%	3	25%
In care	18	5%	0	0%
On CPR	143	40%	2	17%
Care Order at referral?	43	12%	0	0%

The differences in the costs of children who received the service in the Vale compared to the comparison group are therefore likely to be either (a) a statistical anomaly caused by children in a small number of families or (b) a result of differences in the referral patterns for comparison compared to Option 2 children. For instance, it is possible that when there is space, families with chronic problems are more likely to be referred. Unfortunately, with the present information it is not possible to be sure what the reason for this anomalous finding was. However, it seems unlikely that the Option 2 intervention is responsible for these very expensive children's cost to the care system.

Given these findings, the Vale children are excluded from further analysis of the cost implications of Option 2 intervention.

Exclusion of the Vale children from the analysis
The similarities in the outcome measures for children in the Vale and Cardiff suggest that for outcomes not related to cost it seems appropriate to include the Vale children. Nonetheless, there is the possibility that the comparison group in the Vale is not valid. In the interests of clarity, an analysis of outcomes was therefore carried out with only the Cardiff sample. This looked at the bivariate relationship between whether children received Option 2 and outcomes and also a multi-variate analysis that looked at the correlation between outcome variables and Option 2 vs Comparison when holding variables identified as different between the two groups at the point of referral constant (i.e. amphetamine, alcohol or heroin use and father-only family). The findings for this analysis are set out in table 2.9.

Table2.9: Comparison of outcomes for Option 2 and comparison group in Cardiff

	Comparison	Option 2	Unadjusted (bivariate) significance	Adjusted significance
Entered care?	32 (40%)	76 (41%)	0.799	0.096
In care at 31.12.06?	14 (26%)	44 (23%)	0.665	0.294
At home at 31.12.06?	29 (55%)	127 (68%)	0.077	**0.005**
Average days to care entry	160	298	0.179	0.264
Average days in care to 31.12.06	405	372	0.638	0.325
Cost of care per child (all children) (£)	16931.13	13558.36	0.302	**0.049**
Average cost per day in care (£)	43.05	44.02	0.759	0.308

Table2.10: Comparison of outcomes for Option 2 and comparison group in Vale of Glamorgan

	Comparison	Option 2	Unadjusted (bivariate) significance	Adjusted significance
Entered care?	15 (42%)	38 (42%)	0.970	0.924
In care at 31.12.06?	15 (42%)	22 (24%)	**0.047**	0.161
At home at 31.12.06?	21 (58%)	62 (68%)	0.281	0.523
Average days to care entry	78	130	0.228	0.951
Average days in care to 31.12.06	362	281	0.607	0.803
Cost of care per child (all children) (£)	3649.10	16629.39	0.144	0.546
Average cost per day in care (£)	17.41	49.31	0.204	0.963

There are interesting similarities and differences between the local authorities. The similarities are that the impact on care entry seems very similar. In other words, there is little impact on whether children enter care, but in both local authorities there is a delay in care entry and in addition children who enter care post-Option 2 are more likely to return home than children in the comparison group. The differences are entirely in relation to costs. In the Vale, Option 2 is associated with increased costs of care. Indeed,

the average differences are so great that one might expect them to be significant. The fact that they are not is likely to be because the overall pattern is that, as discussed above, a few children referred to Option 2 proved very expensive. On the basis of these figures it appears reasonable to include the Vale in considering the impact of Option 2 on care but to exclude outcomes related to care.

It therefore seems reasonable to conclude that:

- Option 2 in Cardiff significantly reduces the cost of care for children referred to it.

It is also worth noting the different impact of taking into account variables that differentiated between the groups at the point of referral in the two local authorities. In general, these increased the significance of between-group differences in Cardiff (i.e. the impact of Option 2 became statistically stronger) while they weakened it in the Vale (i.e. apparent differences disappeared). This suggests that in general when Option 2 are compared to Comparison children in Cardiff the cases tend have more risk factors for care entry. The opposite is true in the Vale.

2.2.7 The cost of Option 2 compared to the savings to the care system

In light of the discussion above, the cost of Option 2 off-set against the savings to the care system are only calculated for Cardiff.

The grants provided to run Option 2 were:

2002/3	£73,465
2003/4	£76,465
2004/5	£79.322
2005/6	£86,502

Figures for 2000/01 and 2001/2002 were not available. We calculated these conservatively (i.e. £3,000 less p.a. or £67,465 and £70,465). Only half of 2005/2006 was part of the sample collection time frame, and this is reflected in the costs. This provides a total of:

Total for Option 2 Cardiff 2000- 2006: £410,403

In this time Option 2 worked with 187 children. This gives an **average cost per child referred to Option 2 of: £2194.67**

The placement costs for children referred to Option 2 in Cardiff are set out in table 2.9 above. On average each child receiving the service cost £13558.36 while each child in the comparison group cost £16931.13. This was a **net saving in the cost of care of £3372.77**.

When the cost of Option 2 is set against the cost of care each child saves the reduced cost of care minus the cost of Option 2 (£3372.77 - £2194.67 = £1178.10). **Each child referred to Option 2 in Cardiff therefore results in a net saving of £1178.10.**

These figures are very rough estimates. The costs of Option 2 are probably somewhat underestimated. There is no calculation for depreciation or additional parts of the service provided in addition to the grant. However, the likelihood is that the calculation very

greatly underestimates the costs of both care and for the comparison group, and is thus a very significant underestimate of the impact of Option 2 on costs. In particular, the calculations are not able to provide data on:

- the cost of alternative services provided to children not worked with by Option 2;
- additional costs related to children being in care, such as the cost of allocated social workers, managers and administrators;
- the cost of finding and supporting placements, particularly for local authority placements.

Furthermore, the reduced number of children in care at the end of the study period suggests that the longer the follow-up the greater the savings that would be identified.

For Option 2 to demonstrate a saving with this limited information suggests it is in practice likely to be producing very significant cost savings for the care system, though further detailed study collecting information directly from families would be needed to be certain of this.

2.2.8 What factors at the point of referral predicted care outcomes for children that had received Option 2?

The analysis now turns to consider variables associated with children entering care after they had received Option 2 in an attempt to identify factors associated with Option 2 being particularly successful – or unsuccessful – in preventing care. In this section the analysis focuses solely on families that received the Option 2 service. Factors in the referral that increased or reduced the likelihood of children entering care or other care related outcomes are identified through regression analysis, and the findings then discussed (within family structure two-parent families could not be entered as they were the comparison variable for other structures, and father-only families were not entered because the distribution was not appropriate).

What factors predicted care entry for children who had been referred to Option 2? Were these factors the same for the comparison children?

Table 2.11 sets out the relationship between factors noted in the referral and the likelihood of a child entering care after Option 2. In the final column it presents the percentage of comparison children entering care where a particular issue was present in the referral. The information in the table allows us to answer two distinct questions:

- What factors in referrals made it more or less likely that children would subsequently enter care?
- Were these factors equally important for the comparison group or did they have particular significance for Option 2 interventions?

It can be seen that younger children, those subject to a care order, those involved in more serious referrals and those whose parent/s misuse amphetamine are at high risk of subsequent care entry after an Option 2 intervention. It is not possible to say whether this is a good or a bad thing – as these children may more appropriately enter care. In general, as care outcomes are better for younger children, one would imagine that it was appropriate to see a higher proportion of younger children entering care.

It is interesting to compare the proportions entering care where issues are identified in the comparison group. Statistically the only factor associated with children entering care in the comparison group was the number of children in the family (for those who remained at home the average was 2.04, compared to 3.53 for those entering care). This lack of factors linked to care entry is slightly surprising; one would expect some of these factors to be associated with higher risks (e.g. amphetamine use) or the nature of the initial risk and others to be linked to care being more likely to be positive (e.g. children being younger). Taken together these findings suggest the possibility that Option 2 is improving decision-making about care entry. It is not possible to be sure of this without direct information on child welfare. Certainly the factors associated with care entry in the Option 2 sample seem appropriate indicators of risk.

Table 2.11 Factors associated with care entry post-Option 2

	Total	**Care entry n**	**%**	**Sig.**	**% Care for Comparison**
Overall	278	114	41%		40%
Assessed as not appropriate	44	17	39%		n/a
Cardiff	187	76	41%		40%
Vale	91	38	42%		42%
Alcohol	172	103	40%		49%
Amphetamine	47	30	64%	.003	56%
Heroin	65	22	34%		29%
Other drugs	29	13	45%		33%
Nature of crisis				.010	
Threat of CPR	92	32	35%		22%
Threat of accommodation	177	76	43%		51%
In care	9	6	67%		44%
Family structure					
Both parents	135	59	44%	n/a	38%
Mother only	109	48	44%		47%
Father only	12	1	8%	n/a	48%
Other	23	11	48%		n/a
On CPR at referral	119	45	38%		46%
Care Order at referral	35	23	66%	.001	37%
	Mean	**Mean if entered care**			
Number of children in family	3.37	3.53			3.53
Age of child	7.25	6.22		.020	6.17

What factors predicted being in care at 31.12.06 for children who had been referred to Option 2? Were these the same for the comparison children?

Table 2.12 carries out a similar analysis for children who were in care at the end point of the study. For this outcome measure the presence of amphetamine use, larger families, mother-only families and families referred to Option 2 but assessed as inappropriate were associated with children being in care at the end point.

Table 2.12 Factors associated with children in the Option 2 group being in care at 31st December 2006

	Total	n	%	Sig.	% Care for Comparison
Overall	278	66	24%		33%
Assessed as not appropriate	44	16	36%	.001	
Cardiff	187	44	23%		26%
Vale	91	22	24%		42%
Alcohol	172	36	21%		36%
Amphetamine	47	22	47%	<.001	56%
Heroin	65	14	21%		26%
Other drugs	29	8	28%		33%
Nature of crisis					
Threat of CPR	92	20	22%		19%
Threat of accommodation	177	44	25%		38%
In care	9	2	22%		44%
Family structure					
Both parents	135	27	20%	n/a	20%
Mother only	109	33	30%	.014	47%
Father only	12	1	8%	n/a	39%
Other	23	5	22%		n/a
On CPR at referral	119	24	20%		31%
Care Order at referral	35	12	34%		25%
	Mean	**Mean if in care**			
Number of children in family	3.37	3.80		.030	3.24
Age of child	7.25	6.28			6.79

However, it is when the Option 2 children are compared to the comparison group that some particularly interesting findings emerge – and in particular when the findings relating to care entry are also considered. These tables suggest that the effectiveness of Option 2 in preventing the need for care varies with the seriousness of the “crisis” at referral. Specifically:

- Where children were “at risk” of being placed on the CPR the involvement of Option 2 increased the likelihood that the child would come into care, though it had no impact on their likelihood of being in care at the end of the study;

- Where children were “at risk” of accommodation Option 2 seemed to reduce the likelihood of care entry and considerably reduce the likelihood that a child would be in care at the end of the study;

- Where children were already in care at the time of the referral, Option 2 greatly reduced the likelihood that they would be in care at the follow-up point.

In addition:

- Children subject to care orders (including ICOs etc) at the time of referral were the only group of children more likely to be in care at the end of the study following the Option 2 intervention;

- In contrast, children on the CPR were less likely to come into care and much less likely to be in care at the end of the study;

- Option 2 appeared particularly effective with one-parent families of both genders.

These findings suggest that the Option 2 service is best at preventing care entry when children are referred as being at risk of care. It is not effective at preventing care for children in the lower risk category (this may be because for the minority of these children who enter care it tends to happen at a later crisis point). For the small number of children already subject to care proceedings, Option 2 does not reduce the need for care. We can not know why this is. It may be that for many of these children at the very heavy end of referrals, care may be the best choice – and Option 2 may help in making that decision. It may be that social workers are reluctant to change their minds about the need for care despite Option 2 involvement. Or Option 2 may work less well with this group.

Option 2 seems most effective at preventing the need for care in working with the group it was originally intended to work with – namely children identified as at risk of entry into care, many of whom are already on the CPR. This is particularly true where parental alcohol misuse is an issue.

2.3 Key Findings

- We do not know anything about the impact of Option 2 on the 59% of children who do not enter care.

- Option 2 does not reduce the likelihood of children entering care at some point;

- Option 2 does reduce the use of the care system by children. Option 2 children:

    - Spend less time in care;

        - Were less likely to be in care at the follow-up time
        - Were more likely to be at home at follow-up;

- This reduction is achieved because Option 2:
    - Delays care entry for children;
    - Children who enter care are more likely to return home, and this often happens comparatively quickly.
- The reduction in the use of the care system following an Option 2 intervention:
    - Significantly reduced the costs of care for children in Cardiff, resulting in a saving of £1178.10 per child;
    - Is very likely to be a considerable underestimate of the real cost-savings associated with Option 2 in Cardiff;
    - Did not reduce the costs of care in the Vale. This finding appears likely to be because of issues in the nature of the comparison group.
- Further analysis of differences between the Option 2 and comparison group suggested that Option 2 is particularly effective at reducing the need for care when:
    - Children are at high risk of care;
    - Parents misuse alcohol;
    - Families only have one parent.
- Children assessed as inappropriate for Option 2 are as likely to enter care as those who receive a service, but are far more likely to be in care at the end of the study.

The implications of these findings are considered further in the discussion section.

3. THE QUALITATIVE STUDY OF THE EXPERIENCES OF PARENTS AND CHILDREN WHO USED OPTION 2 IN 2006

3.1 Introduction

Qualitative research methods are a useful way to explore and understand the beliefs, perceptions and experiences of individuals. As part of the evaluation of Option 2, it was seen as important to attempt to understand the participants' experience of the services they received in addition to the quantitative analysis conducted and described as part of this report. In order to explore this area, a qualitative design was used based on the analysis of semi-structured interviews of as many family members as could be recruited from those that received an Option 2 service during the previous 12 months. Three research questions guided the collection and analysis of the data:

1. *What were the views and experiences of individuals who had used the service about Option 2?*

2. *What factors influenced the success or otherwise of individual's work with Option 2?*

3. *How could the views of individuals who had experienced the service help us to understand the outcomes in relation to care entry from the quantitative analysis?*

3.2 Methods

Families that used the service over the twelve months period prior to the evaluation study were identified and approached in order to ascertain whether they wished to take part in the research. For those families that agreed, parents and children aged 7 or over were interviewed about their experience of Option 2 and perceived changes since their use of the service. The aim of this part of the evaluation was to build a detailed picture of service users' experiences of the service and the importance of the different service components.

Interviews were carried out by a member of the research team (CW) who had experience of qualitative interviewing and had been trained in qualitative data collection and data recording techniques specific to the study. The interviews were conducted at each participant's home. There were two types of interviews: those that took place with parents and those that were conducted with children.

3.2.1 Interviews with parents

For the parents' interviews, instructions were drafted in semi-structured format, where the interviewer followed a set of written guidelines. The guidelines were based around one key general question: 'What was your experience of the service that you and your family received from Option 2?'. The interviewer had a short list of sub-topics and areas to probe depending on the interviewee's response. The interviewer aimed to obtain a full answer to the main question, using open ended questions, prompts, and obtaining concrete examples if and when appropriate. Towards the end of the interview, participants were asked what they would most like to tell the Welsh Assembly about the Option 2 service. Interviews ranged from fifteen to eighty minutes in duration with most lasting between 20 and 30 minutes.

During each interview, the interviewer took notes detailing every point made by the participant. These notes included direct, verbatim words or phrases that served to effectively support or illustrate what the participant had said and were used as the source of textual data for analysis. The interviewer used the notes to construct a detailed report, clearly showing verbatim quotations within speech marks. Interview reports were written within 24 hours of the interview taking place and prior to any further interviewing of participants. In addition, interviews were taped and listened to following the drafting of the report. This allowed for checking of the accuracy of the report and provided an opportunity to add further verbatim quotes. For a more detailed account of this method and rationale see Orford, et al. (2005), and of its effective implementation see Orford, et al (2006).

3.2.2 Interviews with children

Interviews with children were largely based on a card game that was used as a concrete prompt for discussion of change with the researcher. A five point rating scale consisting of: "much better", "better", "about the same", "worse" and "much worse" was used to elicit ratings from the children on topics which related to various aspects of their lives (such as "how mum and dad get on", "school", "friends", "how happy I am" etc). The interviewees placed a card indicating the rating for each particular topic to indicate their perception of how things had changed since they first started to work with Option 2.

3.2.3 The interviewed sample

In the 12-month period prior to the commencement of the evaluation, Option 2 worked with a total of 16 families. Out of the 16 families seen, the team researcher (CW) visited 14 (the current addresses of the remaining 2 families were unknown). Of the 14 families that were visited, 1 had moved (and the new address was unknown) and 4 families were not at home for a number of visits. Only one family declined to participate in the research study. All identifying details have been removed and each family was assigned a code.

Interviewees were from eight families including a total of 11 adults and 7 children (ages ranged from 9 to 15). All interviews were conducted in the participants' homes in Cardiff and Vale of Glamorgan between February and May 2007.

3.2.4 Analysis

The analysis of post-interview reports from parents was based on grounded theory methods (Strauss and Corbin, 1998) that aim at model building grounded in people's accounts of their experiences. Nine interview reports with eleven parents were available for analysis. In two cases, both parents were interviewed together. The analysis proceeded in 2 stages. The first stage of the analysis involved allocating at random interview reports to each of two investigators for initial coding. This was followed by the identification of higher order categories each encompassing a number of the initial themes. The categories are presented in the 'Results' section of this report. The investigators communicated regularly as a team throughout the period of analysis and report drafting in order to discuss, challenge and refine the results and conclusions. The analysis of interviews for the children followed the same principles although due to the smaller number of interviews, the initial coding was done by one of the researchers (CW)

3.3 Qualitative Results

3.3.1 Interviews with parents

Central to the participants' descriptions is the relationship between the interviewee's family and the worker from the Option 2 project. Given the intensity of contact between the family and the worker, the latter comes to represent to a great extent each family's experience of the service as a whole.

The first thing to note is that all participants were very positive about the service that the family received from Option 2. The emerging picture of the qualitative interviews is one of families that in the main have experienced difficult circumstances that trigger Option 2 involvement and then, usually fairly quickly, find the input from the Option worker supportive and valued. Some interviewees note the difficulty experienced when involvement comes to an end and describe this clearly: e.g. 'I was gutted when [the Option 2 worker] stopped coming to see us'.

We identified through our analysis six main categories that captured the descriptions of the participants in terms of key components that are perceived as core to the service and helpful for the interviewees and their families. Each category is described under a heading and illustrative quotes are used. In almost all interviews, parents illustrated some of the emerging themes by contrasting the help received from Option 2 with their experience of help received from Social Services. In all cases, except for one (O1) the interviewee's experience of Option 2 was perceived as more positive. This interviewee found both Option 2 and social services helpful.

In order to support the proposed categories, extracts from the reports are included in each section. These extracts are in single quotes. Verbatim quotes from the parents are in double quotation marks. Names and gender of Option 2 worker have been replaced by the term [Option 2 worker] in order to preserve anonymity and confidentiality. All identifying details of the families have been removed. The categories are described in the six sections below.

1) A non-judgemental and understanding approach providing options rather than 'being dictated to'

All interviews with parents contained references that fell within this category. Parents talked about the Option 2 worker as someone that could be trusted and related to them in a non-judgemental way. In some cases, participants described the Option 2 worker as a "friend", caring and understanding and providing useful advice whilst maintaining the parents' right to choose a course of action. Below are some illustrative examples taken from the researchers reports:

'When I asked the interviewee what it was about [Option 2 worker] that worked for her and her family, she replied that it was the fact that "[Option 2 worker] wasn't a threat to me and my children","[Option 2 worker] didn't come in here and set boundaries and rules". [Option 2 worker] didn't tell her what to do. "[Option 2 worker] advised me and it was good advice".' (G1)

'We then spoke about how the interviewee had felt that [the Option 2 worker] was somebody to talk to each day. She explained that she "could get things out" which "I can't say to my friends or family" without "being judged". She added that she had been to lots of psychiatrists and she felt " that they don't listen and do "judge" but [Option 2

Table 3.1
The components of the service valued by families (in quotes)

1. A non-judgemental and an understanding approach providing options rather than 'being dictated to'

'listening'; good for listening'
'never forgetting'
'friend'; 'like talking to a friend'; 'was my best friend'
'seemed to care'
'very helpful'
'genuine'
'never seemed to threaten with power'
'they don't judge you'

2. Good open communication between the worker and the family

'Very easy to talk to'
'not clinical'
'feel less threatened'
'worker made them talk about their good points'
'the main thing was that [worker]..opened up before they started asking questions'
'would put things [explain something] in an easier way'
'somebody to talk to each day'
'friendly…but he got to the point if he needed to'
'blatant and honest'

3. Availability, reliability and high frequency of contact

'part of the family'
'getting to really know the family'
'being there 24 hours a day'
'when you can rely on somebody…that's more than 101%..'
could phone whenever she wanted
'really good that [worker] came every day and could see how we lived'
[Worker] attended all the meetings

4. Suggesting practical strategies and offering practical support if needed

[suggested] Ideas about using free time after drugs
'very willing to do anything that we thought that he could help us with'
advice about potty training
[Worker] helping son with behavioural problems

5. Support with substance problem when required

'[Worker] was somebody to speak to about it [drinking]'
[Worker] 'helped me to realise that drink was a really bad problem…he understood'
Playing games (with cards) helped them 'to talk about drug issues'
[Worker] 'made me realise more than the others the critical situation I was in'
advice about cravings

6. Help with family relationships when required

'Me and my daughter had a better relationship in those four weeks [when Options worker was with them]'
[Role plays] made her 'interact with the kids more than when I ever used to play with them'
'made me and my children closer together'

worker] was the opposite. I asked her to tell me a bit more about how she felt. [Option 2 worker] listened well and she explained that this was because [Option 2 worker] "looked at me" and "answered" her but some psychiatrists just told her what to do.' (O1)

'The interviewee said that the "last thing you want when you've got stress is being dictated to". [Option 2 worker] came in "as a friend", not as "a dictator". [Option 2 worker] gave them advice in a non-critical way.' (E1)

'I asked the interviewees what about Option 2 worked well for them. The father said that it was "the fact that they accept you." The mother said, "They don't judge you".' (E1&E2]

2) Good open communication between the worker and the family

Parents' valued the communication that was possible with the worker from Option 2. This appears partly related to the style of the worker described within the previous category and sometimes described by way of a contrast to other experiences that parents had with other professionals. The first quote illustrates the importance of good communication as perceived by a father, particularly when the family is experiencing stress and are under pressure.

'The father said that [Option 2 worker] wasn't "clinical". He was never wearing a suit or a tie or came with a briefcase. (There was no "white-coat syndrome!"). This helped them to feel less "threatened". This was important because "we were in a bad way" and "we were feeling vulnerable". [Option 2 worker] would also "joke around with you" and was "relaxed himself".' (Z1)

The following quote illustrates the fact that the worker whilst friendly could also be firm and communicate difficult issues when required.

'[Option 2 worker] told them that if they messed up now, the boys might get taken into care. The interviewee said that that was a good thing about [Option 2 worker]: [Option 2 worker] was really friendly but [Option 2 worker] "got to the point if [Option 2 worker] needed to". [Option 2 worker] was "straight", "blatant and honest" and she found that really helpful.' (B2)

This final quote within this section, showed some of the skills of good listening as perceived by a parent.

'The interviewee also said: "I felt that [Option 2 worker] was really listening". She explained that [Option 2 worker] never seemed to forget anything. "There was nothing she missed". [Option 2 worker] would remind her of things that she (the interviewee) had forgotten she'd said or done.' (P1)

3) Availability, reliability and high frequency of contact

An important feature of the service appeared to be the fact that the parents felt that the worker was available at any time and that the frequency of contact between the worker and the family was high. This level of contact gave the Option 2 worker the opportunity to get to know the family really well, a fact that was contrasted again to other types of relationships with other professionals. In addition, high availability helped at times of difficulty.

'She said that [Option 2 worker], unlike Social Services, was available 24 hours a day – "That's brilliant, that is". She also added later that [Option 2 worker] was "always there" and "reliable".' (G1)

'The interviewee felt that what worked for their family were the "regular visits" and "getting to know us as a family" and observing them.' (B1)

'[the interviewee] said that [Option 2 worker] was visiting every day and that other services didn't know them like [Option 2 worker] did.' (B2)

'She replied that it was "really good" that [Option 2 worker] came out every day and could "see how we lived" so that he could tell social services what was going on. She mentioned how [Option 2 worker] had come recently for a follow-up visit and it was "good" that he was still on "your case". "It's handy to have a reminder" that if she was to "go downhill [Option 2 worker] is still there…"' (B2)

4) Suggesting practical strategies and offering practical support if needed

Help with practical strategies seemed to be an important component of the support received by families. The interviews had a number of quotes that related to practical suggestions or practical help with a range of situations.

Sometimes, the help involved managing difficult and strong emotions for the parent as illustrated in the quote below:

'The interviewee then spoke about how [Option 2 worker] had helped her with managing her anger. She spoke about how she had asked [Option 2 worker's] advice about how to go to school to deal with a problem. [Option 2 worker] would tell her "count to 10" and "go the other way, from being angry to nice".' (G1)

Other examples involved help and advice in managing the children as illustrated below:

'Another thing the interviewee felt she had learnt from [Option 2 worker] was how to stick to punishments with her children. She explained that before [Option 2 worker], if the children were naughty, she would "ground them", for by example, not letting them go out, then they would "get on my nerves for hours" asking to go out and she would eventually give up. But [Option 2 worker] gave her advice about how when the children were trying to get out of their punishments, to "switch off" or do other things and to go out of the house when [son] was trying to get out of his punishments. She also said that [Option 2 worker] had told her to "give one warning" and that there was no need to repeat it and no need to shout back. "She made me see that I'm the adult...and that I should stick to the punishments".' (G1)

'She stated that [Option 2worker] gave her advice about "how to handle the children when they're misbehaving". She explained that she had previously done many parenting courses but she had forgotten things so [Option 2 worker's] input "re-boosted the courses that I've done". On [Option 2 worker's] advice, she used sticker charts with her children (if they had earned enough stickers they would get a reward at the end of the week).' (O1)

One parent also spoke about help with sorting out finances.

'[Option 2 worker] "advised me with ways to sort out my money problems".' (O1)

As the parent below describes, sometimes the Option 2 worker could help one family with a whole range of areas including both managing the children and managing cravings.

'"Whatever problems I had" [Option 2 worker] helped. This included giving advice about potty training; cravings (she could phone [Option 2 worker] whenever she wanted) and her elder son's behavioural problems. Later, the interviewee added that she could "talk to him about anything".' (B2)

5) Support with substance problem when required

Specific support related to the alcohol and or drug problem was also a recurring theme within the interviews. Parents talked about the support and help received. Sometimes the help involved a clear statement of praise that could act as a powerful reinforcement for change as illustrated below:

'The interviewee said that they talked about drinking – how he (the interviewee) was feeling and if he was taking his medication. The interviewee stated that [Option 2 worker] would "give praise for staying off the drink". [Option 2 worker] made "you feel better".' (C1)

The help sometimes involved being able to talk to the worker about the drinking and the perception that the worker was someone who could understand.

'The interviewee explained that it had been helpful to work with [Option 2 worker] as "he was somebody to speak to about it [drinking]". " [Option 2 worker] understood". [Option 2 worker] "obviously worked with other people in similar situations". "He understood where I was coming from". I asked the interviewee to tell me more about what he had talked about with [Option 2 worker] and he replied that it was "about alcohol & everything". The interviewee stated that [Option 2 worker] "helped me to realise that drink was a really bad problem". The interviewee would tell [Option 2 worker] about how he used to be sick and "he understood". The interviewee realised that "there was more to life than drinking".' (C1)

For another family what was perceived as useful involved helping the parent 'realise' the extent and impact of the drug problem paired with specific strategies to deal with cravings.

'I asked how [Option 2 worker] had helped him with drugs and the interviewee stated that he didn't take drugs anymore and [Option 2 worker] had made him realise "more than the others [social workers, other professionals]" the critical situation he was in and that he "couldn't carry on the way I was" and if he did that he would "probably lose the children".' (B1)

'The [Option 2 worker] "helped with the cravings". [Option 2 worker] told us "how to get through it". The main thing was to "think about the boys". [Option 2 worker] told them that if they messed up now, the boys might get taken into care. The interviewee said that that was a good thing about [Option 2 worker] : [Option 2 worker] was really friendly but

"got to the point if needed to". [Option 2 worker] was "straight", "blatant and honest" and she found that really helpful.' (B2)

6) Help with family relationships when required

The Option 2 worker was perceived as someone who could offer valuable help in terms of family relationships. In most interviews, the parents reported improvements in the relationships following Option 2 input. Sometimes the help related to the relationship between the parents and involved improving communication between the parents or helping the couple to build confidence and self-esteem.

The mother said that [Option 2 worker] made them talk about why they liked each other – their "good points", for example, why she thought her partner was a good father. The father also said that [Option 2 worker] asked them what attracted them to their partner and why they thought they worked well together. The father said that this was "done very cleverly": [Option 2 worker] would question them in a way that "would force yourself to remember what was good"– "thought-provoking questions". Later, the father repeated how[Option 2 worker]would "get you to think". [Option 2 worker] wouldn't tell you that something was wrong or right. (Z1&2)

The interviewee said that they played games with cards, which helped [Option 2 worker]to get to know them but it also taught them stuff about themselves. She found this helpful because she then explained that many couples find out that they don't have anything in common when they stop taking drugs but through the exercises they did with [Option 2 worker]they saw that they "weren't like that." The interviewee said that [Option 2 worker] told them they were "the most compatible couple I've ever met!" (B2)

Sometimes the help related to relationships between the parents and the children. The example below illustrates the reduction of stress in the relationship between a mother and her daughter and the contribution to this improvement in the relationship made by the changes in drinking.

The interviewee said that just having [Option 2 worker] around five days a week had helped her to reduce her drinking but the biggest help had been with the relationship with her daughter as there was "less stress and pressure" from her daughter. She added, "Those 4 weeks [with Option 2 worker] have been the best four I've had" in terms of the relationship with her daughter and reducing her drinking. When I asked her why [daughter] was applying less stress and pressure, the interviewee explained that there was less pressure from her daughter because her daughter "could see that I was trying" because they were doing so much together. (P1)

One parent described how the Option 2 worker offered very practical 'hands on' support with her relationship with her son.

The interviewee could pass on some of her "problems to [Option 2 worker] ". She gave an example of how if she was speaking to [Option 2 worker] on the phone about difficulties she was having with [eldest son], [Option 2 worker] would say "pass the phone to [eldest son] – I'll have a chat with him". [Option 2 worker] "would listen to me and then I'd feel a bit lighter through the day to get on with it". (G1)

For one mother, the perception was that Option 2 helped with both the relationship with the children and with the other parent.

She gave examples about how she now spent more time helping her children with their homework and also now "instead of letting the kids go to the park alone" she goes with them. She also goes "more to parents' evenings" at school. I asked her why these changes had taken place and she stated that this was because "[Option 2 worker] made me realize that I need to spend more time" with the children. When I asked her how [Option 2 worker] had made her realize this, she explained that it was through "asking questions" and when [Option 2 worker] found out that the interviewee didn't do these things [Option 2 worker] would say that it was in her best interest to spend time with the her children. (O1)

[Option 2 worker] made "me and [ex-husband] look at ways of sorting our marriage out"…The interviewee explained that [Option 2 worker] had helped her with "ways to approach [ex-husband]", "what to say to him". However [ex-husband] "never listened". He's "not a talker at all"…She felt that by talking to him "it made me feel better "about getting things out" and not having things "piled up inside" but her ex wasn't interested. (O1)

Table 3.2

What parents would most like to tell the Welsh Assembly about Option 2

- "without [Option 2 worker's] intervention… we would have split up as a family
- "without wanting to sound dramatic, [Option 2 worker] did save this family".
- it's "been brilliant for me and [daughter] for those 4 weeks".
- It's "good for our relationship between mum and daughter
- "when you can rely on somebody…that's more than 101%…".
- "I could have killed my [eldest son] by now" or put him in care if "I didn't have someone like [Option 2 worker] to talk to".
- "They're very helpful"; "good listeners". "Friendly". "I wish I was still with them!".
- "It's good for alcohol help" and "alcohol is a drug". "Thanks!".
- [the interviewee] said that Option 2 was a "good service" and without it he didn't know "where I would be concerning the children".
- Option 2 is "really a big help". They "should have all social workers working like them [Option 2]"
- "Don't put a stop to Option 2, definitely" and "extend it as much as they can".

3.3.2 Interviews with children

One of the major themes that arose from the children's interviews was that the majority of the children felt that their confidence had been boosted as a result of their experience with their Option 2 workers. As a result, the children felt that this helped to lead to improvements with their schools, friends or with other professionals.

For example, E4 (female child, aged 12) said that *"I stick up for myself more".* She attributed this change partly to the fact that with her Option 2 worker "*I could express myself*". Consequently, she felt that things were better with her friends and at school (where she could now speak to more people because she *"was fed up with being shy").*

O2, a 10 year old boy, said that at the beginning, he was *"shy",* with his Option 2 worker, but then *"I became used to it"* and he became *"less shy".* Now he felt that with his social worker *"I'm much more confident and I can say what's on my mind".*

His sister, O3, 11 years old, stated that *"[Option 2 worker] made me strong and funny"*, by *"talking to me a lot".* She also felt that the situation at her school and with her friends had improved: *"as soon as I saw [Option 2 worker] I kept on talking to all the boys and girls in school"*, although she also gave other reasons for the improvement.

G3, the youngest child in the interview, a boy aged 9, when talking about why he felt that things at his school were now much better, said that before his Option 2 worker was present, he thought he wasn't *"intelligent"* but *"then my brain started to work faster"*. When asked why he thought this change had happened, he replied that [Option 2 worker] kept on *"making us do stuff"* and *"helped us read"* so he thought he could do *"better at school".*

The children also spoke about how they felt that the work the Option 2 worker undertook with their parents improved the quality of their parents' relationship and also improved the children's relationship with their parent(s). For example, O2 & O3 felt that their parents were getting on better now. As O2 put it, his parents *"made better friends"* when the Option 2 worker started talking to them, although he also pointed out that since the worker had left, they were now arguing more. As a result of their parents' improved relationship, O2 and O3 felt that their relationship with their parents had also benefited: O2 stated that when his parents were arguing *" they didn't have much time to spend with us".* G2 felt that his mother had *"really calmed down".* He spoke about how the Option 2 worker helped his mum not to *"hit us and swear at us any more".*

One child spoke interestingly about how by mirroring the behaviour she observed in her Option 2 worker, she was able to improve, amongst other things, her relationship with her parents. She felt that *"I listen more to people"* and this was explained as a result of the fact that her Option 2 worker (as well as her social worker) *"listened to me"…*then she had learnt that it was good and showed *"respect"* to listen to others.

Relationship with siblings also improved as a result of work with the Option 2 worker. For example, G2, the oldest child in the interview, a 15 year old boy, spoke about how he now fought much less with his two younger siblings. The change had occurred *"by listening to [Option 2 worker]: those little things that make you think"*. E4 described how she felt her relationship with her siblings had improved, in part because their Option 2 worker had taken them on trips such as to the cinema, which they had all enjoyed and got on well together.

It must be noted, however, that some children, although they also felt that matters had improved, were unable to draw any connections between the improvements and the work with their Option 2 worker (mainly the case for E3 and E5).

Table 3.3 The results of the card game used with the children.

Since Option 2...	Much better	Better	About the same	Worse	Much worse
How happy do you feel?	6				
How is your relationship with brother and sisters?	4	3			
How is school?	3	2	1		
How is your relationship with your parents?	4	1			
How do you get on with your social worker?	4				
How happy do your mum and dad seem?	4	2			
How do you get on with friends?	2	2	1	1	
How do you feel about the future?	4			1	

3.3.3 Changes over time during and following Option 2 involvement

During analysis and discussion of the interview data, it became apparent that families were talking about their experience of change during involvement with Option 2 and whether this was maintained following the end of contact. This was analysed in more depth, with a particular focus on relating the findings to those of the quantitative analysis, and the results are described within this section.

It appears that for families where there were multiple and continuing problems (such as substance abuse, mental health issues, discipline problems, marital problems) although some factors improved after the Option 2 work ceased, other problems still continued. For example, in the case of two families, ID P1 and IDO1, the problems included depression, self-harming, alcohol issues, discipline, marital and financial problems. While both families were working with their Option 2 worker, matters improved considerably (in the case of ID P1, her drinking reduced (from once or twice a week before to once in the 4 weeks that the Option 2 worker was present) and her relationship with her daughter saw a dramatic improvement *("Those four weeks [with the Option 2 worker] have been the best four I've had [with daughter]".* For ID O1 and her two children, the Option 2 worker's presence resulted in the mother's depression being alleviated (the Option 2 worker oversaw the mother's medicine intake), and an improvement in her children's behaviour and the mother playing a greater part in her

children's lives (on asking the mother what the important thing Option 2 did for her and her family, the mother replied with emphasis *"made me and my children closer together".)*

However, when the Option 2 work ceased, these families found it difficult to cope without the extra support and some of the improvements, which had occurred, also ceased. For example, interviewee ID P1 started to drink more heavily and had recently overdosed. 'She had also had a big falling out with her daughter and had not seen her for the past 5 weeks as she had moved out to relatives'.

In the case of ID O1, without the Option 2 worker making sure that she was taking her depression tablets each day, the mother had soon stopped taking her tablets and was currently self-harming. The mother had also stopped using sticker charts to manage her children's behaviour, which she felt was now worse than when the Option 2 worker was present.

It is significant that both these mothers stressed how much they missed working with their Option 2 worker and how they both wished that they could still be in contact with them (ID O1 *"I wish I was still with them [Option 2]"*; ID P1 *"I want [Option 2 worker] to help me and [daughter] put things back together"*). It is arguable that for these families, the support of Option 2 was very important in helping them manage their difficult lives and without this support the complexity and number of their problems was overwhelming.

For other families, however, where there were fewer problems, the families felt that their work with Option 2 had really helped to get them back on track. For example, in the cases of families, ID B1&2, IDZ1&2 and IDK1, the main problems centred around drugs (for IDB1&2 and IDZ1&2) and for IDK1 relationship problems and to a lesser extent alcohol issues. After their work with their Option 2 worker, these families seem to be managing well.

For example, in the case of IDZ1&2, the support and advice with cravings that they received from their Option 2 worker contributed to them no longer taking drugs and they have no contact at all with social services. As far as this family is concerned, without the support and help of their Option 2 worker, they would have gone back to using drugs (*"without wanting to sound dramatic, [Option 2 worker] did save this family"*((IDZ1)).

Family IDB1&2's main problem was also drug use, although their Option 2 worker also helped with their son's behavioural problems. With the help of their Option 2 worker they have also managed to stay off drugs and their son's behaviour has improved. (The Option 2 worker made the father realise *"more than the others [other professionals]" the critical situation he was in and that "he couldn't carry on the way I was"* and if he did, that he would *"probably lose the children"* (IDB1))

In the case of IDK1, the mother is adamant that her Option 2 worker improved dramatically the quality of the relationship with her daughter and if it weren't for the Option 2 worker's help, her daughter would no longer be living at home with her. Although this mother felt that her alcohol intake was not a serious problem, she stated that after her work with her Option 2 worker, her alcohol intake had reduced partly as a result of her relationship with her daughter improving.

Thus in cases where problems were fewer, Option 2 work appears to have helped families to manage and cope successfully. It is possible that such improvements were more difficult to sustain in families with multiple or entrenched difficulties.

3.4 Discussion

An important limitation in the qualitative evaluation is that it was only possible to interview participants from half of the families that worked with Option 2 in 2006. It is possible that those who were not interviewed would have had different opinions. A particular issue is whether those who were not interviewed might have been more likely to have been less positive about their experience of Option 2. A number of the families had had children enter care for periods of time, and they therefore seem to represent a range of outcomes. Nonetheless, we can not comment on what the families that we could not interview might have said.

The numbers interviewed are also small. They can only provide indicative evidence, and the numbers are insufficient to develop robust theories about the impact of Option 2.

Overall, despite these limitations, the unanimity in the positive evaluation of the Option 2 service is noteworthy. Furthermore, a consistent picture emerges when the findings from the different family members are considered together. Both parents and children are positive about Option 2 and perceived improvements in a range of areas of the children's lives are apparent from the results of the card exercise.

As perceived by the families interviewed, Option 2 provides a highly skilled and valued intervention within a framework of respect for the families, sustained support and the fostering of individual responsibility for actions. In terms of the support that interviewees described as receiving from the Option 2 worker, the range and type of support offered appears to cover all categories identified in previous research as being important for families affected by drug and alcohol problems (Orford, et al., 1998). This includes both emotional and practical support as well as information giving within a non-judgemental framework.

An interesting feature of Option 2 is the service's ability to engage and respond to every family referred to it. The qualitative interviews illustrate some of the key ways in which this is achieved – with good communication and listening skills, a willingness to work long or unusual hours, exceptional commitment to each family and a deep knowledge of both child care and substance misuse issues being described by participants.

These positive attributes of the service appeared to have had a significant positive impact on some families. In particular, where families had fewer or less entrenched difficulties Option 2 appeared to have achieved lasting improvements. However, the picture was more complicated for families with complex and entrenched difficulties. For these families the intervention had also achieved positive changes, but the changes did not appear to last and maintenance of improvement was problematic. The reasons for this were various – external events, processes of lapse and relapse in behaviour change or the pressures of individual or social circumstances. However, the picture was one of temporary improvement followed by a return to situations similar to those experienced before.

It is important to note that qualitative methods are concerned with the participants' experiences. In the case of this study, these include the family members interviewed (both parents and children). Qualitative studies are not therefore useful to establish whether the service delivers consistently on a particular outcome measure. What seems evident, however, from the results presented in this study is that the families interviewed have complex and multifaceted problems and as such, require a type of help that can respond to that complexity in a positive way. On the basis of the interviews analysed, it seems that Option 2 can achieve this aim. It follows that any attempt to measure the true impact of a service such as Option 2 needs to include in the evaluation multiple outcomes that related to various aspects of the reduction of family harm e.g. substance use; family relationships, children's development and not be based on single outcome measurement.

Finally, it is important to consider issues of timing and intensity of interventions such as Option 2. It seems clear from participants' accounts that improvements take place. Whether these improvements are easier to maintain if the intervention was longer or came at a different point in time for families are questions that merit further investigation.

4. QUESTIONNAIRES COMPLETED BY SOCIAL WORKERS

4.1 Sample

To distribute the Option 2 Questionnaires to social workers, researchers visited two teams in Cardiff:

- Ely Family Centre - 10 questionnaires were given out and 10 returned
- Global Link Intake and Assessment - 15 were given out and 7 returned

Researchers also visited one centre in Vale of Glamorgan:

- Haydock House, where 26 questionnaires were given out and 6 returned (4 from Family Placement Support and 2 from First Contact Team)

Altogether 51 questionnaires were distributed to teams and 23 were returned, giving a response rate of 45%.

The respondents were 15 social workers, 3 social work assistants, 2 managers, 1 assistant manager, and 1 social work student (1 person did not provide information on this). Staff had a wide range of qualifications and an average of 7.4 years experience since qualifying. They had been in their current local authority for a mean 5.7 years each, though varied from very new to over 20 years in their job.

4.2 Quantitative Results

4.2.1 Number of referrals to Option 2 service

Out of all 23 participants who responded, 12 had made a referral to Option 2 (52%). There was a difference between the local authorities, as in Cardiff 35% of respondents had made a referral while in the Vale the figure was 100%. The nine people who knew how many referrals they had made reported 33 referrals to Option 2 between them. Of these 33 referrals, 27 were accepted. The 5 referrals that were not accepted were all in Vale of Glamorgan team.

There was a striking difference in the referring patterns between the two local authorities. While 17 of the social workers were from Cardiff they had only made a total of 7 referrals between them; in contrast the 6 Vale social workers made 26 referrals (21 of which were accepted). The reason for this difference is likely to be primarily the methods used to get questionnaires returned. In one of the Cardiff teams all the members of a team were given the questionnaires during a team meeting. In contrast, in the Vale questionnaires were returned only by those who were motivated enough to do so – and this appeared to be social workers who had had extensive dealings with Option 2. As a result, while the responses from the Vale are for a small number of workers they relate to a large number of families.

4.2.2 Rating the Option 2 experience

Members of staff were asked to rate Option 2 regarding their professionalism, willingness to take work, the impact on the family and their ability to prevent the child entering care, on a five-point scale from ‘very poor’ to ‘very good’. Twelve respondents with experience of 31 families referred to the service rated their experience of Option 2.

There was a difference between the two local authorities, as social workers from the Vale of Glamorgan were the only ones to give any 'poor' or 'very poor' ratings. In particular, half of the Cardiff social workers rated the last item - 'ability to prevent a child entering care' as being 'very good', whilst Vale of Glamorgan social workers were equally spread over the rating options, with one person rating 'ability to prevent' as 'poor', and one as 'very poor.

Table 4.1: Workers Ratings of the Professionalism and Impact of Option 2

	Very poor	Poor	Reasonable	Good	Very good
Professionalism of contact	-	-	17%	42%	42%
Willingness to take on work	-	-	8%	42%	50%
Impact on the family	-	8%	17%	33%	42%
Ability to prevent care	8%	8%	25%	25%	33%

4.2.3 Case Vignettes: Would you refer this family to Option 2?

In order to explore further both social workers' understanding of appropriate referrals and the other types of services that they might use, workers were provided with some case vignettes based on real families referred to Option 2. Participants were asked whether they might refer them to Option 2 and what other services they might refer them to. Names and case details have been changed to ensure anonymity.

a) David and Martine

David and Martine were heroin users with two young children (aged 3 and 11 months), who had been stable on methadone for 6 months. The case was about to be closed when it was reported that David had missed appointments at CAU. The social worker was suspicious that the couple had started using drugs again.

David and Martine's case was not accepted by Option 2, as the social worker had not assessed the situation as to whether the family were in crisis, and there was no risk of child removal/registration as the facts were not known. The referrer was advised to discuss these points with the family and perhaps to re-refer at a later date.

Response of participants: Cardiff

Most social workers considered that they would refer this case (67%). Social workers gave a variety of reasons for making a referral to Option 2. One was the drug issues in the family. Other reasons included the outreach nature of the service, as social workers felt that visiting the family home could encourage the family to engage. The family were judged to be particularly vulnerable, and some social workers thought this meant Option 2 would be relevant for them. Social workers also said that they would refer the family because Option 2 workers would be able to develop a safe care plan and help manage risk to the child. It was thought that the service might in this case help prevent family breakdown

One reason why social workers would not refer to Option 2 was that the drug use would need to be clarified first, which was actually one of the reasons why Option 2 did not accept this real-life case. Another appropriate reason for not referring was that there was

indication of crisis, only of suspicion, or that further assessment needed to be undertaken prior to making a referral. Some people said they would not refer because they did not know enough about the service.

Referrals to other services: Cardiff

Social workers from Cardiff were most likely to refer this family to CADT (Community Alcohol and Drug Treatment), Option 2 and CAU (Community Addictions Unit). Two said they would refer to Family Support Services. Some of the social workers would also refer to childminding facilities or health visitors; others said they would want to investigate missed appointments or drug concerns.

Place of referral	Number of referrals
CADT	6
Option 2	5
CAU	3
Family support	2
Childminding	1
Health visitor	1

Referrals to other services: Vale of Glamorgan

The Vale of Glamorgan would be most likely to refer this family to Option 2. Some social workers would also refer to CAU, parenting courses, for a core assessment or to NCH for work on crisis intervention.

Place of referral	Number of referrals
Option 2	4
CAU	2
Parenting course	1
Assessment	1
NCH crisis intervention	1

b) Mel and Vanessa

Mel and Vanessa had one child, a three year old, who was previously placed on the child protection register for negligence. Vanessa was a heroin user 'topping up' with methadone, and Mel was an ex-user on a methadone script. There had been reports of domestic violence in the relationship. The house was not child-friendly, with no sign of toys, and the social worker was concerned that it was used as a brothel.

This referral was accepted by Option 2. The family received support with parenting skills, a detox for substance use problems and relationship counselling, as well as practical help with childcare arrangements. At the 12-month follow-up the mother had stopped working the streets and was clean of street drugs, and was living with her son and his grandmother.

Response of participants

Three quarters of respondents thought that a referral would be appropriate (74%). The main reason that social workers from Cardiff gave for referring to Option 2 was to

provide practical support for the drug use in the family. Other reasons included the outreach nature of the project, as Option 2 workers could work intensively within the home, and that Option 2 service would protect Alex from further harm. Social workers also felt that the service would help with the couple's parenting issues. Social workers from Glamorgan said they would refer to Option 2 because of the drug use within the family, and also because the service would help protect the child.

One reason given for not referring to Option 2 was that there was no indication of crisis in the family. One other person said that they did not know enough about Option 2 to decide whether to refer.

Referrals to other services: Cardiff

There were a wide range of other services that workers would refer this family to. Social workers from Cardiff were most likely to refer this family to Women's Aid regarding the domestic violence; other popular agencies were FSS, CAU, Option 2, and Domestic Violence units. For this family, Option 2 were not the most popular choice of referral. There are a wide variety of other services that the social workers suggested, which are listed in the table below:

Place of referral	Number of referrals
Women's aid for safety	8
Famly Support Services	7
CAU	6
Domestic Violence units	5
Option 2	5
Playgroup	3
Barnardo's 5-15	3
CADT	3
Childminding	3
Homestart	2
CAMHS	2
Caring dads project	2
Police to monitor domestic violence	2
Health visitor	2
Other	10

Referrals to other services: Vale of Glamorgan

The Vale of Glamorgan social workers were most likely to refer this family to NCH for work on crisis intervention, and also to Option 2. The other types of referrals suggested are also listed below:

Place of referral	Number of referrals
NCH crisis	3
Option 2	3
Women's aid	2
Other	7

3. Louise

Louise had four children living at home, three girls and a seven-year-old boy whose behaviour problems were causing the rest of the family a great deal of stress. The mother used amphetamines and had some mental health issues such as panic attacks, as well as being a survivor of domestic violence. Louise was having trouble managing his behaviour and coping with the other children.

This case was accepted by the Option 2 team; however, the Option 2 workers were unable to create short-term safety for the family and the son was moved into therapeutic accommodation where he benefited from positive role models. The mother was then given help with coping skills and parenting techniques, and encouraged to spend time on her other children. She later attended a detox and stopped abusing substances.

Responses of participants

The lowest referral rate was found for this family (57%). The social workers from Cardiff who said they would refer to Option 2 thought that the service would be beneficial in addressing the mother's drug problem and supporting her parenting skills. Other reasons for referring to Option 2 were that it would prevent the children from going into care, and also because the family were judged to be in crisis. The social workers from Glamorgan who said they would refer to Option 2 suggested they would do so because the service would provide support for the family, and also would help with the mother's drug issues.

In Cardiff, the social workers who would not refer to Option 2 said that the most pressing issue was the child's behaviour or the issue of abuse and they would deal with these problems first. One other social worker was unsure of whether Option 2 was suitable for families with drug problems. In the Vale, reasons for not referring were because the child's behaviour should be dealt with first, and because there was 'no apparent drug use' in the case description.

Referrals to other services: Cardiff

Social workers from Cardiff said they would refer a wide variety of services. The family would most likely be referred to CAMHS, NSPCC or the Women's Safety Unit. Other types of referrals are shown below:

Place of referral	Number of referrals
CAMHS	7
NSPCC	6
Bardnado's 5-15	5
Women's Safety Unit	5
Domestic Violence	4
Family Support	4
Homestart	3
Children's witness program for DV	3
Health visitor	2
CAU	2
Women's aid	2
Option 2	2
Other	15

Referrals to other services: Vale of Glamorgan

Social workers from the Vale of Glamorgan were most likely to refer to CAMHS and NCH crisis for this family. The other types of referrals that were suggested are listed below:

Place of referral	Number of referrals
CAMHS	5
NCH crisis	3
Women's aid	2
Other	7

4.2.4 Qualitative Results: The experience of Option 2

4.2.4.1 The referral process

Experience of referring to Option 2

The referral process was said to be straightforward and swift, with one person from Cardiff describing how the referral they made was accepted the same day, with work beginning the next. Staff from both authorities commented that Option 2 workers were available to advise on whether referrals were relevant, and a social worker from Vale of Glamorgan said that workers would discuss the family in question prior to the referral being made. One participant from Cardiff felt that the workers were proactive, and highly motivated, and others agreed that a high level of input was common practice when working with Option 2. Several social workers said that they were planning to refer again.

No experience of referring to Option 2

Respondents who had not yet made referrals to the service, all of whom were from Cardiff, gave various reasons for this. Many people showed they understood the nature of Option 2, with around half stating that the service was an intense short-term program for families in crisis and with drug use issues, and was largely preventative in relation to care proceedings. As to reasons for not referring, around half said that they had not yet found any families for whom referral would be appropriate, and two people said that they had not referred due to a limited knowledge of Option 2 services. Another three people gave the same reasons of relevance or limited knowledge, but said this was due to having only recently joined the team – these people plan to use the service 'at some point'.

4.2.4.2 Support to families:

Intensive work

When participants had experience of referring to Option 2, the help that was offered to their referred family was intensive and useful. One member of staff from Vale of Glamorgan said that the Option 2 team had developed a positive working relationship with the family, and many felt that the support offered had been significant or 'instrumental' in producing a good outcome for the family.

Teaching practical skills

The service was praised for its practical focus, for example teaching specific addiction-related or parenting skills. For example, Option 2 workers might help with the safe storing of methadone, as described in the second case vignette by one participant from Cardiff. Several people also mentioned that therapists would teach coping skills to the parents.

Child Protection issues
While many participants commented that the main aim of the service was to prevent accommodation of the child, Option 2 was also recognised for the construction of its 'safe' care plans by the workers, and social workers clearly felt that child safety was a high priority. Some social workers described how Option 2 workers helped develop 'safe' contact between children and parents after accommodation.

4.2.4.3 The nature of the service:

Regular communication
Option 2 was said by many to be very informative, and social workers from both authorities described how the caseworker kept in regular contact, making sure all agencies involved were 'up-to-date' with the family's progress. As mentioned above, Option 2 workers were also available to social workers to advise on whether or not to refer. One member of staff from Cardiff said that staff had been helpful even when, due to their criteria, they were unable to get involved. Therapists were said to provide useful feedback to other teams, and to remain in good contact with social workers, in particular informing them of any child protection concerns.

Flexibility
Many participants, from both authorities, were appreciative of the flexible nature of the service. One participant said that a 'primary strength' of Option 2 was the ability of workers to see families outside of traditional office hours, especially in situations where risk management might otherwise have been difficult; others also mentioned the flexibility of the intervention as a factor in its success. In answering the case vignettes, many of the social workers from Cardiff felt that Option 2 would be an appropriate service to refer to because it was an outreach service, and understood that workers could visit the family home, which might be useful with a parent who was unwilling to engage.

4.2.4.3 Suggestions for improvement

Short-term involvement
A few people felt that due to its short-term nature, Option 2 could only provide medium term improvement and did not deal with underlying emotions or longstanding problems; three people from both authorities described how, in their experience, care proceedings had initially been delayed but after involvement ceased, the child still went into accommodation. One person felt that this experience would make them less likely to refer again, and someone else felt that work after the intervention, eg. review meetings, was too 'spaced out' to have any real impact. However, another felt that the involvement of Option 2 in these circumstances had actually made the family easier to work with, as the episode was contained over the period of the intervention.

The size of the service
Several participants suggested improvements to the service, for example in relation to another limitation of Option 2 – its size. Some people felt that families were missing out as they occasionally have to wait when the service is full, while some felt that the service should be expanded to provide a wider range of support to even more families, for example, supporting the family through rehabilitation. One participant from Cardiff suggested that Option 2 could also have applications beyond its current field, for example in helping youths with behaviour problems.

More information
The social workers that had little knowledge of the service often requested they be told more about it, as several people said their reasons for not referring were that they had too limited an information base. One person suggested that leaflets could be sent to teams on a regular basis, and it seems that some would appreciate more training in this area in order to start using the referral process efficiently.

4.3 Conclusions

- Social workers who had experience of referring were generally positive, and the few negative comments came from those who had the most experience, which reflects their more developed understanding of the service. Critical comments all related to outcomes for families rather than the professionalism of the service, which seemed to be universally appreciated.

- Professionalism, willingness to work and impact on family were all rated as successful aspects of Option 2, however prevention from accommodation was not so highly rated – this lower rating was related to some respondents' experience of the child going into care anyway after the involvement finished. One view was that this was a limitation of the service, but another view was that the service helped in this situation despite the care proceedings.

- For the first case vignette, which was considered inappropriate by Option 2, more people would have referred to the service than would not, and almost everyone from Vale of Glamorgan would have referred inappropriately. For the second and third case vignettes, which were appropriate, more people would have referred than would not.

- Popular reasons for referring were drug use in the family, the outreach nature of the service, the practical support that could be offered, and the ability of Option 2 to prevent accommodation.

- Common reasons for not referring were that the family was not relevant e.g. in case vignette that they did not appear to be in crisis, or that further work would be needed with a family before referral was appropriate. Around half of people who had not referred had a good understanding of the service but had not yet had a relevant family, and a few planned to refer in the future.

- There were also some people who had not referred due to a limited knowledge of the service, often because they had only recently started in their team, and there might be a requirement for training on Option 2 on entry to this area of social

work. One person requested that leaflets could be sent regularly to the relevant teams.

As well as being interesting in their own right, the responses from social workers have implications for other elements of the evaluation:

- There appear to be informal processes of case discussion that sometimes take place before referral. It seems likely that these may influence the comparability of the comparison group. In particular, there may be a higher proportion of "inappropriate" children in the comparison as one might expect the informal discussions to prevent some inappropriate referrals. The most likely factor to be inappropriate in referrals is a lack of a specific crisis. These processed were considerably more pronounced in the Vale than Cardiff, suggesting particular attention needs to be paid to the comparability of the comparison group there.

- The wide range of other services referred to as potential alternatives to Option 2 is striking. This underscores the fact that the comparison for outcomes is not between Option 2 and no service received; it is between Option 2 and a range of other services, several of which are comparatively intensive.

5. DISCUSSION: KEY FINDINGS AND THEIR IMPLICATIONS FOR POLICY, FUTURE RESEARCH AND PRACTICE.

5.1 Limitations and strengths of the study

Limitations

First, the quantitative element of the study only provided information on care entry. This is not a measure of child or family welfare. A study gathering data on child welfare, family functioning and parental substance misuse would provide far more evidence on the effectiveness of the intervention. This was not possible within the time and resource constraints of the current study.

Second, the cost/off-set element of the study relies on minimal information. Most importantly, only costs related to care are included. The direct costs of social work input or other services provided to children in care are not included. The cost of alternative service provision instead of Option 2 is not considered. There has been no attempt to measure the impact on education, health, criminal justice, adult substance misuse or other resources. For these to be included a study that directly accessed families would be needed. The study is therefore probably a significant underestimate of the economic impact of Option 2

Third, the evaluation benefits from the fact that the project set up a comparison group. In an ideal world families would have been randomised to receive the service or not, and the lack of randomisation creates the possibility of variations that might impact on the validity of the findings. Considerable attention has been paid to this issue in the analysis, and the possibility of variations between the groups may nonetheless influence the findings in ways that are not obvious.

Fourth, the “Option 2” group included anyone referred to the service when there was space. Thus 16% of the children in this group had been assessed as inappropriate and more would have received a minimal intervention for various reasons. From a research point of view this is the valid comparison, because families such as these would be included within the comparison group and there was no way to prevent this. However, the impact of Option 2 was considerably greater in reducing care at the follow-up point and in reducing costs if “not appropriate” children were excluded. This is therefore a stringent test of effectiveness: it is the impact of the service on any referral accepted, rather than on any family worked with. Again, the tendency will be to reduce the measurable impact of Option 2.

Fifth, it is not known what services the comparison group received. The questionnaires completed by social workers highlight a multiplicity of services that families might be referred to, including some that offer comparatively intensive input. The impact of Option 2 is not being matched against “no service”; it is being compared to “a range of other services”. The effects that are being discussed are therefore greater than for a comparison group receiving no input, and this makes it likely to be harder to demonstrate an effect. Indeed, social workers had high opinions about some of the other services available. If these are indeed effective services, the impact of Option 2 is all the more noteworthy.

Sixth, the qualitative study was carried out on a small sample of families and individuals. Care needs to be taken in generalising from the findings. In particular, the families who

agreed to take part in the evaluation may have different views to those who could not be contacted. It is possible that individuals who are unhappy with the service would be less likely to participate in the evaluation. There are no grounds for believing this was so, but it remains a possibility. Similar considerations are relevant to the questionnaires from social workers. This is particularly true in the Vale, where few questionnaires were returned and they were only by social workers who had direct experience of Option 2.

Strengths

The study has a number of important strengths. Thanks to the foresight of the manager of Option 2, the research has what appears to be a broadly valid comparison group. This is very rare in evaluations of interventions in a British context, and has enabled a far more critical appreciation of the impact of Option 2. There has also been sufficient information to allow the validity of the comparison group to be explored and differences in the local authorities to be taken into account in the analysis.

An important strength in the study, and a comparative rarity in evaluations of British social work services, is that the study has sufficient numbers to carry out robust statistical testing. The follow-up period – which averaged 3.5 years – is also far more than most evaluations. This is particularly important in a study looking at the impact of an intervention on care entry. It has allowed an appreciation of the impact on care entry over time. Importantly, the study has combined quantitative and qualitative evidence and information from a variety of sources, and this has strengthened the findings.

Finally, many of the limitations of the study can also be construed as strengths. By including all referrals accepted, having a comparison group receiving a range of services, having a fairly difficult outcome in preventing care entry and in following-up a brief intervention over a long period of time, *the evaluation is setting up an extremely stringent test of impact. The fact that Option 2 has a measurable effect despite these factors is strong evidence of a powerful intervention with families in which there is parental substance misuse.*

5.2 Key findings

The literature review painted a bleak picture of the impact of Homebuilders style interventions. There was little evidence of them having any impact in reducing the need for care, or improving family functioning or child welfare. These findings have had a major impact in the USA, where there has been a general loss of belief in the ability to prevent the need for children to enter care. Key factors identified as important in the lack of impact of Homebuilders included the inappropriateness of the brief intervention model for long-term and chronic problems, the lack of focus on services for the comparison group and the inappropriateness of the families referred to the service.

The review of outcomes for children entering care (undertaken as part of this evaluation but produced as a separate report) also underlines the complexity involved in developing effective responses in this area. It highlights the fact that in general children's welfare improves after entering care. In particular, children in care tend to do better than similar children left at home and children returned home from care tend to do less well than those who remain at home. This suggests that interpreting findings in relation to the prevention of care is complex. For instance, an excellent and highly effective service might actually have a detrimental effect on some children's welfare if it kept them in families that were not meeting their needs for longer. This highlights the importance of child welfare rather than prevention of care being the goal of the intervention. Option 2 is

focussed on improving family functioning and child welfare, with prevention of care as a secondary aim. The primary remit for the evaluation was the cost impact of Option 2. This is an important policy consideration, and may influence decisions about whether to adopt the Option 2 model. However, the generally positive impact that care entry has on children's welfare underscores the complexity of evaluating services aimed at preventing children from entering care.

The key findings in relation to the quantitative study of care entry post-Option 2 were that Option 2 did not reduce the likelihood that children would enter care, but that on average it did delay care entry and it increased the likelihood and speed with which children returned home. As a result there were indications of a significant cost saving, at least in Cardiff where the figures were available. These are important findings. They indicate that Option 2 is a comparatively powerful and effective intervention in reducing the need for children to enter care.

The interviews with parents and children pointed to some of the ways in which the service achieved these outcomes. The workers were highly skilled and dedicated and their communication skills with parents appeared to be excellent. The parents and children that we interviewed were very happy with their experience of Option 2. Similarly, social workers who had made referrals to Option 2 generally reported positively on the professionalism of the Option 2 service and its impact on the families referred. There was some confusion amongst social workers about which types of families to refer to Option 2, and when they should refer to Option 2 compared to other services, but general agreement about the quality of the work undertaken.

A further important finding was that Option 2 workers showed great skill in engaging families under difficult circumstances. In every referral accepted as valid, Option 2 managed to engage the family in at least an initial discussion of the appropriateness of the service. The ability to engage families in very difficult situations was identified by both social workers and families themselves as a key strength of the project. This is a central facet of Option 2 that is likely to have wider significance. Difficulties in engaging families in which there is parental substance misuse is a common challenge for child and family social workers and other services working with vulnerable children. It is also noteworthy that in comparing statutory social workers and Option 2 workers, parents and children were often very critical of their social workers' style of communication and general approach and positive about Option 2. It seems likely that there are important lessons that can be learnt from the Option 2 service and applied in both statutory and voluntary sectors about how to engage the most difficult to reach families.

Despite – or perhaps because of – these positives, there was one area of criticism of the service. In both the interviews with parents and the questionnaires to social workers there were indications of unhappiness with the brief nature of the intervention. A number of parents said that they would have liked to have been with Option 2 for longer. In some cases, the improvements during and after the time of the Option 2 involvement were not sustained and families returned to previous levels of difficulty. This included children entering care in some families. In a similar vein, a small number of social workers with experience of the service believed that the intervention was too brief, and that as a result changes sometimes did not last. This had resulted in some children's entry to care being delayed rather than prevented. These qualitative findings are considerably strengthened by the quantitative findings about delaying care entry which support this picture. However, they do not explain why some children remained in care for shorter periods

and were more likely to return home. These findings suggest more long-term impact for some families. This was also supported by the qualitative evidence for some families.

5.3 Discussion of the key findings

The findings are encouraging. Option 2 appears to be a highly professional and appreciated service that has a lasting – though not always permanent – impact on families with serious problems, including parental substance misuse and concerns about child welfare. The Option 2 approach offers considerable potential to be developed as a way of reducing the need for care – and the consequent costs – for some children. However, two important areas remain to be addressed. The first is, is it good for children? The second is, does the impact last? If not, why not and what might we do about this?

Is Option 2 good for children?

It was noted above that an excellent intervention aimed at preventing children from coming into care might in fact prove harmful for some children if it delayed care entry and prolonged children's experience in difficult families. This is a possible impact that Option might be having for some.

There is no reason to believe that this is a general impact. For instance, for the 60% of children who do not enter care there is no reason to believe that Option 2 is having a harmful effect. It is not possible to be sure that Option 2 is having a positive impact on these children – though the qualitative feedback was encouraging – and we know nothing about how long the positive impact might last. But on balance it seems likely that Option 2 will have had a positive impact for many of the families and contributed to lasting positive change for some. Equally, for many children a delay in care entry and/or a shorter period in care may be positive outcomes. Yet we can not be sure of this. The evaluation establishes that Option 2 is a powerful intervention for some very troubled families. This is why it has a measurable impact on the need for public care. Yet, it is this very potency that means more detailed study is required to explore the impact it has on child welfare, particularly when the impact of care entry is also taken into account. Specifically, it needs to be identified whether there are some children for whom the Option 2 service is not appropriate who should enter care immediately – and what the characteristics of such children's situations are.

Does the impact of Option 2 last? Why does the impact not last – and how could its impact be made to last longer?

The literature on Homebuilders interventions suggests that brief interventions are unlikely to be an effective way of reducing the need for public care. In general, children enter care because of complex and chronic problems, rather than a precipitating crisis. In this context, what is striking about Option 2 is that despite this the service does have a significant and measurable impact on care entry. Furthermore, this has been achieved with an issue – parental substance misuse – that research and theory suggests may be particularly intractable and unlikely to respond to a brief intervention. In some ways it can be argued that the Option 2 approach has made the Homebuilders model "work". The outcomes are certainly more impressive than the literature would suggest is likely.

On the one hand it is necessary to consider why this may be. Three factors appear likely to be important. The first is that Option 2 provides an unusually highly skilled intervention. The therapists are extremely experienced and well qualified. They receive

more training and supervision than many Homebuilders interventions report providing. The manager of the service is very experienced, qualified and dedicated to the provision of an excellent service. These are in no way trivial issues in thinking about how other services might replicate the successes of Option 2.

The second factor that may be important is the broader social and environmental context within which Option 2 operates. The vast majority of evaluations of Homebuilders have taken place in the USA. The residual welfare state and high rate of child removal may have contributed to the failure of Homebuilders; it is possible that the gap between the Homebuilders intervention and "normal" services is greater in the States and this contributes to the failure of the intervention. This is difficult to explore in practice, but related policy and practice implications are discussed further below.

A third factor likely to be of significance is that Option 2 uses established and evidence-based methods. In particular, there is a strong body of evidence supporting the effectiveness of Motivational Interviewing as an intervention with alcohol and (to a lesser extent) drug misuse. A key focus of Option 2 has been on the quality of the interaction and the creation of an equal partnership between parent, child and worker. The tentative conclusions of reviews of Homebuilders were that this might be more important than the length or intensity of the intervention; certainly it is at the heart of Option 2.

Nonetheless, the evidence of the evaluation suggested that - for some families at least – the impact of Option 2 may fade over time. This is an important finding worth considering in detail. It has implications both for the ways in which Option 2 or similar services might be provided and for other services.

There are three inter-linked explanations for why the impact of Option 2 in stopping the need for care may not last – relating the nature of the families, the intervention and other services. First, families from which children enter care have profound and inter-related and chronic problems. This makes creating lasting change particularly difficult whatever intervention is used.

Second, related to the above, a brief intervention is unlikely to be effective with such issues. This explanation stresses the lack of "fit" between the problem and the solution, rather than the nature of the issues within the families themselves.

A third potential contributory factor is that the services post-intervention are inadequate. For instance, in the qualitative interviews families tended to contrast the quality of relationship and commitment of the Option 2 worker with what they were used to from social workers. This explanation suggests that the failure to maintain change may be as much about the quality of the services provided after Option 2 as it is about the families in themselves. Thus, if Option 2 can significantly reduce the need for care by on average around 4 months through a 4-6 week intervention, could skilfully delivered "normal" social work sustain this change? Conversely, could poor services undermine the positive changes achieved?

In reality, each of these explanations probably has a part to play. However, it is important not to see the failure of Option 2 to prevent care entry in isolation. It may be about family difficulties that can not be overcome. It is equally possible that it is a result of failures within other professional systems that do not adequately address these difficulties.

5.4 Discussion

The research evaluation taken as a whole highlights the complexity involved in designing interventions or undertaking research in this area. Central to these difficulties is the very serious and multifactorial nature of the problems in most families from which children enter care. A child entering care is a sign of social and familial breakdown of the most profound kind. It is because care is a last resort and the families from which the children come have such serious problems that placement in care so often results in an improvement in children's welfare.

One implication of this is that if we wish to improve outcomes for these most vulnerable children it is not enough to improve the care system. We also need interventions targeted at preventing or reducing the harm that children experience *before* coming into care. If we can create such interventions we may reduce both the need for children to enter care and the difficulties that children have once in care.

Yet the profound nature of the problems that these families are experiencing is not only the reason why children entering care tend to have so many difficulties, it is also the reason why it is so difficult to *prevent* children from entering care. These families have very serious and generally long-standing problems. These tend to include profound individual and social disadvantage. Attempts to reduce the need for care have had very limited success in the face of these difficulties. Some interventions with older children whose behaviour is the presenting issue have shown signs of effectiveness. However, to date there is very limited evidence to indicate effective interventions where the concerns focus on potential child abuse or neglect and the parent's ability to care for children – particularly where there is also parental misuse of drugs or alcohol.

These days there are often calls for "evidence based practice" and "evidence based policy". Yet a crucial element of this is to acknowledge when we do not have evidence about what works. How to prevent children from entering care is one such area. It may be more appropriate to acknowledge our lack of evidence and set about exploring what may or may not work. In this respect, the Option 2 service has a number of extremely important contributions to make.

First, there is much to be learnt from Option 2 in terms of engaging some of the most difficult to reach families in services. Their success in this regard is outstanding. A related point is the way in which the service seems to be received very positively by parents and children. Once again there are general lessons to be learnt about working with people in difficult situations and about broaching difficult issues, such as drinking or drug taking and its impact on children. This also provides a foundation upon which interventions aimed at improving child welfare and reducing the need for care can be built. The ways in which they achieve this are likely to have implications not only for specialist services but also for social work practice more generally.

Second, Option 2 appears to have some impact in delaying care entry and increasing the likelihood of return home. We can not know what the implications of this are for children's welfare without the quasi-experimental study noted above. However, this evidence of some impact on care entry provides a starting point for experimenting with ways in which the service might be able to improve child welfare and if possible prevent children from entering care.

Third, the findings from both the literature review and the current research do call into question whether a short-term, crisis intervention model is appropriate for all of the families worked with. Indeed, for the families we consider most likely to have children enter care – those with complex and long-standing problems – it may be a particularly inappropriate intervention. For these families, the service user feedback was that they wanted more Option 2 input, and the quantitative findings supported this as something they might benefit from.

We consider that Wales has a tremendous asset in a ground-breaking service such as Option 2. Our recommendations are based on a belief that Option 2 provides a highly professional and well received service, which reduces the need for public care and as a result appears to reduce the cost to the public purse of care entry. As such, it provides a good starting point to experiment with ways in which we might prevent children from entering care. Our recommendations expand on this belief and its implications.

5.5 Recommendations

Recommendations for Option 2

1. There seems to be limited evidence to support a time-limited intervention based on a crisis intervention model if one of the aims is to prevent children entering care. **Option 2 may therefore wish to consider experimenting with**:

    d) **longer periods of intervention** (perhaps at less intensity) for some families;

    e) more systematic use of **follow-up sessions and multiple re-referrals**;

    f) more **flexible models of engagement negotiated in partnership with families**.

2. **Targeting more closely on children "at risk of accommodation" or "in care" would increase the success of the project at preventing care entry.** This would need to have support from the local authority, but there is evidence of success of such a model in the USA (Blythe and Jayaratne, 1999). However, the project is not only interested in preventing care.

3. **Services based on the Option 2 model could be usefully developed for families without substance misuse issues.** They might be effective with depression, domestic violence and a range of other issues common within childrens' services.

4. **The service needs to be publicised within Cardiff**, where workers have a poor understanding of the service. The positive outcomes from the evaluation should be made known to senior managers who should encourage knowledge of and referrals to Option 2.

From a research point of view it would be helpful to make referral processes more formal in the Vale i.e. reducing informal discussions prior to referral, however this needs to be

balanced against the potential benefits of the current approach. This is therefore not a recommendation.

Recommendations for other services involved with children and families

5. The success of Option 2 in working with hard-to-engage families suggests that the potential **impact of motivational interviewing and solution-focussed approaches should be explored within child welfare work.**

6. It would be particularly appropriate to ensure that social workers working with families referred to Option 2 had some of the skills demonstrated by Option 2 workers, so that there was less of a perceived difference in the quality of the service they receive after Option 2. This might also improve outcomes for children. We would therefore recommend **training for social workers within Cardiff and the Vale in motivational interviewing, solution-focused approaches and other aspects of Option 2 ways of working**, and an evaluation of the impact on children and families and of any "added value" to the Option 2 intervention. However, research is clear that training alone is insufficient for practitioners to achieve skilled practice. In addition, clinical supervision is required following training. Again, the presence of Option 2 in these local authorities provides unique opportunities to provide such input.

Recommendations for further research
At a number of points the dangers of relying on an evaluation that does not consider child welfare have been highlighted. We would recommend as an urgent priority:

7. **A research study following-up the impact on child, parent and family welfare outcomes and costs of Option 2 compared to comparison children**. In particular this would allow the following questions to be answered:

    - What is the impact of Option 2 on child and family welfare?
    - How long does this impact last?
    - Which types of issues and families does Option 2 achieve the best outcomes with? Which does it work less well with?
    - Does Option 2 have a different impact on the welfare of children at home compared to those who enter care? Specifically, what is the impact of the delay in care entry?
    - What are the full economic costs and benefits of the intervention?

8. We would recommend that **adaptations to the Option 2 model (as suggested above) be carefully evaluated to identify their impact on child and family welfare and care entry.** Outcomes can be compared between projects or with findings from the current evaluation.

Recommendations for policy

A complex picture of how to approach the aim of preventing children from entering care emerged from both the literature reviews and the evaluation of Option 2. Key principles for policy formation in this area include:

- Improving outcomes for children in care requires effective intervention in their families of origin prior to care entry;

- The focus of any such interventions should be child welfare not preventing care;

- To achieve this, services may need to aim both to make earlier assessments and decisions when care entry is likely *and* to develop effective services to improve family functioning and child welfare where care is not appropriate;

- We do not know what services are able to do this at present, and policy should therefore actively explore and evaluate different approaches;

- Service development and evaluation should not focus solely on specialist services (such as Option 2) – it should also consider ways of improving general social work practice, and lessons to be learnt from specialist interventions;

- The evaluation suggests that Option 2 is a positive model for achieving some of these aims. However, it is not “the” answer to preventing children from entering care. Rather, it provides an excellent starting point for exploring systematically how we might succeed in improving outcomes for these extremely vulnerable children and their families.

In Option 2, Wales has a service of international excellence in preventing the need for care for children whose parents misuse drugs or alcohol. We would recommend that the approach be developed and expanded, with ongoing evaluation, and the implications of the success of Option 2 be considered for social services more generally.

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Appendix A: Method used for the review of the literature

Previous studies on IFPS were identified through the following databases: Scopus, Ebscohost, EJS, PubMed Central and Ingenta.

The following key words were entered: family preservation, intensive family preservation services, family reunification and Homebuilders. Later searches were refined by adding "substance abuse". By this process some studies were identified as well as some journals that publish issues relevant to IFPS. Some of these journals are: Children and Youth Services Review, Child and Welfare, Social Work Research, Social Work, Journal of Child and Family Studies, Social Service Review. Alerts on databases were also set-up with the same key words.

Following identification of a number of comprehensive reviews of studies prior to 1995, studies from 1996 onwards were focussed on. Finger-tip searches of the journals noted above were carried out and the Google Scholar database was also searched using the keywords above. References within articles identified in the above ways were also followed-up.

IFPS studies were also identified through searches for agency websites on Google. Many IFPS or FPS agencies had available summaries of their program evaluations on the web. Others were obtained via email requests. The following institutions or parts of the US government aimed at the provision and enhancement of family and child wellbeing were also identified through the web, and through references on their websites or email correspondence further research studies were identified:

- The Assistant Secretary for Planning and Evaluation (ASPE) (www.aspe.hhs.gov)
- National Family Preservation Network (www.nfpn.org)
- Administration for Children & Families (www.acf.hhs.gov)
- National Coalition for Child Protection Reform (www.nccpr.org)
- Institute for Family Development (www.institutefamily.org)