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Evaluation of the Integrated Family Support Service - Second Interim Summary Report

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Second Interim Summary Report

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Views expressed in this report are those of the researcher and not necessarily those of the Welsh Government

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Executive Summary

SQW, supported by Ipsos MORI and Professor Geoff Lindsey of the Centre for Educational Development, Appraisal and Research (CEDAR) at the University of Warwick, was appointed to undertake an evaluation of the Integrated Family Support Service (IFSS) model in August 2010. This second report presents the findings from the second year of the evaluation (September 2011 to September 2012).

Delivery, management and governance arrangements

The size of the Integrated Family Support Teams (IFSTs) varies across the three Phase 1 sites, with 15 people in Site 1, 10 in Site 2, and 12 in Site 3.

There is a mixed picture in terms of IFST stability across the sites. In Site 1, although IFST membership has been settled and remained stable, there have been high levels of staff sickness due to stress. Site 2 has continued to benefit from a stable IFST membership this year. In contrast, Site 3 has suffered from higher levels of staff turnover and churn. There have been some job uncertainty issues affecting the stability of the IFSTs. The lack of and irregularity of the throughput of cases has also created some difficulties.

Across the three Phase 1 sites, there have been some difficulties around defining and implementing the Consultant Social Worker (CSW) role effectively. Feedback suggested that the issues were often linked to the seniority, salary level and support requirements or expectations of the CSWs. Additionally, the teams appeared unsure about how best to capture added value from the CSW role through the on-going research.

Generally, the IFSTs have become more familiar and confident with implementing IFSS over the past 12 months. Staff felt they have developed an appropriate mix of skills required to meet the needs of eligible families and they are supportive of IFSS.

Different styles of working and IFST staff behaviours are emerging across the sites. Formal structures such as ‘reflective’ meetings to encourage team-based discussion of cases have worked reasonably well. However, in one

particular site, there was evidence of increased ‘self-working’, which may create issues in the future.

Staff are spending on average, 40% or less of their time in direct contact with case families. Even allowing for other key activities such as training, team meetings, wider service engagement and travel etc., this suggests that there is capacity amongst IFST workers to take on additional cases.

Although there generally has been a strong core commitment to the IFSS Boards from partners, one or two gaps still remain – noticeably with the Police and Mental Health. Overall, attendance levels have been mixed and are perhaps falling.

The Operational/Implementation/Steering Groups have played an important role in sharing information, raising IFSS awareness and addressing day-to-day operational process issues but some of this activity may need to be re-directed to the Boards as IFSS further develops and is mainstreamed.

There is some uncertainty about the value of the Section 58 agreements, although the process of developing them was regarded as being useful.

IFSS throughput

Although individual IFST staff were able to describe in broad terms the types of family that they thought were most likely to gain from IFSS, this was with a narrower group than described in the IFSS statutory guidance. Therefore, it was thought that the guidance on eligible families would benefit from being honed and refined further. Specifically, the feedback to the evaluators suggested that additional work is required to clearly articulate what types of families it is believed would benefit most from IFSS support. Importantly, the definition will need to focus on the potential responsiveness of the family and their willingness to change.

The general consensus amongst IFST staff and Board members was that the quality of referrals had improved as the social workers’ knowledge of IFSS had increased and the IFSTs had become more experienced. However, despite investing significant time and effort in seeking to raise awareness of

IFSS amongst social worker teams, throughput during the year was lower than expected. A total of 228 referrals were made to IFSS across the three Phase 1 sites in 2011/12, which is higher than the 210 referrals recorded in the first year of IFSS but still lower than expected. A total of 174 referrals progressed to the initial IFSS assessment stage, and 26 of these cases were re-referrals.

There were relatively small volumes of eligible families completing Phase 1 (4-6 weeks of intensive support) of IFSS last year. Across all three sites, the total figure was 85, compared to a figure of 89 in Year 1. In part this slight decline is due to non-recording of families who are supported for less than the full Phase 1 period, but even so the lack of overall throughput is apparent. For example, in Sites 1 and 3 (no data are available for Site 2) 41 of the referred cases received advice through IFSS without having a full consultation or progressing to the 72 hour assessment. Going forward, the evaluators think it is important that all three sites accurately record the number of cases where 'advice only' is provided and where consultations take place, as well as those that formally progress to the 72 hour assessment.

A number of families explained that they had made an active choice to sign-up to IFSS. They had accepted that they had reached 'rock bottom' and needed help. Other families saw taking part in IFSS as a way to show that they were willing to 'comply' and do what was asked of them.

The intensity of IFSS meant that families considered it to be a very significant commitment. Some families were surprised about the amount of work they themselves would have to do as part of the Programme. Families and IFSTs suggested that an improved hand-over or induction process using a familiar social worker may help to increase recruitment to IFSS.

IFSS implementation

IFSS referral cases are distributed across the IFST members based on capacity as opposed to professional expertise. This approach brings with it the potential for some risks, albeit so far recognised in only a very small number of cases, that some underlying issues are missed. It is acknowledged

that to some extent, these risks would always exist regardless of how cases were allocated, but they would arguably be reduced if all sites were operating higher levels of team-based working.

Evidence from the three sites shows that over the last 12 months, there has been some variation in terms of how IFSS was delivered, both between the sites and between individual cases in each site. For instance, IFST staff stated that the length of Phase 1 varied depending on the responsiveness or size of the family. Given the flexibility that was designed into the model from its inception, this growing divergence is to be expected and welcomed, as long as local delivery remains within the broad parameters of the model.

Feedback from all three Phase 1 sites suggested that there was some concern amongst IFST staff that the transition from Phase 1 to Phase 2 was too severe for some families. One IFST Manager suggested that there should be consideration of developing an additional stage in the IFSS process, although this may not be necessary as the IFSS model is not intended to be a rigid one.

Some families stated that they had felt nervous about the prospect of a reduction in the level of IFSS support as they moved from Phase 1 to Phase 2. Having access to their IFST worker's telephone number was greatly valued and reassuring.

The evidence collected during the second year of IFSS activity suggests that in places, the Programme is starting to have an influence over wider service delivery. Across the three sites amongst IFST staff, there was evidence of strong and universal support for IFSS as a delivery model, including the innovative tools and techniques used.

Families reported that they were very fond of the IFST workers. They stated that their IFST practitioner often became 'part of the family' – gaining the trust of all the family members. A few family members explained that they felt they had developed genuine friendships with their IFST worker.

IFSS outcomes and impacts

It is still too early to form any robust conclusions about the long-term impact of IFSS on family outcomes and the sustainability or persistence of such impacts. However, the available monitoring or tracking data from the sites suggest that generally, broadly positive trajectories are still being achieved by the majority of the participating families (albeit based on relatively small numbers). Data from Site 1 show that of the 31 cases accepted onto Phase 1 of IFSS, 21 completed this stage of the process. Similar data for Site 3 indicate that of the 34 cases accepted onto Phase 1, 23 completed.

Monitoring data suggest that a major improvement occurs between the beginning and the end of Phase 1. The next stage of the intervention through to the six month review is characterised by a more gradual improvement in terms of family functioning. During the six month review and the final review after 12 months, another significant positive shift is evident.

Consultees identified numerous examples of where the intervention had made a tangible difference in terms of helping family members with substance misuse and tackling complex wider issues as they sought to turn their lives around.

Wider discussions with the three IFSTs highlighted a broader set of factors which led to positive outcomes. Although it is difficult to generalise, it was reported that IFSS seems to deliver most impact to those families that can be characterised as being ‘new’ to the system or ‘early intervention families’.

The majority of the families interviewed felt that the IFSS programme had resulted in a very positive impact on the family. While this can partly be explained by the sample selection, in that those families who had benefited the most were most likely to engage with the evaluation process, it does provide re-assurance and illustration of the model working in some families.

However, not all families interviewed felt that they benefited from IFSS. Three families (out of 23) had a negative experience of the Programme. Others had had more positive experiences but believed that IFSS had done little for them in the longer-term.

Issues for consideration

A series of issues have emerged from the second year of the IFSS evaluation. These are presented in the table below for consideration.

	Issue	Lead responsibility
1.	IFSS Boards should review levels of throughput within their teams and set clear annual targets for number of referrals for their IFST based on local capacity and need. Progress against this target should be tracked on a quarterly basis.	IFSS Boards subject to agreement by the Welsh Government
2.	Where there is variability and low attendance at IFSS Boards, the respective Boards should consider why attendance is drifting downwards and take action to draw back in key members.	IFSS Boards
3.	All newly established IFSTs should ensure that they invest sufficient time, effort and energy into building relationships and raising awareness of IFSS in order to achieve an appropriate flow of suitable referrals in their *first year* of operation; whilst existing IFSTs should maintain levels of awareness of IFSS to ensure sustained levels of appropriate referrals are achieved.	IFSS Boards and IFSTs
4.	IFSS Boards should be tasked with ensuring that effective monitoring and evaluation frameworks are established so that the longer-term impacts of IFSS delivery can be captured at a local level and the findings can be disseminated widely. These should be used to inform future IFSS activity and wider service delivery.	IFSS Boards
5.	In updating the statutory guidance on IFSS, consideration should be given to provide further detail on eligibility/target families for IFSS (to further support promoting the service locally); and, the role of the Consultant Social Worker to ensure the added value of the role is maximised. The IFSS model is intended to be flexible. The ability of the sites to tailor and shape the model should be retained, so that they are able to respond to local need. Therefore, it is important that all sites are made aware that there is scope within the model to allow delivery to be adequately tailored to effectively meet the needs of individual families.	Welsh Government
6.	Consideration should be given locally to what can be done to support families who are not ready or sufficiently motivated to engage in IFSS	IFSS Lead Officers IFSS Boards
7.	Each IFST needs to be careful to maintain collaborative team-based working and reflection to ensure high quality delivery of the model. The IFSS Boards and the IFST Managers should ensure that there is a strong culture of collaborative working and staff interaction within the IFSTs. This should feed through into individual IFST appraisal processes.	IFSS Boards and Lead Officers
8.	IFSTs will require access to current thinking and practice across the fields from which team members have come. This is probably best done by the individual development plans of staff including time for them to maintain and build their knowledge, with support	IFST Managers, staff and professional bodies/former

	Issue	Lead responsibility
	from the IFST Manager and their former employers.	employers
9.	Care needs to be taken around handover points within the model. This will help to ensure that families are properly introduced to the IFSS worker and 'inducted' at the start of the process, and then moved back smoothly to working with their social worker (in the absence of the intensive IFSS input). Similarly, signposting and referrals to wider service providers will also need to be managed carefully in order to minimise any adverse effects on the family.	IFST staff and social workers

Source: SQW 2013