



Dundee Early Intervention Team

Independent Evaluation Report

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The University of
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1.0 Introduction



1.0 Introduction

The Improving Futures programme was launched by the Big Lottery Fund in March 2011. The £30.5 million programme provided up to £1.08m to 26 pilot projects across the UK, to test different Voluntary and Community Sector (VCS) led approaches towards achieving the following outcomes:

- Improved outcomes for children in families with multiple and complex needs.
- New approaches to local delivery, demonstrating replicable models which lead to more effective, tailored and joined up support for families with multiple and complex needs.
- Improved learning and sharing of best practice between public services and VCS organisations.

Whilst the programme allowed discretion for projects in identifying and assessing needs, an age limit of 5-10 years was placed on the oldest child at the point of engagement to encourage partnership working between family-focused organisations and schools, though this criterion was loosened in the final stages of the project. In Scotland, a decision was taken to set the upper age limit at 12 to reflect the difference in primary school progression age.

In October 2011, Big Lottery Fund awarded an evaluation and learning contract to a consortium led by Ecorys UK with Ipsos MORI, Professor Kate Morris and Family Lives. The evaluation was funded over six years, to assess programme effectiveness and impact, alongside continuous dissemination activities. Further information on the national evaluation can be found on the Improving Futures website¹.

This report presents the evaluation findings for the Dundee Early Intervention Team's Improving Futures project, delivered by a partnership of organisations led by Aberlour Child Care Trust and including Barnardo's Scotland, CHILDREN 1st and Action for Children Scotland. The findings are based on:

- A desk review of various documents including business plans, application forms and monitoring reports
- Analysis of project monitoring data inputted by project staff and collected through the Improving Futures Monitoring Information System (IFMIS)
- A qualitative case study visit in November 2014, during which researchers interviewed staff, stakeholders and families
- An in-depth interview with the project coordinator

The views expressed in this report are those of the independent evaluators, based on a review of the available evidence, and do not necessarily reflect the opinions of the project or the Big Lottery Fund.

1.1 Project overview

The partnership was awarded £1,080,000 from the Big Lottery Fund in January 2012 to deliver a needs-led service to families who do not meet the threshold for social care or support from Dundee's Integrated Children's Services. There was a locally-recognised gap for support for such families, particularly in terms of early help to prevent escalation of crises to the point where statutory intervention would be required.

The service was developed to draw together the individual expertise and resources of the four charities in the partnership, creating a synergy with potential to provide effective and sustainable provision strengthening Dundee's Integrated Children's Services offer. Prior to securing the Improving

¹<http://www.improvingfutures.org/>

Futures funding, the partner charities provided a range of relevant services in Dundee, including: kinship carer support; programmes for families affected by parental substance misuse; family group conferencing; housing projects; disability services; education/employability programmes; support for victims of domestic violence; and abuse recovery services. Adding to this combined experience, the partnership looked to local strategies and priorities to ensure alignment and complementarity in their offer.

As an example, the service was designed to contribute to the Dundee Community Planning Partnership's commitment to deliver on the Dundee Single Outcome Agreement: this stipulates that local children will be Safe, Healthy, Active, Nurtured, Achieving, Responsible, Respected and Included (SHANARRI). These objectives are linked to those of the Getting it Right for Every Child (GIRFEC) agenda, a Scottish policy initiative which aims to improve outcomes and support the wellbeing of children and young people by supporting them and their parent(s) to work in partnership with support services. The GIRFEC approach is based on four key principles which closely align with the aims of the Improving Futures programme more broadly, as well as DEIT's delivery model. The principles require providers to work in a way that is:

- Child-focused
- Based on an understanding of the wellbeing of a child
- Based on tackling needs early
- Requires joined-up working.

The service has also been developed within the context of Dundee's Early Years Framework, which has led to the development of the local parenting strategy – 'Being a Parent in Dundee', a strategy which is based on principles of acknowledging and building parents' capacity to take the main responsibility for their children's healthy development. Finally, key links were identified with local strategic partners. This included the Dundee Community Health Partnership, which saw an opportunity to work in tandem with health visitors, who are ideally placed to identify families experiencing multiple and complex problems and who could benefit from early intervention.

The DEIT project was developed to complement the range of services available to children and families in Dundee, and intended to be rooted in the Dundee Integrated Children's Services Strategy and Plan 2012-15 and Early Years Framework Strategy. The development of the service was endorsed by the Dundee Partnership (CPP), the Integrated Children's Services Strategic Planning Group and the Chief Officers Group comprising CEOs of Dundee City Council, NHS Tayside and Tayside Police.

1.1.1 Key project activities

This project aimed to establish an early intervention and preventative support service for families in Dundee, drawing on an evidence base that demonstrated that early intervention not only promoted positive outcomes, but could also be cost effective by preventing escalation to statutory services. The service aimed to work with families to find and make effective and sustainable solutions to social, health, relationship or parenting difficulties, both before and at the point of crisis; thereby minimising the likelihood of difficulties escalating and subsequently reducing the need for more intensive and costly services at a later stage.

The service was developed to provide managed, intensive, flexible and phased, outcome-focussed responses, addressing multiple and complex difficulties over a sustained period of time. Responses were intended to be robust and include a comprehensive yet proportionate assessment of need and a tailored programme of interventions (including brokering support from other services as appropriate),

that would be supportive and strengths-based, although at times challenging. The model was developed to be applied through a Team around the Child and Family (TACF) approach.

The support to families was coordinated and delivered by a team of experienced professionals comprised of Service Manager and Early Intervention Family Workers. The family workers were allocated to families on a key worker basis, with a remit to provide 'persistent and assertive' support in collaboration with families and other professionals and agencies. This approach was intended to give families tailored, joined-up support within their own homes and/or within community facilities (including schools), on a 1:1 basis or through group-based programmes. Families were able to access the service directly or via referrals from a range of agencies throughout the public and voluntary sectors.

The practitioner role was developed in keeping with social pedagogy theory and in line with this, their approach was work with the 'whole' child bringing 'head, hands and heart' to the work. Additionally, the model was developed to include a pool of volunteers with pre-existing parenting experience recruited from communities across Dundee, to provide credible practical parenting support.

At the outset of the project, it was assumed that key aspects of delivery for DEIT would include:

- Support to children/families who do not attend health appointments and in particular: dental appointments; immunisation appointments; treatment for specific health conditions e.g. asthma; orthoptic appointments and follow up care at hospital-based paediatric services; and speech and language therapy appointments where communication had been identified as an issue.
- Support to families who do not attend any types of support groups within their local community for a range of reasons, limiting the child and parent/carers' experience of social interaction, social development, networking, friendship/support and stimulation e.g. establishing a morning routine to ensure children are ready to attend nursery or playgroup or school.
- Lower threshold concerns such as establishing a routine for a child, supporting parents in healthy food choices and basic food preparation/cooking.
- Provision of practical support to parents, managing the after nursery/school period and ensuring a routine at bedtime.

The structure of the support model was developed to provide a high level of flexibility in delivery. Essentially, DEIT had the ability to deliver supportive interventions beyond the 9-5pm working week, responding to the fact that many families experience their greatest stresses in early mornings, evenings and at weekends. As such, the service provided support between 7.00am and 10.00pm Monday to Friday, and at weekends where necessary. In addition 24/7 telephone support was provided. The model set out that families would access regular reviews to ensure that the right support continued to be provided for as long as was necessary or required. Finally, the partnership model meant that the support provided a single point of access to services.

1.2 Report Structure

The remainder of this report is structured as follows:

- **Chapter Two** gives a profile of the families supported, drawing upon both the monitoring data and practitioners' accounts of the main presenting issues for families, including risks and strengths.
- **Chapter Three** reviews the main lessons learned from project delivery, exploring key aspects of the delivery model in more detail.

- **Chapter Four** considers the main achievements of the project, including the type of outcomes that were recorded and reported and the strength of this evidence, and assesses the extent to which these outcomes have been sustainable. It also considers sustainability in the context of the wider project.
- **Chapter Five** draws the report to a close, with a set of overall conclusions and a number of recommendations for the project partners to consider in potentially developing the model further.

2.0 Profile of the Families Supported



2.0 Profile of the families supported

2.1 Key target groups

The Dundee Early Intervention Team was developed in order to provide a service to families in need or facing multiple or complex problems, but who did not meet the threshold for statutory intervention. While the project was required to follow the Improving Futures Programme eligibility criteria (as described in the introduction to this report), the delivery partnership had some freedom to establish its own targets within those criteria. In its business plan, the project established targets to support 200 families. Update reports provided by the project to the Big Lottery at the end of year four (October 2016) stated that the project had supported 212 families to that point, exceeding those targets.

Analysis of the data compiled by the project on the IFMIS database provides information on key characteristics of the families engaged. The database holds information on 154 families at entry point to the project, consisting of 224 adults and 354 children. This data shows that:

- The majority of the adults supported were parents, though one grandparent was included.
- Almost all the cohort identified as White British – only two adults were recorded as Black, Asian and Minority Ethnic (BAME).
- There was a 50/50 split between lone parent and two parent families.

As well as demographic information, the IFMIS database provided an opportunity for project staff to record the key risks facing children, adults and the family more generally. Importantly, staff members were also able to record the key strengths of each client, which is particularly useful in an asset-based approach to supporting families, and the system provides a valuable monitoring tool when completed at engagement, interim and exit points. Exploring these risks and strengths provides an insight to the issues faced by the families engaging with the project.

Looking to the data, the most common risks and strengths recorded among the adults entering the project are summarised in **Table 2.1**. The IFMIS data shows that just under half the adults entering the programme (42%) were suffering from parenting anxiety or frustration. A similar number were having problems with discipline and boundary setting for their children (41%) and just over a quarter were experiencing suspected or reported stress or anxiety (27%).

Table 2.1 Adult risk factors and strengths. Baseline IFMIS data

Adult risk factors	Percentage of adults
Parenting anxiety or frustration	42
Discipline and boundary setting	41
Suspected or reported stress or anxiety	27
Other mental health problems	12
Other physical health problems or lifestyle factors	9
Adult strengths	
Parental awareness of safe practices (e.g. internet safety, road safety)	43
Supporting with school work / homework	38
Regular face-to-face contact with school staff, reporting positive relationships	36
Listening to and reading with the child(ren) on a regular basis	29

Table 2.1 Adult risk factors and strengths. Baseline IFMIS data

Attending regular play sessions with the child(ren)	22
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Source: IFMIS database. N = 224.

The biggest adult strength captured by the IFMIS entry data was parental awareness of safe practices such as internet/road safety (43%). Helping children with homework (38%), regular contact with school and positive relationships with school staff (36%), and listening/reading to children on a regular basis (29%) were also amongst the most common adult strengths recorded at entry. Just under a quarter of parents were recorded as attending regular play sessions with the children (22%).

The most prominent strengths within the group of children entering the project related to their health and social needs, as shown in **Table 2.2** below. Around one-third of the children engaged with the project (31%) completed their routine healthcare milestones such as GP appointments, health checks and immunisations, and a similar number (27%) regularly attended dental care appointments.

However, 10% of the children whose data was recorded on IFMIS entered the project with suspected ADHD / ASD or conduct disorder that was as yet undiagnosed. While 22% of children entering the project had reported low-level behavioural difficulties, a quarter (27%) reported supportive peer friendships at school.

Table 2.2 Child risk factors and strengths. Baseline IFMIS data

Child risk factors	Percentage of children
Low-level behavioural difficulties	22
Suspected ADHD / ASD or conduct disorder (undiagnosed)	10
Persistent disruptive behaviour	9
Suspected ADHD / ASD or conduct disorder (diagnosed)	9
Persistent disruptive and violent behaviour	8
Child strengths	
Attending routine GP appointments, health checks and immunisations	31
Attending dental care appointments	27
Supportive peer friendships at school	27
Regular contact with friends outside of school	21
Regular participation in exercise or physical activity	18

Source: IFMIS database. N = 354.

Family risk factors according to the IFMIS data (see **Table 2.3** below) are varied, with the most prominent being relationship dissolution between adults of the family – just over a quarter (27%) of the families recorded on IFMIS reported this to be an issue. One-fifth of the families had experienced worklessness lasting longer than 12 months (21%), and 11% reported some difficulties in keeping up with debt repayments, household bills or rent. However, more than half of the families (58%) were accessing appropriate benefit entitlements and a similar number (56%) had a family budget in place which was being actively managed. It was also positive to note that half of the families had good family links, with 50% having active and regular supportive contact with grandparents and other relatives and 45% reporting strong and supportive relationships in the immediate family.

Table 2.3 Family risk factors and strengths. Baseline IFMIS data

Family risk factors	Percentage of families
Relationship dissolution (divorce or permanent separation)	27
Workless family (over 12 months)	21
Family reporting social isolation	17
Some difficulties in keeping up with debt repayments, household bills or rent	11
Suspected or reported relationship dysfunction (no counselling)	10
Family strengths	
Adult family members accessing appropriate benefit entitlements	58
Family budget in place and being actively managed	56
Take-up of Child Tax Credits	53
Active and regular supportive contact with grandparents / other relatives	50
Strong and supportive relationships within the immediate family	45

Source: IFMIS database. N = 154.

2.2 Identifying and referring families

While a small proportion of families engaging with the project self-referred, the majority came to DEIT through referrals from local partners. These included education, health services or other VCSE organisations. Interviews with project staff for this research highlighted that close working with schools and health visitors had been important in ensuring appropriate referrals were made to the service. For example, project staff attended health visitors' monthly team meetings, along with school meetings, to identify relevant families. The benefits of this were multiple; it improved DEIT's visibility and networks, while enabling staff to ensure partners were clear on the referral criteria. Staff had not identified any difference in need or characteristics of the families according to the referral route.

DEIT family workers undertook initial visits to families in partnership with staff from referring agencies where possible, including health visitors and school nurses. This facilitated smooth transitions between services.

3.0 Lessons Learned from Project Delivery



3.0 Lessons learned from project delivery

3.1 Working with families

The intervention was solution-focused and asset-based, and sought not to create any sort of dependency. Families were assigned a family worker, who supported the family on a key worker basis. The workers provided 12 weeks support on average for each family, with intensive contact in this time. Family workers used a child-centred philosophy and recognised the family as experts in the problem and the solution, supporting families to identify the unique solutions that would work for them.

The project began working with families by doing a family assessment which established the family's own view of their situation and need. The family worker provided appropriate support in and around the home, but also linked families with other relevant professionals and services to access support and address pertinent issues.

“We look at what we can do in the home, where we can strengthen relationships between family members, and then look more widely at their extended family, what support they are accessing, activities they were involved in, in the community and strengthening their relationships with schools, to make sure there is support all round.”

Family worker, Dundee Early Intervention Team

A key aspect of DEIT's approach was to combine advocacy and support while equipping families with skills and resources to enhance their capacity to resolve issues themselves. Examples of this included work with relevant professionals to help families address any problems relating to their home environment which may reduce their quality of life or increase risks; links were established with local authority and private landlords to connect families with designated tenancy support officers. Family workers also advocated on behalf of families experiencing difficulties with assessments of their housing needs, and supported families to take complaints forward about the standard of their homes. Alongside this advocacy, family workers educated and enabled parents to take responsibility for keeping their homes safe, risk free and at an appropriate standard.

The achievement of better health for families was central to the family worker's support offer. For example, workers supported families through their children's diagnosis and titration periods (establishing the correct levels of medication) for ADHD, ADD and other related health issues. Workers also supported parents to register their children with GPs and dentists, and to attend specialist appointments. Equally, families were encouraged to maintain good health and hygiene practices learned at school and nursery when at home, and to access resources that helped them to understand and manage their children's developmental and health needs. Close partnership working with Health Visitors ensured that families knew about health initiatives, drop-in clinics and enabled them to keep up to date with important checks and immunisations. Finally, family workers supported parents to access mediation, counselling and mental health support services, which helped them to maintain safe and stable homes for their children.

Family workers supported families to overcome food poverty by accessing the local foodbanks. According to data compiled by the project, almost 30% of the families supported by DEIT in their fourth year of delivery (both in employment as well as those not working) used the foodbank service. As well as this practical support, family workers linked families with community groups where they were able

to receive guidance and resources to promote and help them to access affordable, healthy eating choices. Similarly, DEIT led a community parenting group which offered advice and guidance on weaning and supported parents from the service to lead the delivery of this.

3.2 Key approaches to support provision

This section of the report examines key aspects of the DEIT provision for families. These approaches are noted to be of particular relevance and success to the delivery model.

Social pedagogy

DEIT staff undertook nine days of training in social pedagogy, an approach which is based on building relationships with the families and underpinned DEIT's provision. Social pedagogy is based on the "head, hands and heart approach", with the head having knowledge, the heart building relationships, and the hands providing practical skills. The training equipped staff to ensure there was no power imbalance between the family and the worker, encouraging the worker to take the lead from the family and view them as the experts. As one member of staff described, the approach *"promotes to families that you are the expert, you know your children, we'll never know them as well as you do"*. This encourages families to identify the support they need with the worker facilitating that accordingly.

Staff interviewed for the evaluation felt that the training equipped them with a range of positive exercises and theories to use with families in a safe and manageable way, improving their work with families as well as their own personal and professional development.

"It's amazing, certainly for me on a professional and personal level, to improve my skills and confidence, and my ability as a worker...it's the relationship you get with the family...you bond so much quicker, that's how you get the assessment and intervention done so much quicker. There's loads of benefits from the approach and it's fun."

Family worker, Dundee Early Intervention Team

Flexible support for families

The ability to access support seven days a week between 7am and 10pm was a significant change for families and one that staff believed enabled positive outcomes for families. Putting extended delivery hours in place allowed staff to become involved in family lives at key points in the day, for example allowing them to provide support during bed time routines, at meal times and with attendance at school. This enabled family workers to support families on an intensive basis where required within their own homes and communities, with one key worker building meaningful relationships with the whole family.

Interviews with DEIT staff established that working with families in their homes helped them get to the core issues more quickly. One member of staff cited an example where they had been more easily able to identify child protection issues, which the team were able to escalate. Another noted that being around in the morning meant that parents trusted the family workers much more quickly as they were helping them with practical parenting tasks: *"we roll up our sleeves and do whatever it takes to help them"*. There were no set hours for support provision and the level of contact was dictated by the family's needs; in some cases a visit may be required once a week but others may need a couple of hours a day when they first engage with the service.

“Compared to a previous service you were much more involved. You were actually there for routines and boundaries because you came at different times of day which helped us. I can’t fault the service at all.”

Parent, Dundee Early Intervention Team

Importantly, project management staff noted that this wider, more flexible approach to support provision had been achieved within the workforce without the need for complicated shift patterns or changes to contracts. They noted that statutory partners had been keen to learn from this following positive feedback from families.

Easy to access support

DEIT’s service and referral process was designed to be easily accessible, removing the need for duplication of information sharing and multiple assessment processes. Feedback from parents to project workers showed that they wanted the help they received from services to be meaningful, realistic and challenging but not dismissive. Both parents and children stated that having someone to listen to them had been significant, as well as someone to give them the help they needed, when they needed it with consistency, reliability and honesty. Parental feedback around the assessment process had also been positive; one noted that they found the development of an action plan as particularly useful, stating *“it broke it down, on your own it just felt a big muddle. Then it didn’t feel such a huge hurdle and we felt more in control”*.

“...We honestly have had a break through since we were introduced to [family support worker]. For the first time, we have been able to be honest about the things that we were struggling with and it has helped us to break it down and start to work towards things being better as a family. We realise now that things were bad and that we were heading down a path that could have ended up with things being much worse but [family support worker] didn’t judge anything, she just came in and listened and we were given honest and sometimes hard to hear advice. We have both been able to talk and have felt listened to. And the girls have too. It has been hard for us but it has already changed things for the better and we are all feeling more positive, like a family again.”

Parent, Dundee Early Intervention Team

Building community resilience

DEIT staff recognised that, as they provided a short-term intervention, building capacity within families and their wider communities was vital. The support provided by the service helped people to see what support was available in their community; the project signposted people to community assets and helped to prevent isolation of families within the communities. The project had a good relationship with key local VCSE organisations, which facilitated the process of combining support for individual families with support to strengthen their local communities.

One example of this can be seen in the increase in volunteering amongst the parents. A number of parents supported by DEIT decided to become ‘Parent Volunteers’ and began setting up their own ‘Parent Pods’; going into local services and libraries and sharing information with other parents about the services available to them in their local communities. Utilising community assets in this way gave the work sustainability that has potential to last beyond the lifetime of the project.

“One of the key things through delivering our service is that we do not take families out of the community to work with them, we basically build upon community assets and strengths... so work is done in the family home, in the community and it's about fine processing, building networks... because we're just a short term intervention, so there's no point going in and coming out.”

Family worker, Dundee Early Intervention Team

3.3 Working with partners and other services

The partnership model of delivery brought together four key VCSE organisations in the area, amalgamating a wealth of knowledge and experience. Working in a formal partnership meant that signposting mechanisms were more straightforward and access to services was improved for families.

The partnership was governed by an operational managers group which met monthly, and a wider steering group which met quarterly. The operational group enabled key staff from each partner organisation to come together regularly and share learning and information. The project manager noted that the group facilitated good, working input from each partner, and described the group as “a *godsend*”, developing strong relationships with each of the operational partners and drawing on their experience for guidance.

The operational managers group also made up part of the steering group, along with senior managers from the four partner organisations. Importantly, they were also joined by representatives from Dundee City Council Social Work and Education and Communities Departments, Dundee Children's Integrated Service and NHS Tayside. This representation was important to ensuring the project fit alongside other provision in Dundee providing early intervention. Finally, the project also had a 'reference pool' of staff which sat on other established networks in Dundee, again ensuring strategic fit locally.

At a delivery level, each family worker was responsible for a geographical area of Dundee, which had been beneficial in terms of building relationships and networking with local stakeholders such as schools and health visitors. Understanding the wealth of services on offer to families locally was also key; as one family worker noted, *“it's unbelievable how much Dundee has to offer, its just about making services more available and wide-spread for families. When you tell families what's out there they are really shocked that it's at their doorstep”*. As an example, workers were able to link families with the Dundee Carers Centre, family mediation services through Relationship Scotland, and enabled parents to access the Incredible Years parenting programme.

DEIT's relationship with schools developed over the project's lifespan. Feedback from a group of headteachers illustrated that, where they had made referrals to DEIT, the benefits were experienced by the child, the school and the wider family. In practical terms, schools had a close connection with the DEIT family worker, who linked with relevant staff including headteachers. As one staff member noted, they worked as a 'unit' with the school so they felt included in the process.

“They [headteachers] were seeing benefits in three distinct areas and had a feeling they were supporting families before they were in crisis and before they were going into the statutory level. Then that was much more effective and the benefits were clear. The benefits they could see were to the actual school, improvements in behaviour, indicators that attendance was improving, child protection. There were benefits to the child itself and benefits to the family.”

Steering group member, Dundee City Council Education Services

3.4 Challenges

In the early stages of delivery, DEIT revised the referral process to reduce the referral of families ineligible to be supported by the project. While some were outwith the age criteria (for example, the eldest child being under the age of five), or didn't live in Dundee, others had needs beyond the level of early intervention support. Work with local partners to highlight the referral criteria was useful. However, while the partnership with health visitors had been useful to both parties, it resulted in some frustration that families with very young children could not access the service. The service did not support families where the main issue was substance misuse, and while the team received a number of referrals of this nature, they were able to signpost families on to appropriate support.

The project's referral criteria also excluded families who had already been in receipt of support from statutory services. This meant that social care teams were not able to "step down" families from social services to DEIT. Stakeholders interviewed for the research acknowledged that the service would be a useful tool for families moving on from statutory support, but that the need was so high that this could potentially saturate the service. This would also contradict the preventative ethos of the project.

The short term nature of the funding posed challenges for the project, particularly in terms of having to divert resources to focus on sustainability for the service. In Year 3, the team introduced a full time Team Leader to oversee the delivery of family support, thus allowing the Service Manager to focus on securing continuation funding for the project. As the project end date drew nearer, DEIT was forced to begin the procedures for an exit strategy, leading to referrals being closed for a period of four months in January 2015. This had a significant impact on the number of families receiving the service throughout the year. Furthermore, the uncertainties of future funding contributed to a number of staffing changes with the loss of six key staff members (one of these was to maternity leave, one through redundancy, and the remaining four moved on to new employment).

As a direct impact of funding uncertainty and a reduced team, DEIT had to carefully balance the service promotion so as not to have a far greater number of referrals of children and families than could realistically be supported. In the latter part of Year 3, the team moved towards the exit strategy and the referral and allocation process was reviewed to ensure that the families in the greatest need were allocated a support worker. This meant changes to the existing allocation criteria, but proved more effective, reducing the number of non-engaging families as well as ensuring families were signposted to more appropriate support at an earlier stage.

4.0 Project Achievements and Sustainability



4.0 Project Achievements and Sustainability

This chapter of the report examines the key achievements of the project to date, both for stakeholders, including partner agencies, and the families themselves, but also in terms of the Improving Futures overarching programme outcomes. A variety of sources of evidence to demonstrate outcomes for were gathered: by project staff, by the evaluators, and through the Improving Futures Monitoring Information System (IFMIS) tool.

4.1 Outcomes for children and families

This section looks at the project outputs which speak to Improving Futures **Outcome One**: Improved outcomes for children in families with multiple and complex needs.

To obtain a greater level of detail with regards to how much progress was made by those engaged with the programme, an analysis was conducted of the numbers of people assessed to be experiencing risks and strengths in the IFMIS database, as recorded by project staff at the client's entry and exit points with the project. **Table 4.1** lists the indicators for risks that had reduced between these two points according to IFMIS records. Some of these indicators had only applied to small numbers of clients at entry point, however they have been included as a reduction in the number of people experiencing this risk was still beneficial. It is also difficult to attribute progress on all indicators to the programme, though the evidence suggests many of them are as a direct result of intervention.

Table 4.1 Improved risk factors for adults, children and families on entry and exit points on IFMIS

Improved risk factors
<p>Adult risk factors</p> <ul style="list-style-type: none"> • Parenting anxiety or frustration • Problems with discipline and boundary setting • Serious and limiting disability • Suspected or reported illegal drug use - not receiving treatment • Suspected or reported stress or anxiety • Other mental health problems (specify) • Low financial capability skills
<p>Child risk factors</p> <ul style="list-style-type: none"> • Low-level behavioural difficulties • Persistent disruptive behaviour • Persistent disruptive and violent behaviour • Suspected ADHD / ASD or conduct disorder (undiagnosed) • Two or more fixed term exclusions • Occasional unauthorised school absence • Persistent unauthorised school absence • Suspected or reported bullying issues (victim) • Achieving below expected levels for age (no known special educational needs) • Achieving below expected levels for age (special educational needs with statutory statement in place) • Poor hygiene and self care • Suspected or reported stress or anxiety • Other mental health problems • Subject to a child in need plan • Missing child / runaway

Improved risk factors

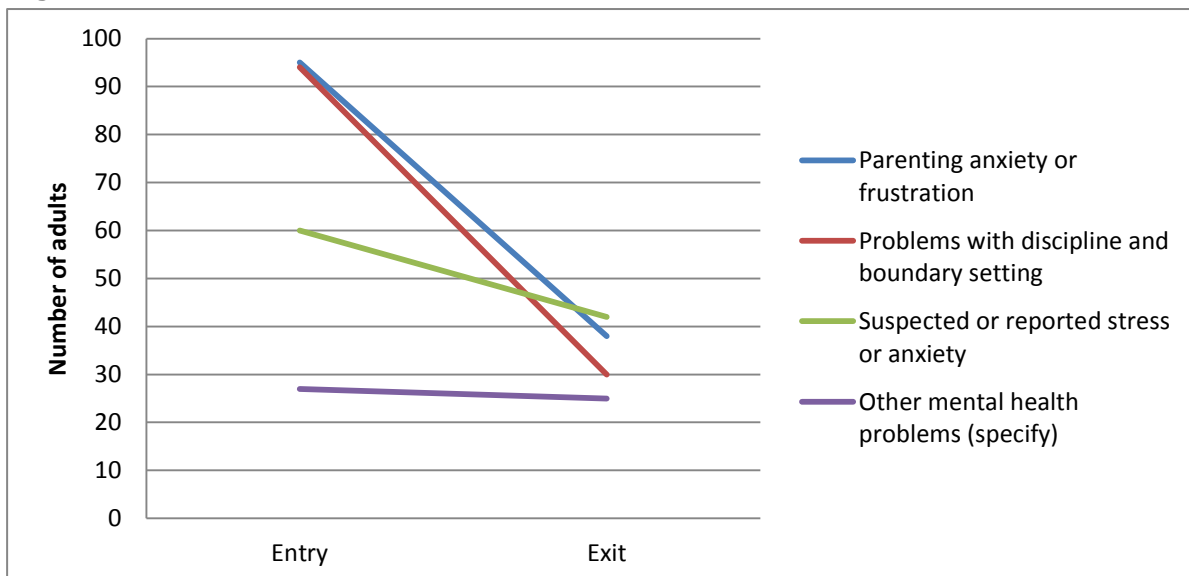
Family risk factors

- Suspected or reported relationship dysfunction (no counselling)
- Temporary separation of parents
- Domestic abuse (child harm)
- Domestic abuse (adult harm)
- One or more family members in continuous employment (past 12 months)
- Workless family (over 12 months)
- Unsecured borrowing (e.g. pay-day loans, credit cards, doorstep loans)
- Difficulties in keeping up with debt repayments, household bills or rent
- Some difficulties in keeping up with debt repayments, household bills or rent
- Significant difficulties in keeping-up with repayments (arrears of >1 month)
- Housing repossession actions underway
- Family living in temporary accommodation
- Poor quality housing with significant cold, damp or mould problems
- Overcrowded living conditions
- Lack of basic utilities (cooking, heating, lighting)
- High levels of noise / chaotic home environment
- Lack of access to safe public open space
- Family involved in neighbour disputes
- Police call-out to neighbour disputes involving the family
- Family reporting social isolation
- Family evicted and homeless
- No bank or building society account

4.1.1 Improved outcomes for adults

As **Table 4.1** demonstrates, adults engaged with the project experienced a reduction in a broad range of risks. This section of the report will examine the risks that had the most prevalent and significant reductions. It is interesting to note that the three factors with the biggest decreases were also those which were experienced most commonly. **Figure 4.1** shows that parents reporting problems with discipline and boundary setting saw the biggest reduction, with a decrease of 68% from 94 parents on entry to 30 on exit. Parenting anxiety and frustration was reported as an issue for 95 adults on their engagement with the programme; at exit point this had reduced by 60% to 38 adults. Suspected or reported parental stress or anxiety also reduced for around a third of the cohort, from 60 adults to 42.

Figure 4.1 Decrease in adult risks



Source: IFMIS database. N = 224.

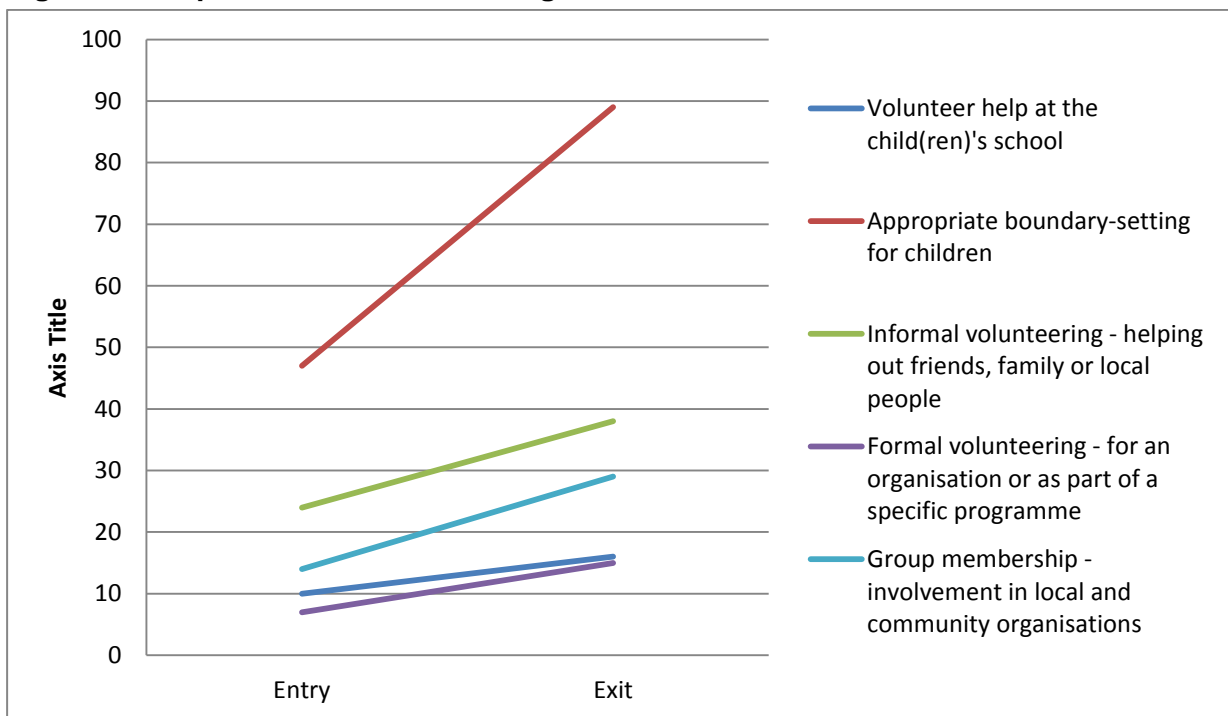
DEIT’s delivery model, and the focus it placed on practical parenting support, can be clearly linked to the improvements demonstrated in the parent / child relationships. This is supported by qualitative feedback from parents, where parents talked about the benefits they had experienced from having someone to talk to. On a more practical note, parents also commonly talked about having learnt strategies for parenting and feeling that they were now equipped with tools to manage their situations, linking to the reduction in stress and anxiety that the IFMIS data highlighted.

“This support is probably the best support I’ve ever had... [the family worker] is always there – I can talk to her if I’m down, she’s on the other end of the phone.”

Parent, Dundee Early Intervention Team

An examination of the improvements in adult strengths recorded in IFMIS also supports the comments made by parents about the benefits of the service. For example, there was a 47% increase in adults setting appropriate boundaries for their children, from 47 parents at entry to the project, to 89 at exit. There was also a significant increase in local community participation amongst the adults of the cohort. On entry to the service only 14 adults were involved in local community groups or organisations; at the point of exit from the project, this had increased by 52% to 29. As **Figure 4.2** shows, there were also significant increases in the number of adults volunteering formally and informally, suggesting better links with the local community.

Figure 4.2 Improvement in adult strengths



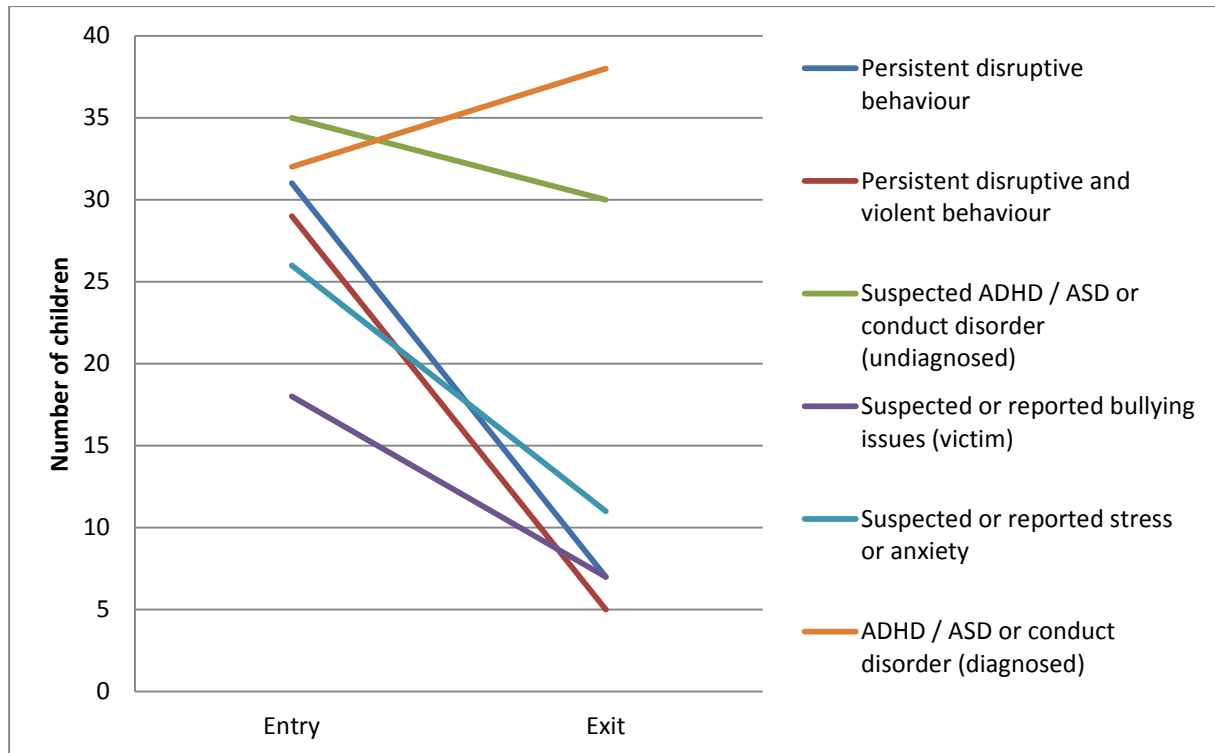
Source: IFMIS database. N = 224.

4.1.2 Improved outcomes for children

The IFMIS data for child risks showed some significant changes for those involved with the project. For example, the number of children exhibiting persistent disruptive behaviour reduced by three-quarters from entry to exit. The reduction in those presenting with persistent disruptive and *violent*

behaviour was even larger, with the number dropping by 83% from 29 children to just five. These changes are illustrated in **Figure 4.3**.

Figure 4.3 Decrease in child risks



Source: IFMIS database. N = 354.

As **Figure 4.3** shows, project staff also recorded a decrease of 14% in the number of children presenting with suspected, but undiagnosed, ADHD / ASD or conduct disorders. At the same time, a 19% increase was recorded for children with a diagnosis of ADHD / ASD or conduct disorders between entry and exit points. Linking these changes with the changes in persistent disruptive behaviour, it is reasonable to assume that the project had been a factor in these differences, having instigated improved relationships between schools and families, as well as other organisations such as health providers, and providing specialist support to facilitate and secure ADHD diagnosis and treatment. **Table 4.2** highlights an example of such work.

Table 4.2 Family case study: supporting a child with ADHD**Family case study – R, aged 9**

The family comprises mum and two children; a nine year old boy, R, and a seven year old girl. The boy was getting into progressively more trouble at school, experiencing frequent disciplinary measures (including exclusion from school) as a result of his anxiety and impulsivity, to the extent that he was becoming violent with both teachers and other children. Teachers suspected that he had Attention Deficit and Hyperactivity Disorder (ADHD), and made a referral to CAMHS. R had been on the waiting list for some time and the situation was deteriorating; when the mum called CAMHS for advice, she was told a referral to DEIT might be beneficial.

The family worker put a range of interventions in place after building up a relationship of trust with R. These included activities illustrating how his day at school would be structured to enable him to deal with change and moving from one activity to another, putting in place safe spaces within the school and working with the teachers to put equipment in place such as a gym ball instead of a chair, allowing him some freedom of movement. She also worked on building R's resilience and coping strategies. R's mum explained:

"She made a sheet which was to show his panic zones, and he would put in the names of all the things he was stressed about. Everything to do with school was in there, including the headteacher. Now when he does that exercise, it's totally different. The headteacher has come out of the panic zone and now she's one of his safe things. Now he does one with learning zones on it, where he puts all the things he's enjoying learning about. He likes debating and he's good at maths. He gets involved. He doesn't hate school any more."

Although the mum had previously worked closely with school to try to resolve R's issues, she felt that having support from DEIT had made a substantial difference to all of them:

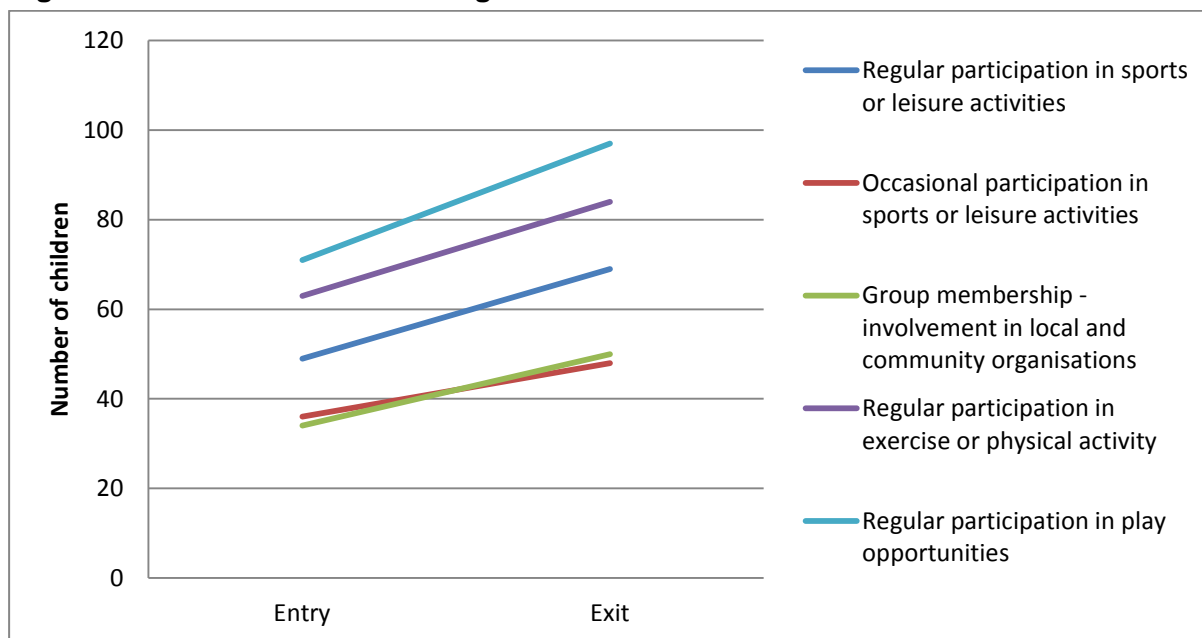
"Having [the family worker] made a world of difference. He was used to me shouting in his corner for him all the time, but I'm his mum. To have someone else in his corner – someone who wasn't in his family or wasn't part of the school – made such a difference."

R has now been formally diagnosed with ADHD and is receiving medication for the condition. These developments, along with the mechanisms put in place by the DEIT worker, have made a huge difference to the family. Mum describes R as now being able to play board games, and the time he needs to calm down now is significantly reduced:

"I would describe Dundee Early Intervention Team as a godsend. [My son] wouldn't be where he is now without [the family worker's] help. He could always do it but he was lost. He needed the tools. She helped us to see what those tools were."

Increased child strengths broadly relate to socialisation and improved relationships outside the family. **Figure 4.4** illustrates that, on exit from the project, a greater number of children were reported to be participating in play opportunities, sports or leisure activities, and exercise or physical activity regularly – each of these indicators had seen increases of around one quarter at exit from entry point. As with the adults, participation in group and community activities had increased amongst the children.

Figure 4.4 Increase in child strengths



Source: IFMIS database. N = 354.

These changes link clearly to chronologies and records of the support provided to families by the family workers, where families were commonly linked to local community groups including art groups, play sessions and more structured support such as that provided by the Dundee Carers Centre.

“I have seen my son totally change, in a good way, since he was able to talk about his feelings and be believed and have someone on his side supporting him and me. It was really important to us that he was listened to and that he wasn’t told it was all his fault any more. Nobody listened to him or to me.”

Parent, Dundee Early Intervention Team

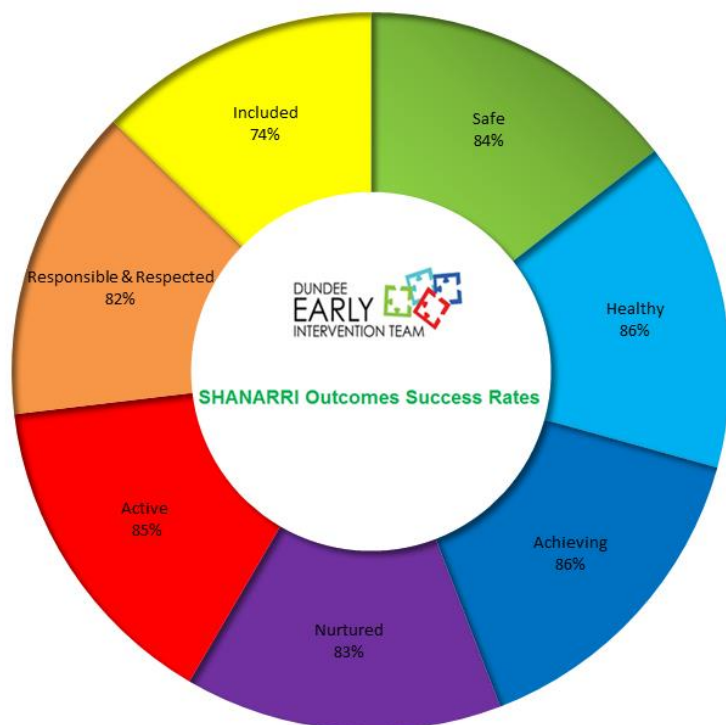
As previously noted in this report, DEIT offered its service in line with Scotland’s GIRFEC agenda, which focuses on the wellbeing of a child, with wellbeing considered as a broader concept than child protection and welfare. To ensure that all stakeholders – children, young people, parents, and the services that support them – has a common understanding of what wellbeing means, GIRFEC describes it in terms of eight indicators, which are commonly referred to by their initial letters - SHANARRI. **Table 4.3** sets out the definitions for each of the SHANARRI indicators.

Table 4.3 SHANARRI indicator definitions²

Indicator	Definition
Safe	Protected from abuse, neglect or harm at home, at school and in the community.
Healthy	Having the highest attainable standards of physical and mental health, access to suitable healthcare and support in learning to make healthy, safe choices.
Achieving	Being supported and guided in learning and in the development of skills, confidence and self-esteem, at home, in school and in the community.
Nurtured	Having a nurturing place to live in a family setting, with additional help if needed, or, where possible, in a suitable care setting
Active	Having opportunities to take part in activities such as play, recreation and sport, which contribute to healthy growth and development, at home, in school and in the community.
Responsible	Having opportunities and encouragement to play active and responsible roles at home, in school and in the community, and where necessary, having appropriate guidance and supervision, and being involved in decisions that affect them.
Respected	Having the opportunity, along with carers, to be heard and involved in decisions that affect them.
Included	Having help to overcome social, educational, physical and economic inequalities, and being accepted as part of the community in which they live and learn.

DEIT tracked their service users with the SHANARRI indicators, measuring children's progress against each category; with support from the family worker, families 'scaled' themselves at the start of support, at each review period (of which families would have had at least one), and then again during their final review. At the end of year three, the team produced a report collating this data, and the results are summarised in **Figure 4.5**. Each section of the chart shows the percentage of families which reported improvements for their children against each of the SHANARRI indicators.

² <http://www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing>

Figure 4.5 DEIT SHANARRI outcomes success rates

The chart shows significant improvement against each of the indicators, but with the greatest gains in the categories of 'healthy' and 'active'. This reflects the improvements shown in the IFMIS data, where children were more likely to be participating in sports and leisure activities. Equally, the gains in the 'responsible and respected' and 'included' categories reflect the IFMIS findings that more children and adults were participating in community groups.

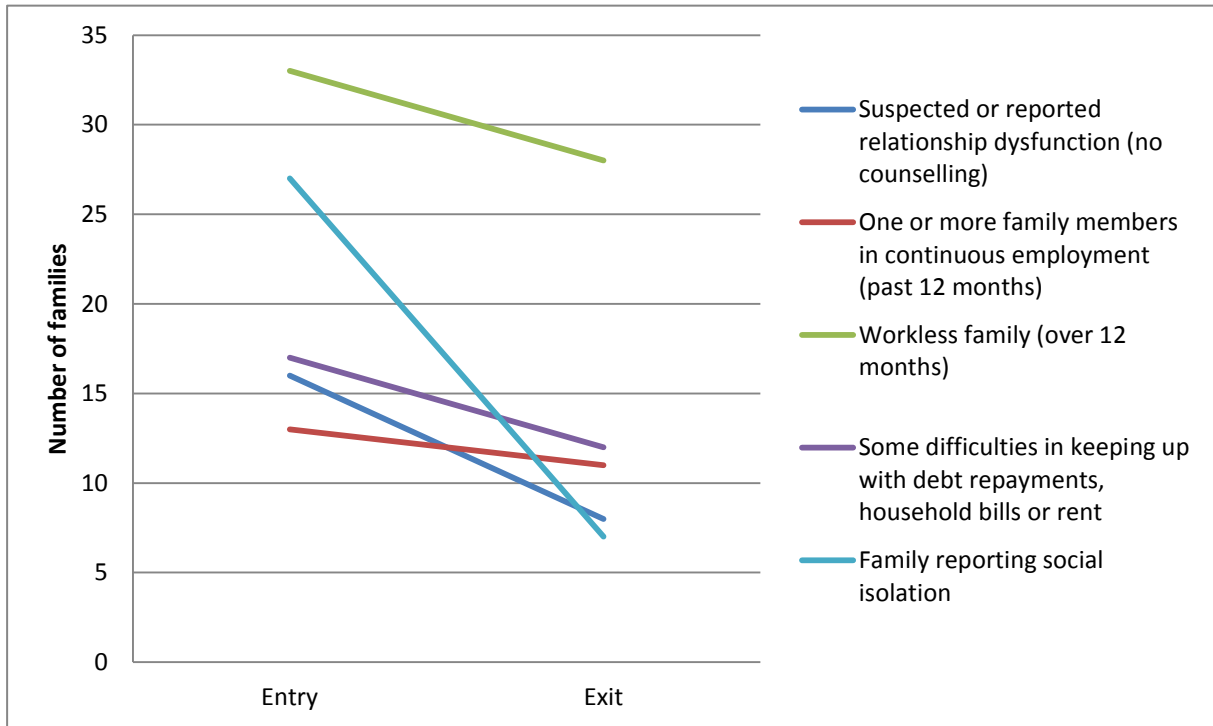
4.1.3 Improved outcomes for families

Following the patterns seen in the improvements experienced by adults and children, the successes at a family level also related strongly to improved relationships, both within the household and more widely. **Figure 4.6** shows us that there was a significant decrease in families reporting social isolation – this figure dropped by 74% from 27 families to just seven, linking clearly to the increased community participation seen for both adults and children. It was also positive to note that those reporting relationship dysfunction had decreased by 50%. The chart shows that the families engaged with the project had also experienced some economic improvements; there were decreases in the number of families experiencing difficulties in meeting financial obligations such as debt repayments, and the number of workless families decreased by 15%. However, there was also a decrease in the number of families with one or more family members in continuous employment over the past 12 months. The national evaluation of the third year of the Improving Futures programme found that projects generally had failed to affect significant change on employment outcomes for adults³, and this was also the case for DEIT.

Figure 4.7 highlights the increases in family strengths. The practical assistance offered by DEIT family workers was reflected by the increase in improved routines for families; at exit point, the number of families with regular bedtimes, mealtimes and school routines had increased by 39% to 110. There were similar improvements in the moderation of TV watching and computer use, and in the regular participation in family activities, which increased by 40%.

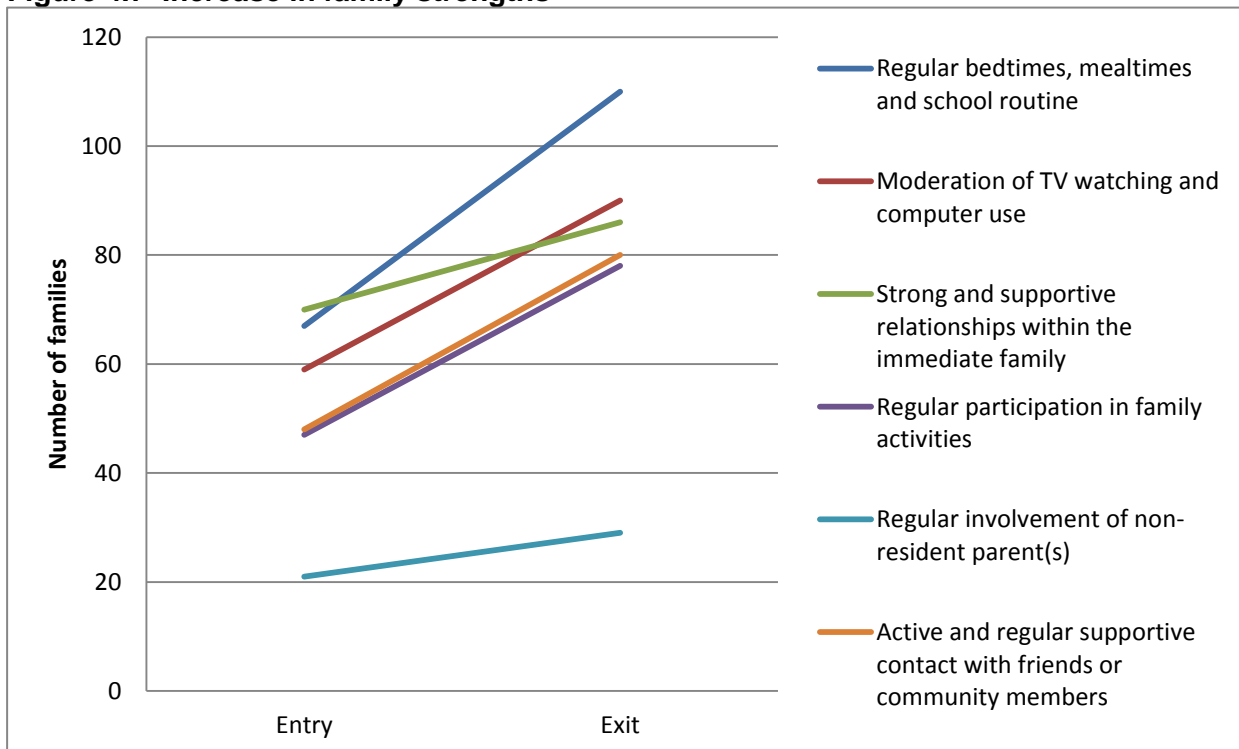
³ https://www.improvingfutures.org/year_3_full_report.pdf

Figure 4.6 Decrease in family risks



Source: IFMIS database. N = 154.

Figure 4.7 Increase in family strengths



Source: IFMIS database. N = 154.

Again, linking with the outcomes seen for children and adults separately, the reduction in social isolation is reflected in the 40% increase in the number of families reporting active and regular supportive contact with friends or community members, increasing the support network available to families to enable them to better sustain changes made.

DEIT's own monitoring data reflects the improvements highlighted by IFMIS, continuing to build on their successes year on year. In year three, 64% families had improved outcomes after support, and at the mid point of year four, this had increased to 85%.

Finally, it is important to note that there were low numbers of families returning to the service after they exited; at the end of year three, only three families had received more than one intervention from the service. This suggests that the project has a successful impact on families.

4.2 Service and systems outcomes

This section of the report looks at the project outputs which speak to the Improving Futures outcomes Two and Three:

- **Outcome Two:** New approaches to local delivery that demonstrate replicable models which lead to more effective, tailored and joined-up support to families with multiple and complex needs.
- **Outcome Three:** Improved learning and sharing of best practice between public services and voluntary and community sector organisations.

It was clear from the research and resulting evidence that the learning and development from the work undertaken in Dundee with the Improving Futures funding contributed to more effective partnership practice, not only amongst the four core organisations involved in the delivery of DEIT, but also in the wider community. Operationally, family workers had worked alongside education staff, health staff and staff from statutory services to develop support packages that increased the child's overall health and wellbeing and reduced risk in line with the GIRFEC agenda.

More strategically, DEIT contributed to a number of consultation groups in Dundee including the Community Development group and the Early Years Matters group. Members from the service represent the voluntary sector on a number of strategic planning groups and continue to have a presence at the local Health Visitor Meetings, GP Practice Meetings and at the Armistead Child Development Centre monthly meetings.

Links with key services throughout the city have continued to be developed, and staff have been particularly active with Mental Health Services, sharing practice and attending information sessions with Dundee Child and Adolescent Mental Health Service, the ADHD Support Group, the National Autistic Society and more recently with Adult Mental Health Services. This is a core area of need for the families engaged with the project, and as such is a priority link for the team going forward. DEIT also hosted a number of students from across the city studying for a variety of health and social care qualifications, offering opportunities to develop learning and practice in group sessions, in (supported and supervised) direct work with families as well as offering them a chance to experience the opportunities that being part of a partnership team brings.

“Many of the referrals that Health Visitors submit to DEIT would be referred to MASH [the Multi Agency Safeguarding Hub], the Social Work Department or Dundee Families Project if DEIT was unavailable. The intensive level of support and the times they operate, early morning and out of office hours is a service that is not available from any other support agency.”

Health visitor feedback, DEIT Learning Event 2015

Feedback from stakeholders about the project has been positive, and the project has been held up as an example of good practice locally; the DEIT service model has been included in Dundee City

Council's Integrated Children's Services Inspection Report as an example of good practice. Parents and children who have received support from the service were invited to participate in the process with Her Majesty's Inspectorate of Education HMIE and The Care Inspectorate, giving visibility to the project and illustrating the results it has achieved.

4.3 Sustainability

As with most organisations in the VCSE sector, securing funding has been challenging for DEIT in recent years. However, the project team worked hard to find avenues to sustain the model, given the success it has achieved. All four partners have committed to prioritising the development of the partnership model. The various services co-located with DEIT from across the partnership currently benefit from a streamlined referral pathway into all of the services which has developed over the lifetime of the project. This approach was in order to remove barriers for referrals and offer a more tailored approach to supports, making full use of the resources available within the various co-located services and externally across the partner organisations.

The team also plans to bring together the DEIT service with their 'Wee DEIT' offer for families with children under five years old. This will provide a more effective, single service for families, increasing the age range to 0-12 years. The new approach to service delivery features the key strengths from each service and within the partnership makes DEIT well placed to meet the outcomes set at local and national level; improved health, attendance at school and effective early intervention are identified as priorities for Dundee City Council.

"There are no other agencies to pick up this work, it would have been seen as unmet need."

Stakeholder feedback, DEIT Learning Event 2015

The service continues to work in partnership with the Local Authority and Health. New strategies for streamlining the referral and allocation processes between Education, NHS, Social Work and DEIT are being explored within the context of GIRFEC and Team Around the Child. There is clear value placed on the service by the local authority, which provided bridging funding for the project until new funding was secured from the Big Lottery Investing in Communities programme. Dundee's Integrated Children's Services commissioned a piece of research which highlighted the specific need for early intervention and prevention within early and primary years in the city. In response to this DEIT has been asked to present at a number of strategic planning forums, with ongoing discussions with the public sector and third sector partners on future sustainability of a much valued resource.

As Dundee City Council continue with their recommissioning of Children and Family Services, DEIT will be focussing on evidencing how they continue to meet DCC Key Outcomes and how these are reflected in the outcomes for families, those of the individual partnership organisations and the DEIT Service's own specific outcomes.

5.0 Conclusions



5.0 Conclusions

5.1 Concluding thoughts

The families that were supported through the project would not meet the threshold for support from statutory services, and feedback showed that, while there was service provision in Dundee for families in need, there was nothing available in the area to support families at an early intervention stage; while some families may have been referred on to social services or Dundee Families Team as an alternative, they would have been unlikely to meet thresholds for support and as such, would not receive any help. The service increased accessibility of support for families when they needed it most, in both a timely, tailored and focused way. This research confirms that the model of practical support for families, delivered in their own homes at times that are convenient for the family, is highly valued amongst families and stakeholders alike. The model supports the ethos of the Getting It Right for Every Child (GIRFEC) approach, where help is available to families at a stage of early identification with as little intrusion as possible, putting the service in a good position to meet national strategic priorities.

While the project put the best interests of the child at the centre, it took a holistic approach to the wellbeing of a child. It built on the strengths and capacities of children and their families to improve wellbeing; advocated preventative work and early intervention in partnership with other agencies to support children and their families; and, wherever possible, to reduce the need for crisis interventions. The evidence explored in this report demonstrates that adults, children and family units reduced the risks they faced and increased their strengths, showing improved relationships both within families and with their wider networks and communities.

The partnership developed to deliver DEIT has been a key factor in its success. The structure has enabled staff to support families to engage and access a range of services, both within the delivery partnership and with external agencies. The work done to develop relationships with schools and health agencies has encouraged them to take a more holistic view of the needs of those they were working with. As the report has shown, this led to improved diagnosis of neuro-developmental conditions, and improved relationships within educational settings. These are essential building blocks for a child's future.

5.2 Recommendations

- **Recommendation 1: To continue to develop a strong evidence base for the DEIT service.** The project collected a range of evidence on outcomes for the children and families it supported and it is positive to note that this was aligned to the GIRFEC agenda, allowing the project to tie its achievements to the aims of the national policy agenda. However, it is vital that project staff continue to develop this evidence base to meet the needs of future funders.
- **Recommendation 2: To give greater focus to adult health and skills in future delivery.** While the service facilitated reductions on a number of adult risks, there remained little progress on issues around employment, literacy and qualifications, and physical health. The project could utilise the partnerships it developed with healthcare and education providers to address these issues in future, providing a more holistic service for the adults who are engaged.
- **Recommendation 3: To further explore the potential for mainstreaming the project model as a commissioned service within Dundee.** The evidence indicates that the DEIT model has demonstrated its credibility as a service, providing valuable support to families at an early intervention stage and adding value to existing support structures in Dundee. In light of this evidence, it would seem appropriate for the project team to continue to work alongside the local authority and explore avenues for potential mainstreaming of the project in the city.