Early Years Integration Transformation Programme

Grant Application Form – Project support for local co-ordination and delivery

Project Duration: Sept 2021 – March 2022

Submission Deadline: 31st Aug 2021

Return Grant Application Form to EarlyYears@gov.wales

If you have any queries on any aspect of completing this form then please get in touch with Karen Faulkner at Karen.Faulkner@gov.wales /03000252804		
Section 1 – Organisation Details		
1.1	**Local Authority (Lead Body)**	Cardiff Council
1.2	**PSB Name**	Cardiff Public Service Board
1.3	**Lead Contact Name**	Avril Hooper
	Coordinating Officer	Natalie Dix
1.4	**Address**	The Conference Centre

		Eastmoors Road Splott Cardiff CF24 5RR
1.5	**Email Addresses**	a.hooper@cardiff.gov.uk Natalie.dix@cardiff.gov.uk
1.6	**Contact Telephone Numbers**	**Avril Hooper** M: 07968508746 O:02920351392 **Natalie Dix** M: 07890 619044 O: 02920 351717

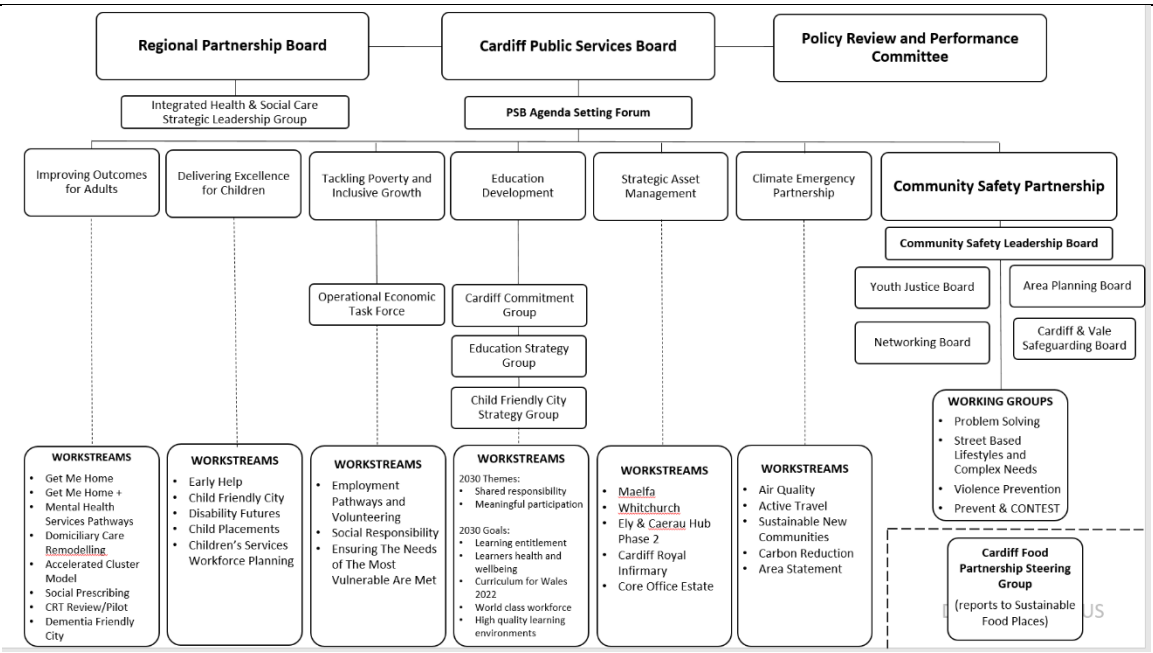
Section 2 – Governance and Partnership Arrangements

2.1. Key Senior Partners – Please confirm the key partners involved in your project. *(Please provide names and organisations they represent- to include LA, Health Board and Public Health Wales)*

Sarah McGill: Corporate Director - People & Communities in People & Communities Directorate, Housing & Communities Cardiff Council
Jane Thomas: Director Adults, Housing and Communities in People & Communities Directorate Cardiff Council
Deborah Driffield: Interim Assistant Director Children's Services in Social Services, Children Services Cardiff Council
Mel Godfrey: Director of Education and Lifelong Learning Cardiff Council
Paula Davis: Lead Nurse, Children, Young People & Families Health Services (CYPFHS) Cardiff & Vale University Health Board
Fiona Kinghorn: Executive Director of Public Health Cardiff & Vale University Health Board
Suzanne Hardacre: Head of Midwifery / Lead Directorate Nurse Cardiff & Vale University Health Board

2.2. Governance Arrangements – Please clarify the structures you have in place to oversee the project e.g. strategic board, steering group etc.

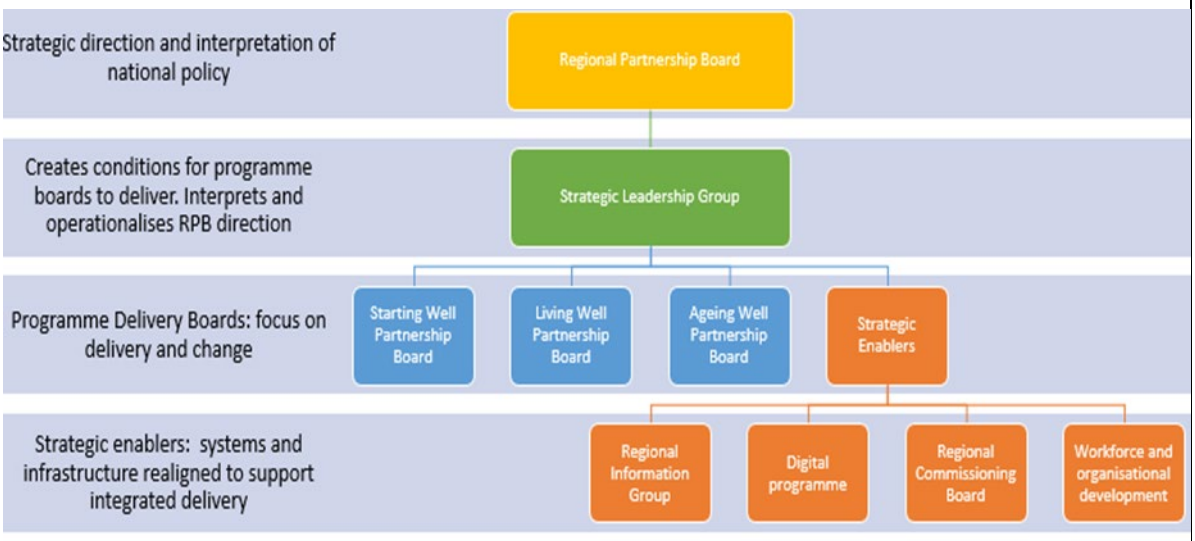
Public Service Board*



* Delivering Excellence for Children has now been replaced by the Starting Well Board

Starting Well Board

The Cardiff and Vale Regional 'Starting Well Partnership,' reports to the Regional Partnership Board through a Strategic Leadership Group. This partnership operates under the Cardiff & Vale Local Health Board footprint and will be the strategic board that oversees this project.
Membership consists of:



Early Years Pathfinder Steering Group

Senior key partners as named in 2.1 will designate leads from their respective service areas to be part of the steering group.

Early Help Operational Group

The Early Help Operational group will act as a *sounding board*. Findings and proposals from the Steering group will be shared with this group.
Within the group there is representation from Early Help, Cardiff & Vale University Health Board (Health Visiting, Safeguarding), Primary Mental Health, Children's

Services (Wellbeing Protection & Support), Education (Youth Service, Inclusion, and Engagement), Early Action Together, South Wales Police, and Rise.

Key Aim
To ensure that families receive the right help at the right time to enable them to achieve their full potential. This will be achieved through the provision of integrated early help and preventative services. An organisational outcome of this will be a reduction in the number of families, young people and children that require remedial intervention.

Purpose of the Group
To share, review and evaluate performance data, best practice, and emerging operational issues, across Early Help services, with the goal of providing effective integrated early help for families, young people, and children across Cardiff.

Children & Young People
Awaiting confirmation as to which group

2.3 Please outline when you expect to receive formal agreement from your PSB to become involved as a Pathfinder.
(Successful PSBs will need to have formal PSB agreement as part of the application, an email from the PSB Chair would suffice)
Application being taken to the PSB on July 26th 2021.

Section 3 – Project Details

3.1. Please outline the main aims and objectives of your project. What will the grant enable you to achieve?

The grant will enable us to:

- **Facilitate the work with partners to take forward the priorities identified within the EIF report Appendix 1 (awaiting report)**
- **Contribute towards achieving the objectives/commitments that are set out in our local plans, as outlined below.**

Cardiff Well-being Plan

Well-being-Plan-2018-23-Eng.pdf (cardiffpartnership.co.uk)

Cardiff is a great place to grow up

Commitment We will:

Adopt a 'Think Family' approach, making sure that public services are joined up and that children and families are given the right support, in the right way, at the right time in the first 1000 days of a child's life.

Capital Ambition

cabinet report 2020 ENGLISH.indd (cardiff.gov.uk)
Children & Families

We will:
Deliver flexible and responsive support services for families – available as and when required – through the Cardiff Family Advice and Support service.
Education, Employment & Skills
We will:
Develop a Cardiff model of integrated early years provision which links early learning, childcare, health, and family support.

Cardiff 2030 – A ten-year vision for a city of learning and opportunity

2030 CARDIFF 28th Oct .indd
Commitments to Action

We will:

Develop a Cardiff model of integrated Early Years provision, which links early learning, childcare, health, and family support, sharing lessons from the Welsh Government Early Years Integration Pathfinder areas.

Child Friendly Cardiff Strategy

Child Friendly City Strategy ENGLISH low res.pdf (cardiff.gov.uk)
Goals:

1. Every child and young person is valued, respected, and treated fairly.
2. Every child and young person has their voice, needs and priorities heard and taken into account.
3. All children and young people grow up in a safe and supportive home.
4. All children and young people access high quality education that promotes their rights and helps them develop their skills and talents to the full.
5. Children have good physical, mental and emotional health and know how to stay healthy.

Cardiff Children's Services Strategy 2019-2022

https://www.cardiff.gov.uk/ENG/resident/Social-Services-and-Wellbeing/Children/Childrens-services/Documents/Childrens%20Services%20Strategy%202019.pdf
We will:
A Think Family approach will be used to understand the needs of the whole family, not just the child, by working in partnership with families and other professionals

Cardiff & Vale University Health Board Shaping Our Future Wellbeing

Transformation and Improvement - Shaping Our Future Wellbeing - Cardiff and Vale University Health Board

3.2. Briefly outline the areas of support required to facilitate local co-ordination and delivery.

- An experienced facilitator who can bring together professionals across different early years domains, to achieve the objectives of the project.

3.3. Please list the targets/ outcomes to be achieved during the grant period

Outcome	Milestones
Key partners responsible for pre-birth and early years services are collaborating to develop an integrated and responsive early years system for pre-birth – 7 years of age.	• A Pathfinder steering group is established with representation from key partners. • Terms of Reference are created that includes membership/ key aims/ purpose of the group. • A timetable of regular meetings is set with records of agendas and minutes. • Short, medium & long-term goals are agreed for an achieving an integrated early years system.
The views and experiences of infants, children, young people, and families inform service development.	• Work undertaken with infants, children & young people to understand their experiences. • Views and experiences of families are sought to gain an understanding of their experiences and to identify what works well, as well as the potential barriers to accessing and engaging with services.
Pre-birth and early years services and their respective referral pathways are mapped and understood across Cardiff; gaps and what needs to change are/is identified.	• Consultant establishes current position and referral pathways of services for pre-birth – aged 7 years across Cardiff • Consultant establishes current position of services, and views of families, in relation to support during the first 1000 days regarding parent/ Infant relationships and parent mental health that supports early attachment. • Consult with parents/ carers across Cardiff to gain their views and understanding of parent-infant relationships and interactions and its importance to child development.
There is a consistent approach across services in relation to Parent/ Infant	• Audit the training, knowledge and understanding of all

Relationships within the first 1000 days.	practitioners working with parents, babies, and infants to establish the workforce's understanding of the critical role that parent-child relationships and interactions play in early child development and wellbeing during the first 1000 days and across the lifespan. • Assess practitioners' confidence in their skills and abilities to apply this knowledge to practice – at the level appropriate to their role.

3.4. How will this work link with your PSB's wellbeing objectives and priorities?

The Pathfinder work will link with the "Cardiff is a great place to grow up" commitment of the Wellbeing Plan

Cardiff Well-being Plan

Well-being-Plan-2018-23-Eng.pdf (cardiffpartnership.co.uk)

Cardiff is a great place to grow up

Commitment: We will

Adopt a 'Think Family' approach, making sure that public services are joined up and that children and families are given the right support, in the right way, at the right time in the first 1000 days of a child's life.

3.5 Confirmation of what work has already been undertaken to support the integration of early years services in your area including engagement with the early years system work being taken forward in your Health Board region by existing PSB pathfinders. *(Please provide relevant supporting information)*

APPENDIX 1: EIF Maternity & Early Years Matrix Report (AWAITING REPORT)
APPENDIX 2: Early Help

a. Structure
b. Assessment of Need tool
c. Distance Travelled Tools Framework
d. Thinking Together Conversations Framework

APPENDIX 3: Parent-Infant Relationship collaborative working (Appendix 3)

Section 4 – Project Finance

Please outline your project expenditure against the following headings:

Item of Expenditure	Amount (£)
Consultant	**£25,000**
Total	**£25,000**

Section 5 – Project Monitoring
5.1. What arrangements will be put in place to monitor the project and how will you ensure lessons learnt/ areas of best practice are reflected as part of medium/long term project planning?
• Reporting through governance structures • Quarterly review of a phased development plan • Data collection • Regional steering group • WG reporting/sharing of practice
Section 6 – Authorisation

Lead Body **(Signature)** **(Name)** **(Position)** **(Date)**	**Key Partners (Local Authority):** **(Signature)** **(Name)** **(Position)** **(Date)**
Key Partners (Health Board): **(Signature)** **(Name)** **(Position)** **(Date)**	**Key Partners (Public Health Wales):** **(Signature)** **(Name)** **(Position)** **(Date)**

Grant Application Guidance

Section 1 - Organisation Details	Telephone/mobile numbers and e-mail addresses of relevant personnel (i.e., the person who signed the application as lead body in section 6).
Section 2 – Governance and Partnership Arrangements	Please list the names of key partners involved in the project and the organisations they represent, to include LA, Health Board and Public Health Wales and clarify governance arrangements for the project

Section 3 – Project Details	This section will focus on what you will achieve/ undertake as a result of receiving project support funding. 3.1 A brief description of the main aims and objectives of your project including details of what will be delivered as a result of the funding. 3.2 Outline the targets/ outcomes you aim to achieve during the grant period (the targets/ outcomes will form the basis of the grant award letter and progress will be monitored against these over the duration of the grant period. 3.3 Briefly outline the potential areas of support which will be required to facilitate local co-ordination and delivery of the project. 3.4 Please clarify the PSB wellbeing objectives and priorities to be addressed by the project. 3.5 Please detail what work has been undertaken to support the integration of early years services in your area including engagement with the early years system work being taken forward in your Health Board region by existing PSB pathfinders and provide supporting evidence/ documentation of this.
Section 4 – Project Finance	<u>Eligible Costs</u> Funding will be available to each Pathfinder to fund a Project Co-ordinator and/or facilitation costs and associated travel and subsistence costs, to build on the work which is being undertaken in co-ordinating and implementing pathfinder activity, to assist with medium and long term planning and in gathering further intelligence on what it will take to develop a more joined up, responsive early years system locally. <u>Ineligible Costs</u> The grant cannot be used to provide a financial contribution towards redundancy costs. This is a revenue grant and cannot therefore be used to

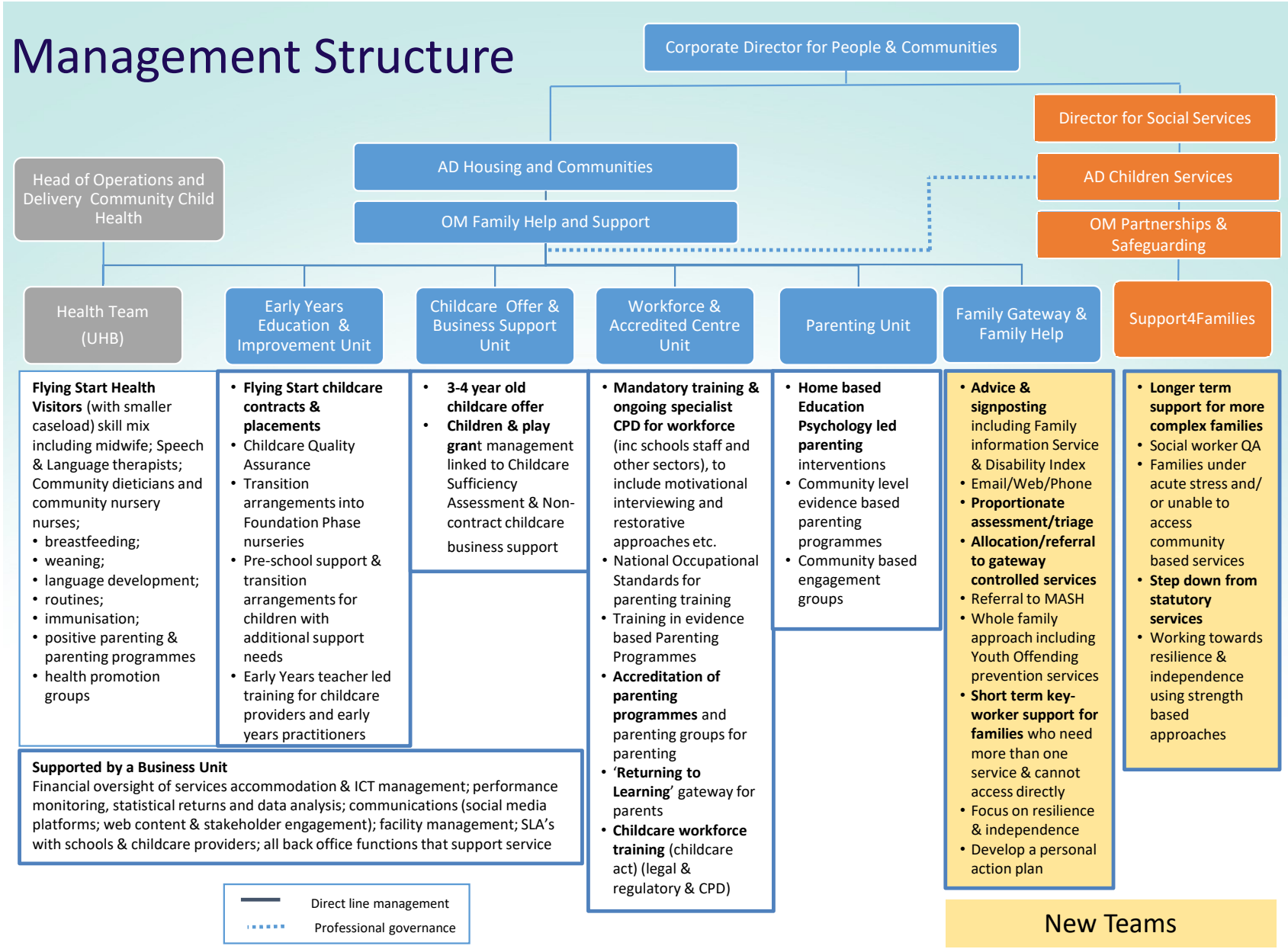
	fund large scale capital costs. Small purchases may be eligible providing they are within your Local Authorities individual capitalisation threshold.
Section 5 – Project Monitoring	Please outline what systems and processes will be put into place to effectively manage the project and clarify how you will ensure lessons learnt/areas of best practice in the way services are being delivered will be factored into medium/longer term project planning.
Section 6 - Authorisation	Application Form must be signed by the lead body contact and authorised signatories from each of the organisations listed. Email confirmation will suffice.

Welsh Government Privacy Notice

The Welsh Government Grants Privacy Notice is available to view at https://beta.gov.wales/privacy-notice-welsh-government-grants. The Grants Privacy Notice makes sure we continue to comply with privacy law and regulation.

If you have any questions or require any further help please contact us at mailto:dataprotectionofficer@gov.wales

Management Structure



Early Help

Assessment of Need

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

CARDIFF
CAERDYDD

Cyngor a Chymorth i Deuluoedd Caerdydd
Cardiff Family Advice and Support

Cardiff
Caerdydd

Introduction

In Cardiff, we believe that every young person and child should have the opportunity to reach their full potential. Children attain their best outcomes when they are offered services and support that enable them to grow and achieve in their own families, when it is safe to do so [1]. A key element to our approach to supporting families, young people and children in Cardiff is a commitment to **Early Help.**

The Social Services and Well-Being (Wales) Act [2] supports those with care and support needs to achieve well-being. Well-being means a person is happy, healthy and comfortable with their life as defined in Appendix 1. Everyone is entitled to well-being and everyone has a responsibility for their own well-being, but some people need extra help to achieve this.

Support will be provided through partnerships and service co-operation. Staff will work with families to identify the care and support they require to achieve the outcomes that matter to them. Services aim to prevent the escalation of need by ensuring the right support is available at the right time.

Research shows that while the largest impact on a child's future development occurs during the first few years in children's lives, it is also important to intervene at the early stages of a problem, whatever the age of the child. The Council aims to do this by **working with families** to develop their own sustainable solutions rather than 'doing for' or 'doing to'.

We are all responsible for safeguarding and promoting the welfare of young people and children. Services across the city will be flexible and responsive to provide families with effective support at the earliest possible stage. As soon as a practitioner becomes aware of any additional needs, they will discuss the problem with the family and offer advice and support to meet that need, making referrals to other agencies as necessary.

Agencies will focus on effectively engaging with families and breaking down barriers to participation. Support will change depending on the family's level of need with the aim of reducing provision when appropriate to **build resilience in families** and not dependence.

This partnership approach to Early Help is to ensure that all agencies work together, share information when appropriate and have a family centric focus to ensure that families receive the **right level of support at the right time**. Staff will provide all families with an Active Offer of support, with service provided in both Welsh and English and other languages if necessary.

By providing help at the lowest level of intervention, we aim to reduce the number of families requiring remedial intervention and to ensure that all families can achieve their best outcomes.

This document:

- Sets out Cardiff's integrated approach to early help and intervention for families
- Describes the spectrum of need and the appropriate indicators and services
- Describes good practice in seeking consent, information sharing and professional disagreements
- Provides a flow chart that describes how people and professionals can access Care and Support as outlined in the Social Services and Well-Being (Wales) Act 2014.
- Provides supplementary information and guidance on developmental indicators in families, young people and children and ACEs research.

Cyngor a Chymorth i Deuluoedd Caerdydd
Cardiff Family Advice and Support

Table of Contents

Early Help

Why Early Help?

Work has been undertaken by agencies across Cardiff to develop a common language that describes preventative support as **Early Help**. Early Help focuses on having the right conversations with the right people to ensure that families get the support they need.

A substantial body of research has shown how chronic stress on individuals during childhood can result in long term harm. These stresses are known as Adverse Childhood Experiences (ACEs) and have the potential to affect a child's development (Appendix 2) [3]. Those with greater exposure to ACEs are more likely to develop health harming and anti-social behaviours in the future, as well as a greater likelihood of developing diseases such as diabetes, cardiovascular disease and mental illness.

Two of the well-being goals put in place in the Well-being of Future Generations (Wales) Act 2015 are relevant to reducing the prevalence of ACEs across Wales [4]. Preventing ACEs and developing resilience in families will support the achievement of a healthier Wales by improving people's physical and mental well-being. The goal of ensuring that all children grow up free from ACEs, as well as understanding that ACEs are not isolated events but associated with environments that tolerate inequality, will feed into creating a more equal Wales where everyone is able to fulfil their potential.

It is better for families and the wider community to identify and intervene in problems early to prevent their escalation than to respond later when action is necessary. Early help support can be provided at any point in a young person or child's life with interventions provided early in a child's life or in the development of a problem.

Early intervention can help young people and children to live happy, healthy and successful lives by developing their resilience and skills as well as improving a family's home life, relationships and overall health [5].

Early action could:

- Reduce the number of young people and children who are impacted by adverse childhood experiences (ACEs).
- Raise educational attainment and aspirations of families.
- Improve access to better employment opportunities.
- Minimise safeguarding and care expenditures by building resilience in families.
- Reduce the number of foster and residential placements that now cost an average of £3,800 each per week.

Every family's situation is unique. Discussions and decisions on how to best meet their needs, and which agency is best placed to do so, will be based on:

- A clear understanding of the family's strengths and needs,
- Discussions with the whole family, including the view of the children, and
- Informed, evidence based professional judgements.

Changing circumstances mean that support requirements will vary over time depending on the impacts and relationships between a family's strengths, vulnerability and risk factors.

By working together, practitioners can ensure that families receive the **right level of support at the right time.**

Early Help in Cardiff

The ambition in Cardiff is to provide a more coherent approach to early intervention and prevention services. This will enable us to provide **information, advice and assistance** to all families whilst providing the right support level of supportat the right time for those who need it the most.

Home to 350,000 people, the city of Cardiff sits at the heart of the wider Cardiff Urban Zone in the South East of Wales. Cardiff is a city of huge contrast with areas of significant affluence in the north of the city and deep and longstanding areas of social-economic disadvantage mainly located in the 'Southern Arc'. Pockets of hidden deprivation also exist within less deprived areas.

The high levels of children who are looked after as well as increasing numbers of referrals and assessments for Children's Social Services is placing strain on support services for families. The Cardiff Partnership recognises the importance of focusing on effective intervention and support for families as opposed to managing short-term crises [1].

The Well-Being of Future Generations (Wales) Act 2015 has put in place seven goals to improve the social, economic and cultural well-being of Wales while ensuring the health and well-being of future generations [2]. Providing an accessible Early Help service feeds into the goal of creating a healthier Wales by reducing the impact of ACEs.

The Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015 was developed to improve arrangements for the prevention, protection and support for anyone (women, men, children and young people) experiencing or affected by violence and abuse. It acknowledges that women and girls are disproportionately impacted by all forms of violence which is a violation of human rights and both a cause and consequence of inequality between women and men [8].

Children aged 0-17 are entitled to special human rights protection under the United Nations Convention on the Rights of the Child [9]. The Children's Commissioner for Wales published the Children's Right Approach for Wales in 2017 as a framework for integrating children's right into every aspect of policy and planning [12].

Cardiff is the first city in Wales to participate in Unicef UK's national Child Friendly Cities initiative [10]. A Child Friendly Cardiff is a city where the voices, needs and rights of all young people and children are respected and a place where these individuals are safe, healthy, happy and able to share in the city's success, regardless of their belief, ethnicity, background or wealth.

Cardiff aims to ensure that families receive help at the **lowest level of safe and effective intervention** by [11]:

- Having an accessible Family Gateway to provide information, advice and assistance and is able to refer families on to appropriate services,
- Adopting a Think Family approach to ensure families are given the right support, in the right way, at the right time, and
- Actively working to identify those at risk of ACEs and delivering multi-agency responses when necessary to support families before they reach crisis point.

Key Principles of Early Help

The approach to providing Early Help will be underpinned by the following key principles:

1. A **strengthening families approach** that focuses on families' strengths and supports parents to bring up their child at home to achieve their best outcomes where realistic and possible. Families should be empowered to identify their own problems, needs and solutions.
2. A **Think Family approach** will be used to understand the needs of the whole family, by working in partnership with families and other professionals.
3. An **outcomes based approach** with clear and measureable outcomes for children and families. New initiatives and re-targeting of resources will be based on evaluated evidence of 'what works'.
4. Providing **the right level of support at the right time** by implementing a clear plan, outcomes and tailored support with the family.
5. A **connected partnership approach** that will utilise wider cross partnership initiatives to maximise impact and re-target partner resources to reduce demands or de-escalate interventions to the lowest appropriate levels.
6. A **shared understanding and language** will be developed across the city and a "no wrong door" approach with all partners involved in supporting families.
7. Understanding the **impact of poverty** and routinely using advice and into work services to maximise income and resolve family income and housing issues.
8. **Effective and meaningful engagement** with families will allow these groups to actively participate in the model implementation and feedback their views and suggestions for on-going review and outcome evaluation.
9. **Effective and continuous workforce development** will be required to provide workers with the necessary confidence and experience to work directly with families, especially when providing outreach or intensive interventions.

Service Aims of Early Help

Early Help will aim to:

- Provide **information, advice and assistance** in a timely manner to reduce the need for ongoing support.
- Develop a shared understanding across the city, developing a **no wrong door approach** with all partners engaged in supporting families.
- **Improve outcomes** across a range of indicators for families and children of all levels of need.
- Enable families with emerging short-term problems to be better helped to manage these problems, **build resilience** and avoid the need for longer-term support.
- To better support families with complex problems with a relationship based **whole family approach** to prevent the need for statutory intervention.
- Improve the range of services available for families involved with statutory safeguarding and care services to be able to secure the best possible long-term futures and enable a **'stepping down'** to support services as soon as this is safe.

Levels of Need

Practitioners may require guidance as to the most appropriate response for a family's needs. This document sets out a clear framework on how support will be provided to families across the spectrum of need described in Figure 1 [6]. Understanding and applying these levels will enable families to receive support early in the emergence of a problem.

The provided support will be **proportionate to the needs of the family**. Intervention should be at the lowest level appropriate to meet the needs of the family while supporting them in achieving their personal outcomes and the things that matter to them.

Practitioners should be open and honest with families when determining their level of need. Providing the right support may require practitioners to share information – the family's consent should always be sought when sharing information unless a child is at risk of significant harm.

Examples of the agencies that provide support at each levels are included in Appendix 3.

It is important to note that families can and do **move between levels of need**. Families, especially those with complex needs, should be able to move through levels as quickly and effortlessly as possible without repeat assessments, unless there has been a significant change in their circumstances.

National Assessment and Eligibility Tool

The Social Services and Well-Being Act 2014 requires local authorities to have a **'What Matters'** conversation with the child, young person or person with parental responsibility based on the five key elements of assessment as part of the National Assessment and Eligibility Tool (Appendix 4):

- Assess the family's circumstances,
- Regard their personal outcomes
- Identify any barriers to achieving these outcomes,
- Assess any risks to the family if their outcomes are not achieved, and
- Identify the family's strengths and capabilities.

In addition, the first point of contact is required to capture the National Minimum Core Data Set – this only needs to be completed in full if the needs are eligible and a care and support plan is required (see pg 19 for more details).

The last part of the National Assessment and Eligibility Tool outlines the actions to be taken by practitioners and family members to help the child or young person to achieve their personal outcomes.

Cyngor a Chymorth i Deuluoedd Caerdydd
Cardiff Family Advice and Support

The Right Help at the Right Time Framework

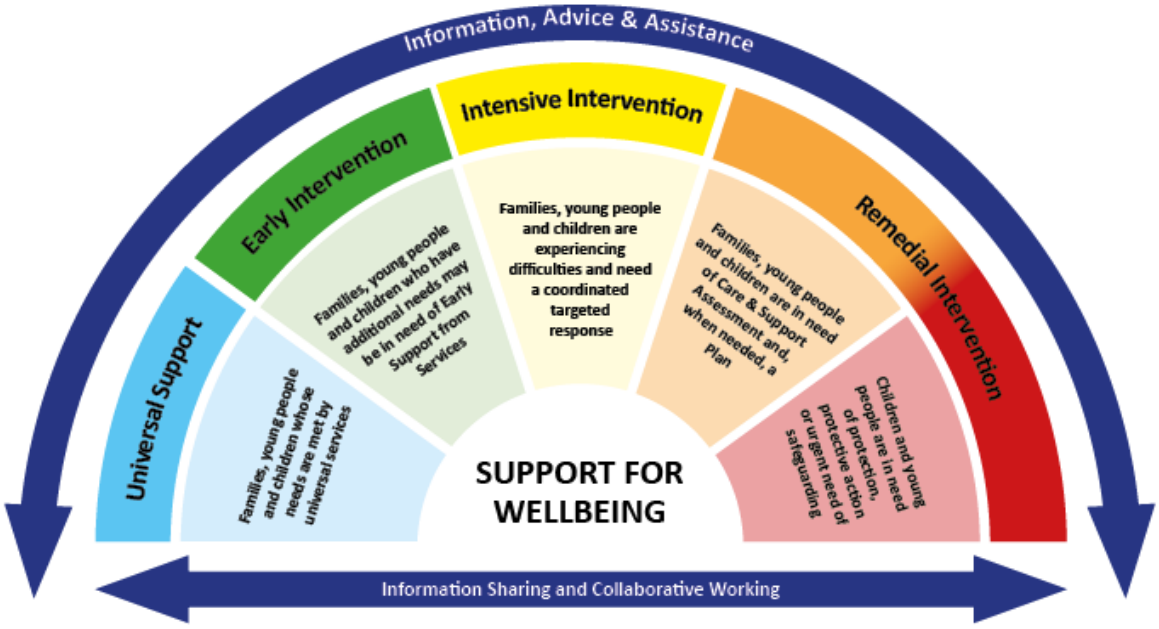


Figure 1: Based on the spectrum of need for families, young people and children from Welsh Government [6]**.**

UNIVERSAL: ***Most families have no additional needs and will never come into contact with specialist or statutory services.*** For most families, access to universal services will be sufficient to meet their needs and to achieve their best outcomes. Services should guide and support families to find their own solutions.

EARLY INTERVENTION: ***Some families may require some additional support to be healthy, safe and to achieve their best outcomes.*** These needs can be due to temporary or enduring circumstances. Additional support at school, home or the local community may be required. This response may be provided by a single agency or a partnership between several agencies.

INTENSIVE INTERVENTION: ***A coordinated targeted approach is required by families of higher or more complex levels of need to promote well-being or to prevent needs from becoming more complex or acute.*** An intensive package of support is needed to manage these concerns but statutory social work or specialist interventions are not required. Support is likely to be more intensive or will take place over a longer period of time.

REMEDIAL INTERVENTION: ***Some family members are in need of protection or safeguarding and need immediate statutory social work or highly specialist interventions to prevent significant harm to their health and welfare.*** Children's social work services will take the Key Worker role in safeguarding services and coordinating services at this level of need.

Indicators of Need & Signs of Safety

Every family is unique. Decisions about levels of support should be based on discussions between practitioners and the family.

The indicators described within Family Help and Family Support provide illustrative examples of how need may present itself and are not an exhaustive list of fixed criteria that must be met. It is important to note that these are only indicators and both professional judgement and discussions with the family will be required to determine their needs. Every family is unique.

Each family will have different strengths, needs and resources available to them. Effective communication between the family and practitioners is essential to ensure that the family receives the **right level of support at the right time.**

The impact on a young person or child in regards to their health, development and harm or likely harm should be considered. While some indicators alone may not be concerning, a holistic assessment should be undertaken to examine the interplay of different factors. Protective factors may reduce a child's vulnerability. Concern may also be escalated due to the degree of severity of an indicator.

For more information on indicators for different levels of needs, see Appendix 5.

A Signs of Safety approach will be used when assessing the level of support required by a family:

Worries	Strengths	Moving Forward
Past Harm: What has happened to this family in the past?	What's working well in this family?	**Agency Goals:** What does the agency need to see the family doing (and over what period of time) to be confident that there is enough safety and resilience to close the case?
Future Danger: What are we worried might happen to this family if they do not change their behaviours?	**Strengths:** Positive aspects of the family meeting basic needs.	**Family Goals:** What does the family think they need to be doing in order for the agency to close the case?
Complicating Factors: What makes building resilience and working with this family more complicated?	**Safety:** Behaviours that demonstrate the capacity to protect vulnerable family members over time.	**Next Steps:** What are the agency's and family's ideas about what needs to happen next in working towards these goals?
	What support and resources can the family access?	

Cyngor a Chymorth i Deuluoedd Caerdydd
Cardiff Family Advice and Support

UNIVERSAL Mostly no additional needs.	Any needs can be met by universal services. Physical and emotional needs are being met. Relationships between carers, siblings and peers are good. Children and young people exhibit age appropriate knowledge and behaviour. Children and young people are regularly attending education, training or employment. Parents provide for their children and protect them from harm while providing consistent, age appropriate guidance and ensuring all family member attend health appointments.		
	Factors relating to health and development of the young person or child	Factors relating to parents and carers	Factors relating to environmental factors
EARLY INTERVENTION Additional need may mean that families need Early Support from services. (Family Help)	• Disengaging from education, employment or training • Emotional well-being or mental health concerns • Not attending appointments • Drug or alcohol use • Low self esteem or confidence • Poor school attendance or exclusion • Slow in meeting developmental milestones	• Parental conflict • Lack of appropriate boundaries • Poor parental engagement • Parent in prison • Teenage pregnancy and parenthood • Parent has mental or physical health problems or a learning disability • Parent requires advice on parenting issues	• Social isolation • Extremist views in family or community • Historic domestic abuse • Family involvement or risk of involvement in offending • Loss of significant adults (bereavement, separation) potentially impacting on child's well-being
INTENSIVE INTERVENTION Families need a coordinated targeted response to overcome difficulties (Support 4 Families)	• Being a young carer • Disabilities • Persistent patterns of absence from home or school • Self harm concerns or suicidal thoughts • Risk of overdose • Sexually inappropriate behaviour • Some evidence of inappropriate responses or behaviour • Low self esteem or confidence • Difficulties with peer group relationships • Repeated pattern of not being brought to appointments is affecting physical or emotional well-being • Child or young person seriously affected by parental mental health, substance misuse or domestic violence. • Offending behaviour	• Domestic abuse or allegations exist • Physical or learning disability • Mental ill health, serious illness or substance misuse • Parental history affecting their ability to care for child • Parents do not respond to advice or support • Complex family relationship breakdown • Unsafe, erratic or inconsistent parenting • Parent has experienced female genital mutilation • Offending behaviour	• Children returning home from care • Subject to discrimination • Chronic social exclusion • Environmental does not meet the family's needs or is placing the family at risk of harm • Poverty is impacting the ability to care for the child • Risk of ideological grooming or holding extremist views
REMEDIAL INTERVENTION Families are in need of a Care and Support Assessment and, when needed, a Plan. Children and young people are in need of protective action or urgent need of safeguarding (Statutory Services)	• Sustained bouts of depression or self harm • Serious risk to self or others • High level of caring affecting child's emotional wellbeing or life chances • Unexplained injuries, suspicious injuries or inconsistent explanations • Neglect seriously affecting child development • Children in custody • Serious mental health issues • Severe or chronic health problems • Child who has abused another child • Child at imminent risk of suffering female genital mutilation	• Parents have been unable to care for another child • Domestic abuse having a long term impact on child's well-being • Parents support female genital mutilation • Parental substance use or mental health issues placing the child at risk of significant harm • Parent has a learning disability that affects their ability to care for a child without support	• Being homeless or at immediate risk of becoming homeless • Children in contact with an individual identified as a risk to children • Families seeking asylum with no leave to remain or recourse to public funds • Significant concern of radicalisation • Children being exploited • Children who are being trafficked • Children at risk of forced marriage, honour based abuse or female genital mutilation

Support Available in Cardiff

Integration and knowledge sharing across services is essential in providing the **right level of support at the right time** to families. Existing services have been brought together to create three new services to provide support for families of all levels of need (Figure 2):

1. The **Family Gateway** will be the main route for referrals and requests for help and will provide information, advice and assistance.
2. The **Family Help** service will provide a rapid response to families that need short term intervention
3. The **Family Support** service will work will families facing more complex or severe issues

A **Key Worker** (KW) is a family's main worker at a certain point in time. This could be a Family Help Advisor, a Support 4 Families Worker, a Social Worker or a staff member from an external agency who is already working with the family.

The KW is the key point of contact and will form a partnership between the family and practitioners from different services (see page 27 for more details). They will smooth the transition and introductions between the family and any new workers from different agencies. If appropriate, they may carry out some intervention or support with the family.

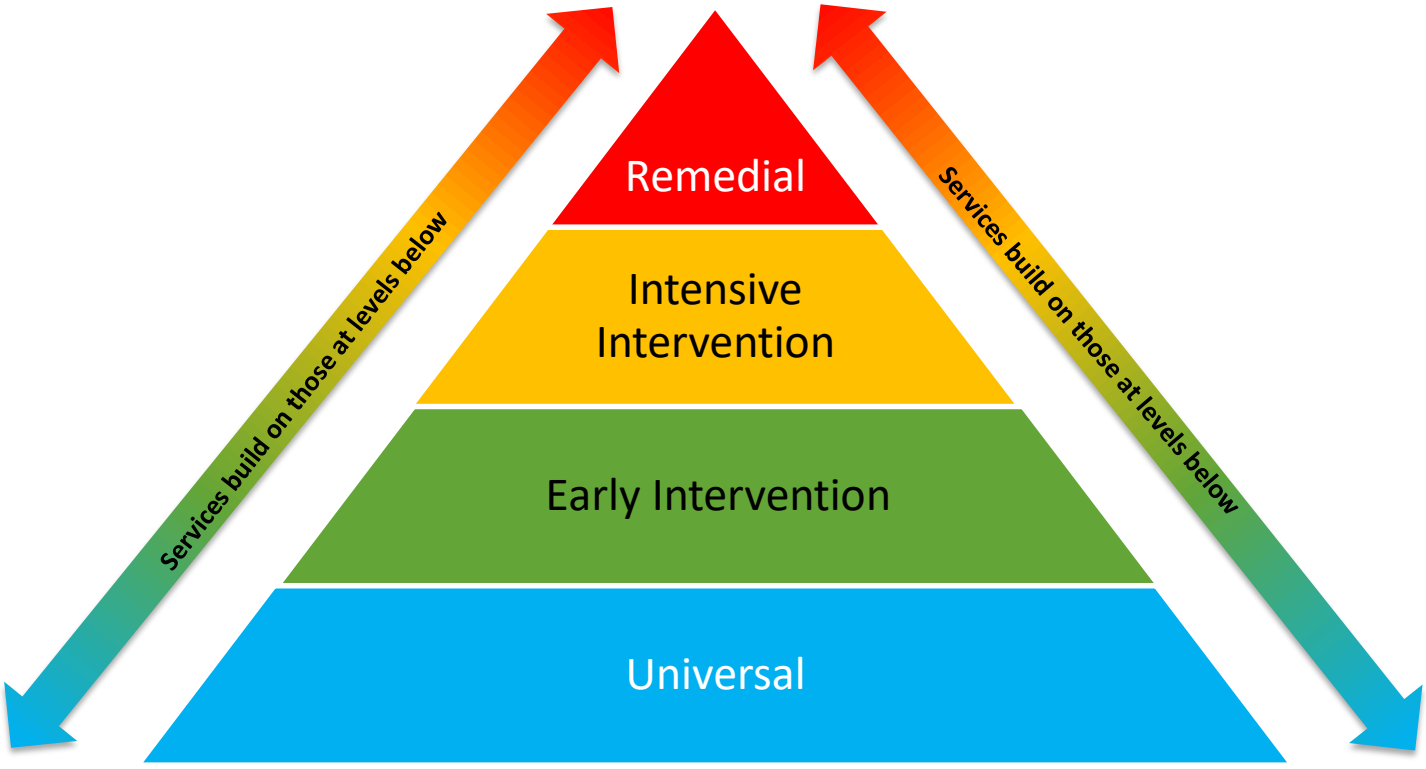


Figure 2: Service model for families in Cardiff.

Family Gateway

The Family Gateway is a clear, accessible referral route for anyone who has **well-being concerns about a child or wants to learn more about support available for families**. Referrals or requests for advice or signposting can be made by professionals or members of the public.

The Gateway provides a clear pathway into other support services and to other Gateways when necessary. The Gateway can be accessed via a dedicated phone line, email and website and is staffed by Contact Officers with Social Worker oversight. Staff will be given Signs of Safety and safeguarding training to assist with the broad range of issues that may enter the Gateway.

The Gateway can provide advice on:

- Child behaviour
- Child care
- Parental support
- School attendance
- Employment, money and housing

Other services provided by the Gateway will include:

- Information and signposting to other services and Gateways,
- Proportionate assessment and triage, and
- Referral into targeted services.

In these cases, the basic needs of the family are being met but advice is needed on specific issues. These needs can be met through advice or signposting to other services.

There will be two types of referral into the Family Gateway:

- Those requesting **early help**, and
- Those where there is a clear **safeguarding concern** (MARFs).

Referrals with a clear safeguarding concern will be directed immediately to a Gateway Social Worker who will make a decision regarding the service best placed to support the family. This will involve direct referrals to statutory services such as the Multi-Agency Safeguarding Hub when necessary (Figure 3).

Examples of Universal Services

- Youth Services
- Housing
- Money Advice Team
- 3-4 year old childcare offer
- Community based group parenting programmes
- Into Work
- Flying Start
- Family Information Service
- Community Reinforcement and Family Training
- Third sector provision

Case Study

Bina and Saul

Saul calls the Family Gateway asking about local childcare as Saul needs to maximise his income and is currently working part time. He is also looking to meet other parents in Adamsdown. In conversation he reveals that he and his partner have recently separated and he has sole custody of his 3 year old daughter, Bina. His mother lives in Grangetown and supports Saul to be able to work part time but would not be able to care for her granddaughter full time. Saul also does not know many other parents in the area and thinks that both he and Bina would benefit from improved social opportunities.

Family Gateway

Through the Family Gateway, Saul learnt that he lived in a Flying Start area and was eligible for free part time childcare. The Gateway provided information on local play and community groups in Adamsdown so that both Saul and Bina could get to know other families. The Family Gateway was also able to check that Saul was accessing all benefits to which he is entitled and signposted him to return to the service or his local Hub for future queries.

Debbie and Theresa

Debbie contacts the Family Gateway to find affordable childcare for her two children (10 month old, and 2 years 10 months old). The older child has been recently diagnosed with a disability. Debbie is self-employed. Her partner, Theresa, works as a teaching assistant full time but is currently on maternity leave and is due to return to work in the next month. They previously paid for a private day-care nursery place but Theresa took over caring for both children when she was on maternity. Debbie is unsure how to support her family while keeping her job.

Family Gateway

The Family Gateway informed Debbie about the childcare offer and how to apply, meaning that a large portion of childcare costs will be covered for the 2 year old, as well ensuring that the child will be accessing a foundation phase nursery place by contacting the school admissions team.

The Contact Officer also directs the Parent to the Welfare Benefits Advice to ensure the family is financially supported with the newly diagnosed disability. Debbie is also signposted to the Business Wales website for advice on money saving and business grants for small businesses.

A referral is also made to the DTAF (Disability Service) for advice on the support available to the family.

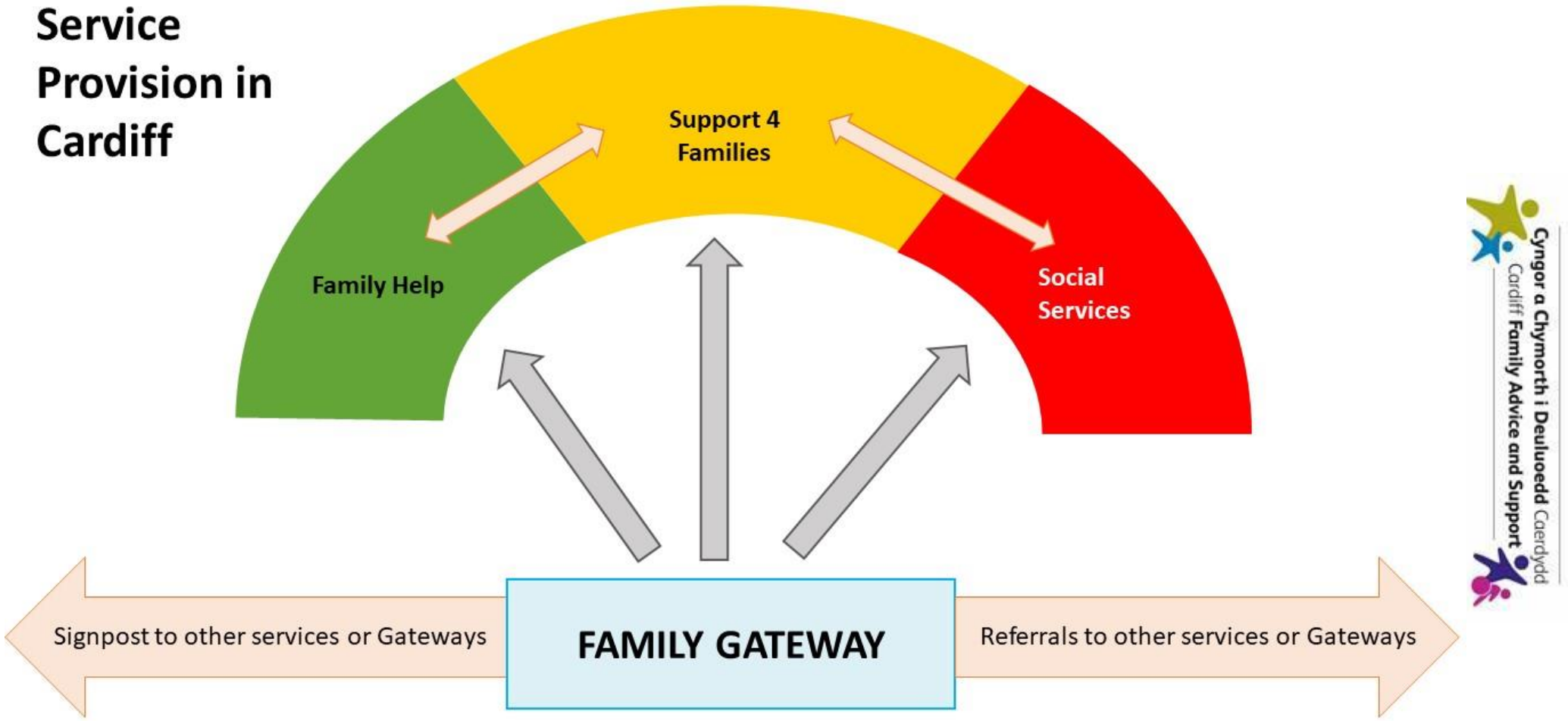


Figure 3: Provision of support for families in Cardiff.

Family Help

The Family Help Service will provide a rapid response to families that need **short term intervention.** A focus will be placed on families who, without help at this stage, are **likely to require more intensive support or safeguarding in the future**.

The Family Help Service consists of a team of Family Help Advisors who work closely with Gateway staff. Staff are fully trained in Signs of Safety, safeguarding and a range of interventions. When needed, they will visit families to carry out further assessment.

Family Help Advisors provide families with advice and support and are responsible for delivering some interventions. They will establish contact with appropriate professionals when required and help the family to maintain appointments.

Examples of Services

Relevant services include all previously mentioned services in addition to:

- Barnardo's Family Well-Being Service
- Youth Support
- Home Start
- Well-being 4U
- Housing Floating Support
- RISE – VAWDASV
- AFC – Disability Focus
- Cardiff Parenting Support
- Youth Offending Service

Anne, Ayesha and Lee

Ayesha calls the Family Gateway and is very distressed. She is struggling to manage the behaviour of her 7 year old daughter, Anne. Anne is not behaving at home and there have been instances of aggression both at home and in school. After the incidents, Anne is very remorseful and reports feeling unable to control her behaviour.

Both parents have experienced issues with their mental health (anxiety and depression) and are currently receiving support from their GP. Ayesha also has physical health difficulties and Lee has recently left work to become her full time carer. Lee is less confident in his parenting abilities than Ayesha and Anne's behaviour is much worse when only he is present, which is often due to the frequency of Ayesha's medical appointments and her fatigue. Lee was recently denied a PIP claim which is impacting on the family's financial stability with recent use of the food bank and rent arrears.

Family Help

A Family Help Advisor performed a more detailed assessment with the family. The Advisor recognised the difficulties faced by the family but was reassured that both parents were supportive of each other and already receiving help from their GP. Ayesha and Lee were referred to the Cardiff Parenting Service for parenting support. With the family's consent, the Advisor updated Anne's school on their situation – Anne's form teacher and school nurse have a better understanding and are working with Anne on her behaviour at school.

The Advisor requested Carer Assessments for both Lee and Anne. An Adult Services assessment means that the house is more suitable for Ayesha's physical needs. The Advisor referred the family to Tenancy Support for help with rent arrears, helped to maximise the family's income through a benefit check and referred Lee to a specialist service for assistance with his PIP appeal.

The Advisor and the family developed a plan that describes next steps if things do not improve.

Support 4 Families

The Support 4 Families team will work with families facing more complex or severe issues. A focus will be placed on families where, without support, there is **imminent risk that they are likely to require a safeguarding or care intervention**. This service will also help families who have stepped down from statutory services but still require ongoing support.

The Support 4 Families team provides social work interventions led by a group of multidisciplinary professionals working together to find the right solution for the family. Support Workers offer intensive and assertive support in the following ways:

- Direct delivery of a range of evidence based family intervention and programmes,
- Providing practical help and support,
- Co-ordinating multiagency approach when required (if acting as Key Worker),
- Advising on a wide range of community based services, and
- Addressing issues such as domestic abuse, substance misuse and mental health.

Families and staff work together towards building resilience by focusing on the strengths of the family. Support takes place over a longer period with families able to reduce or re-engage with support as needed with changing circumstances.

Data and information sharing is especially crucial in Support 4 Families, both between practitioners to ensure children and families are receiving the right level of support at the right time and for performance monitoring of families and services.

Staff will assess families with the eligibility criteria and will be able to step up to and down from Statutory Services as appropriate (Appendix 1)

Examples of Services

Relevant services include all previously mentioned services in combination with social worker support inclusive of the Unborn Team. Examples of additional services include the Adolescent Resource Centre and the Youth Offending Service among others.

Nicole and Joe

Nicole struggles to pinpoint the support her family needs when she calls the Family Gateway. She reveals that she has previously used drugs and is currently experiencing a relapse due to a lack of support. She lives with her husband, Joe, and two sons aged 2 years and 5 months.

Nicole discloses that she has been using crack cocaine or heroin every other day. Joe does not trust Nicole to look after the children alone, which is impacting on their relationship. While Joe has abstained from heroin for three years, he is concerned that the current issues with Nicole's drug use could impact his recovery plan (Joe attends a substance misuse support service).

Joe provides good support to the children but he is struggling as the main carer. Joe says that Nicole is a good mum but has been affected by the recent loss of her father. The family does not have any social or wider family support locally. Nicole is unwilling to engage in community resources for substance misuse support as in the past she has been offered substances by other attendees and feels that this could be a step back for her family. Nicole reveals that her oldest child was on the Child Protection register until a year ago.

Support 4 Families

A Support Worker performed a more detailed assessment with the family in person to get a better idea of their situation. The Support Worker recognised the difficulties faced by the family but recognised Joe's abstinence from drug use, the excellent support he provides to the children, the family's willingness to ask for help and the fact that the family were moved off the CPR in the past.

Nicole is referred to a bereavement service for support with the recent loss of her father. Nicole lost her job due to her behaviour change after her father passed away. The Support Worker checks that the family are receiving the benefits to which they are entitled and ensures they can continue to make their tenancy payments. As the sole earner, it is important that Joe receives the help he needs to support his family both financially and emotionally.

Alternative substance misuse rehabilitation options and parent groups for those with addiction issues are presented to the family. Joe is praised for his abstinence and supported to continue.

Though the family does not have much support locally, they are referred for respite childcare and to Homestart to give both parents a break. With consent from the family, the Support Worker contacts the children's school and Health Visitor to inform them of the situation to see if they can provide additional support.

The Support Worker and the family developed a plan that describes next steps if things do not improve. Neither parties want Joe and Nicole's children to be put on the CPR or taken away from the family home. Buy in from everyone involved is essential to not only work on supporting Nicole through this difficult time, but to keep this family together if it is safe to do so.

Care & Support Needs and Safeguarding

Families, young people and children will be referred to statutory services if, following assessment, they have needs that can only be met through a **care and support plan.**

Appendix 6 outlines the four eligibility conditions that must all be met in order for a family to be assessed as **eligible for a care and support plan**. The only exception to this is if there are **safeguarding concerns**, in which case the family is automatically eligible.

In terms of eligibility criteria for care and support, the Social Services and Well-being [Wales] Act 2014 states (Appendix 1):

A proportionate assessment of need is conducted which considers:

1. Personal outcomes
2. Barriers to achieving personal outcomes
3. Risks to the family if their personal outcomes are not achieved
4. Strengths and capabilities

An individual has an eligible need for care and support if an assessment establishes that **overcoming barriers to achieving personal outcomes** requires the local authority to prepare and ensure the delivery of a care and support plan.

The family, young person or child should be treated as **equal partners** when working with the local authority to assess current and future care and support arrangements.

Can the identified need be met via signposting to preventative services or in another way?

- If **YES**, the child is not eligible
- If **NO** or the child is **in need of protection**, they are eligible

Examples of Services

Relevant services include all previously mentioned services in combination with social worker support, in addition to:

- Fostering
- Residential care
- Looked After Children
- 13+ Think Safe
- Adolescent Resource Centre (ARC)
- Youth Offending Services
- Friends 4 U
- Child Health and Disability Team
- Integrated Family Support Services
- Emergency Duty Team
- Special Education Needs

Safeguarding is about protecting children and adults from harm. Harm can be physical, sexual, psychological, exploitative or neglect. Educating those around them to recognise the signs, dangers and risk of harm is vital.

Safeguarding is everyone's responsibility. Every individual, professional and organisation must do everything they can to ensure that children and adults at risk are protected from harm.

Any child who is facing or is at risk of facing significant harm or for whom there are serious concerns about their welfare, will automatically be eligible for care and support.

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The new RISE-Cardiff service supports women and their children **at imminent risk of abuse** who need **a place of safety** such as a refuge, but can also support women with **preventative and support services** in the community. The 24/7 service works closely with the Police, Health and Social Care services to ensure the safety of all family members.

The RISE-Cardiff service provides specialist interventions delivered by Independent Personal Advocates (IPAs) who are experts in a range of issues relating to Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) including:

- Domestic abuse and coercive control;
- Rape, sexual violence/abuse;
- Forced marriage;
- So-called 'honour' based violence;
- Stalking;
- Sexual harassment;
- Sexual exploitation (including through the sex industry);
- Trafficking/modern day slavery.

Cases are risk assessed using the nationally accepted DASH-Ric risk assessment form and professional judgement to identify individuals as either Standard, Medium or High risk.

RECOVERY INFORMATION SAFETY EMPOWERMENT

RISE-Cardiff assess the shared and individual needs of victims and their children. Using a needs-led, strengths-based and trauma informed approach, RISE is focussed on early intervention, always mindful of putting the safety of victims and their children at the centre of service delivery. IPAs can work separately with family members and also together as a family unit to build individual resilience, promote independence, encourage empowerment, enable responsibility, control and choice and promote the family member's participation in the agreed programme of support.

Services respond to and wrap around individual need and, where possible, the same IPA supports the family member throughout their support pathway. Work with children is age-appropriate and responds to their level of need and risk.

Domestic Abuse and Sexual Violence (Men)

The RISE service was commissioned specifically for female victims following direct feedback from survivors, recognising that men and women experience abuse differently and therefore need bespoke responses and support. A service for male victims is currently being commissioned with local authority partners across South Wales and Gwent and is unlikely to be available until April 2020.

In the meantime, the RISE service assists with delivering their expert support to male victims of domestic abuse and sexual violence, and any children in their care, assessed as Standard and Medium risk. Those deemed High risk are supported by the male victim Independent Domestic Violence Advocate (IDVA) provided by Safer Wales. Access into safe accommodation is currently provided by Gwalia Care and Support at the dedicated male refuge in Cardiff.

Services offered include:

A One Stop Shop, offering:

- Advice, information and signposting
- A full triage assessment of need and risk
- Responding to of all Police referrals (PPNs), both adult victims and children
- Management of referrals from victims, friends, family and professionals
- Access to other services such as solicitors and the Citizens Advice Bureau
- Coordination of target-hardening referrals

Accommodation-Based Support, including:

- Access to appropriate safe accommodation via the VAWDASV Gateway online system
- An Intake and Assessment facility to undertake fuller assessments of need or for respite whilst target hardening or other activity takes place
- A range of crisis and refuge accommodation across the city
- A range of step-down supported accommodation

Community-Based Support, including:

- Advocacy and support through the Criminal Justice and civil justice systems
- Access to psychological counselling and recovery toolkits for victims and children
- Housing-related support to prevent loss of, or to establish new tenancies and reintegration into the community
- Age-appropriate self-help interventions, either on a one to one or group basis
- Dedicated services for pregnant women and for those with children aged under 5

Assessment Process

Under the Social Services and Well-Being Act 2014, adults, children and carers have a right to assessment when it appears that they may have a need for care of support, regardless of the level of that need and of the individual's financial resources. Any assessment must be proportionate to the family's needs and appropriate for their circumstances.

Any family that is referred on to additional services by the Family Gateway should complete a proportionate assessment using the Signs of Safety approach using the Assessment Framework (Appendix 7). The assessment is not a doorway into care and support but a process that can help families to understand their situation and any challenges they may face in achieving their personal outcomes.

The family will complete the assessment with a Family Help Advisor or Support Worker to identify their strengths, needs, skills and resources. If the family provides consent, practitioners with whom they have already worked can join them to smooth introductions and assist with assessment. This process will also identify any professionals or services that could support families in their journey.

The staff member will then coordinate a meeting involving the family and any services identified previously to help the family engage with appropriate services and to develop a plan that incorporates the support they need as well as appropriate monitoring time lines, progress markers and contingency plans if progress is not made in the required time.

While families may participate in short or more intensive interventions with services, they will always be in contact with their Family Help Advisor or Support Worker. Different services will have their own data systems but the proportionate assessment will remain with the family and their Family Help Advisor or Support Worker to ensure that the family does not need to tell their story repeatedly.

If a family is working with a social worker or social care agency, a Children's Social Care Assessment may be required. The proportionate assessment will remain with any families that step down to intensive intervention from statutory care.

National Policy

The Social Services and Well-Being Act 2014 outlines five elements of assessment that requires local authorities to:

- Assess the family's circumstances,
- Regard their personal outcomes
- Identify any barriers to achieving these outcomes
- Assess any risks to the family if their outcomes are not achieved
- Identify the family's strengths and capabilities

For more information, go to pg 7.

Risk Assessment in Cardiff

When assessing children's needs, it is essential to assess risks, especially for children who are suspected to be at risk of harm.

If a family is determined to have care and support needs, or there are safeguarding concerns, they will be referred into statutory services (pg 18).

A number of questions should be considered when making decisions about the level of support required by a family:

- What are the strengths of the family? What are they doing well?
- What are the future impacts for the child if things do not change?
- What did the family say about these concerns?
- Are there any factors that are complicating the problem?
- What advice or support has already been provided? What is the view of other professionals involved with the family?
- What support does the family need to build on their strengths?
- Does the family consent to information sharing?
- Does the family agree to an offer of help and support?
- What action will be taken is consent is not provided?

Informed Professional Judgement

Strong professional judgement is essential for Cardiff Family Advice and Support staff in determining a family's level of need. The previously mentioned indicators of need are only examples of how needs may be expressed. Every family is unique and will differ in terms of their strengths, resources and needs. Staff will need to communicate with families to get a full understanding of these factors and to ensure that the family receives the right level of support at the right time.

Practitioners should seek guidance and approval from their line manager or safeguarding lead. Any conversations and actions relating to agency decision making should be clearly documented within the family's record. Advice and support in decision making can also be provided by social worker oversight throughout Cardiff Family Advice and Support

Resolving differences

Practitioners from different agencies may have differences in opinion while assessing a family's level of need.

Exchanging ideas and having different opinions are a sign of developmental thinking and add value to the conversation. All practitioners working with families should be able to share their perspective and constructively challenge the decisions and actions, or lack of actions, of others.

A lack of resolution to a professional disagreement should not inconvenience a family. De-escalation is always the preferred method when working towards resolution.

When disagreements cannot be resolved between practitioners, they should consult their line managers who will work with the line manager from the other agency to resolve the problem. If disagreements are not resolved at this stage, line managers should consult senior management from each agency.

If there are any safeguarding concerns, practitioners should follow the Protocol for the resolution of professional differences set out by the Cardiff and Value of Glamorgan Local Safeguarding Children's Board found at: https://www.cardiffandvalersb.co.uk/wp-content/uploads/CV-LSCB-Protocol-for-the-Resolution-of-Professional-Differences.pdf

Consent and Information Sharing

No single agency will ever have the full picture of a family's needs and circumstances. Therefore effective communication and information sharing between agencies is essential in joining up support to improve outcomes for families.

Consent is a key component of the Early Help service. Before a practitioner can share information or make a referral to other services for additional or targeted early help support, consent must be provided by the family (unless there are safeguarding concerns as outlined on pg 18).

Practitioners should be open, honest and respectful with families about what information could be shared as well as why it is being shared, how it will be shared and with whom. Practitioners should seek consent to information sharing unless it is unsafe to do so. Clearly recorded communication within and between agencies should be as accurate and complete as possible.

The Early Help Referral contains a 'consent to share information' section. Families can state which services they agree can receive their shared information. Consent to further information sharing can be sought at any point during the assessment process.

The Early Help Service complies with the EU General Data Protection Regulation (GDPR) rules. Article 5(1) of the GDPR requires that personal data shall be:

- Processed lawfully, fairly and in a transparent manner
- Collected for a specific, explicit and legitimate purpose
- Adequate yet relevant and limited to what is necessary for the purpose of the data collection
- Accurate and up to date
- Kept in a form which permits individual identification for no longer than is necessary for the purpose of data collection
- Processed in a secure manner

Go to https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/principles/ for more information.

Consent is only valid if it is:

- Voluntary,
- Informed, and
- Provided by an individual with the capacity to do so.

Good practice in sharing information

Before going on to describe elements of key practice regarding confidentiality and information sharing, it is important to note that practitioners can always seek advice from social worker oversight throughout Cardiff family Advice and Support on a 'no-names basis'.

- Practitioners should consider whether sharing information is a proportional response based on the level of risk faced by the family.
- All sharing should occur on a need to know basis. Any shared information should be marked as confidential and not to be disclosed other than with the purpose of protecting children.
- Gaining the informed consent of children and/or parents is essential when agencies want to share confidential information. Families should be made aware of how a lack of consent may affect the help that agencies are able to provide.
- Agencies will respect the wishes of those who do not wish to provide consent, except in situations where the safety of children or others may be at risk or when it is inappropriate to seek agreement.
- If consent is not provided but the child is deemed to be at suffering or at risk of significant harm, **information can be shared** across agencies but **parents should be informed** that this will happen unless doing so will increase the risk of harm to the child.

Young People and Consent

Parents or carers must be asked to provide consent to information sharing on behalf of children aged 12 and under. Consent to share information can be given by young people aged 16 – 17. Young people aged 13 – 15 can give consent as long as they are deemed capable of understanding the issues and making an informed decision.

- Consent does not need to be sought if seeking consent would:
    - Increase the risk of putting the child into harm,
    - Compromise a criminal investigation, or
    - Cause undue delay in taking action to protect the child.
- If information is shared, the necessity, relevance, accuracy, timeliness and security of the shared information will be recorded. If consent is not obtained, practitioners will record why the safety of the child was deemed to be at risk or why it was inappropriate to seek consent.

Role of Key Worker

Families, young people and children have been shown to benefit from having one key individual (the Key Worker) to help them through the system when participating in a coordinated multi-agency assessment and action plan.

The **Key Worker** will be the key point of contact with the family. Their role is to form a partnership between the family and practitioners from different services. Effective communication between agencies is essential to provide the family with the right support.

When speaking to a Contact Officer, families will be asked if there is a suitable individual able to act as their Key Worker and whether they consent to involving that individual: "Is there a key worker with whom you are currently working that you would like to involve in your assessment and support plan?"

Families will know from their discussion with a CO that a Family Help Advisor or Support Worker will be contacting them soon to set up a meeting.

The action plan developed with the family and relevant agencies determines collective responsibility by outlining individual tasks. The Key Worker may be assigned a role within this plan if appropriate but will mainly act to smooth introductions to new workers and transitions between services. The Key Worker may be different or remain the same each time a family moves between levels of support.

The Key Worker is accountable to their own agency for delivering the role but is not accountable for the actions of other practitioners and agencies.

Think Family Approach

The ability of parents to meet the needs of their children can be affected by their own needs. Services for families with a parent with an additional need (e.g. mental health problem, learning disability) will focus on securing safety for children, offering support to avoid future crises and service provision if they do arise, and ultimately promoting resilience and wellbeing for all family members, both today and in the future.

A **Think Family** approach encourages services to look at the whole family when coordinating care and work with a 'no wrong door' policy with all points of entry opening into a system of joined up support.

A coordinated plan facilitated by Cardiff Family Advice and Support, developed with the family and other agencies when appropriate is the best way of providing targeted early help to families with complex issues. This will involve working with families to identify their strengths, needs, skills and resources and to make their own plans to improve outcomes.

Practitioners will then monitor the plan, coordinate service delivery and ensure that the plan meets the changing needs of the family. Families and children are empowered to take responsibility and make the decisions that affect their lives.

Plans should clearly outline how progress will be measured with realistic timescales for required changes. Progress (as well as lack of progress), how it has been measured and by whom will be included in later review meetings.

A contingency plan, outlining what will happen if progress is not made in the desired time frame, with be discussed with the family and recorded.

All practitioners share responsibility for the plan and ensuring that actions are carried out timely. Practitioners are accountable to their own agency for the services they deliver to families, young people and children.

Supporting young people and children with a disability

Cardiff believes that a child with a disability is a child first and should be encouraged and helped to access the same support and opportunities as other children without disabilities. Research tells us that children with disabilities are three times more likely to experience abuse and neglect [7] therefore identifying a disability at an early stage of referral is essential. Whilst all services should be available for families who have a child or children with additional needs, specialist services will also be available for those that require them.

Disabled young people and children are included in the delivery of all services. Cardiff Family Advice and Support will work with disability services to ensure that the needs of the family are assessed and met by the most appropriate services.

Specific needs that might impact families might be in relation to:

- physical, or learning disabilities
- sensory impairment
- chronic illness

Under the Social Services and Well-being Act (Wales) 2014 [2], 'a disabled child is presumed to need care and support in addition to, or instead of, the care and support provided by the child's family'. This group may be more vulnerable and their health and development is likely to be impaired or further impaired without the provision of early help, intensive intervention or remedial intervention.

Children with disabilities and their families will require different levels of support and access to services depending on their individual circumstances, the nature of the child's disability and its resulting impact on the family.

Statutory services are not necessarily the best service to identify and meet the needs of children with disabilities and their families as long as whatever service does work with the family has a good understanding of the family's needs and can provide information about local support and how to access it.

Cardiff Families First Disability Focus provides services to support disabled young people and children at home and to access their local community – more information can be found at https://www.actionforchildren.org.uk/in-your-area/services/disability/cardiff-families-first-disability-focus/

Supporting young carers

The 2011 census showed that Wales had the highest proportion of carers under the age of 18 in the UK and it was calculated that there are approximately 30,000 carers under the age of 25 in Wales. The likelihood is however that the number is far higher since processes for identifying young carers are often under developed.

The Children Act 1989 placed a duty upon local authorities to provide an assessment of need for Young Carers. The Social Services and Wellbeing Act (Wales) 2014 has strengthened the offer to Young Carers. Within this Act, a carer is defined as “a person who provides or intends to provide care for an adult or disabled child”.

Local authorities and health boards have a duty to provide support to carers. The Act requires any person exercising functions under the Act to ‘seek to promote the well-being’ of carers (including young carers) who need support. In addition, any persons exercising functions under the Act must have due regard to Part 1 of the United Nations Convention on the Rights of the Child (UNCRC), including 41 of the UNCRC articles.

Cardiff and the Vale of Glamorgan are currently working in partnership to review their pathways for young carers in order to deliver an assessment and support function which complies with the duties upon local authorities.

Assessments for most young carers will be undertaken at a preventative level, however, it is recognized that some young carers will need a statutory response to their needs. It is important for the needs of the young carer and those of their family as a whole to be identified in order to support them and their family in accessing services proportionate to their needs as early as possible.

Family Feedback

Any feedback will help to enhance Cardiff Family Advice and Support as it tells us about your experience with us and how we need to improve in the future. This page describes how to provide feedback for Cardiff Family Advice and Support.

Compliments

Use the compliments section in the Feedback section to tell us about something we have done well. Depending on the information you provide, we will be able to inform the relevant person or service.

Hearing positive feedback will tell us why this had a positive impact on you or your family and suggests that we should keep doing what we're doing.

Contact us

ContactFAS@Cardiff.gov.uk

Tel: 03000 133 133

Complaints

Cardiff Family Advice and Support is a new coordinated approach to providing families across Cardiff with the right level of support at the right time. There may be some teething problems with rolling out a new service. We welcome feedback on our services so that we can get things right the first time in the future.

Any family that is unhappy about a service they have received has the right to complain. Complaints will always be taken seriously. Cardiff Family Advice and Support will always respond to acknowledge your feedback.

Use the complaints tab in the Feedback section to help us to make changes and to improve our services. Any professional disagreements should follow the protocol described in the 'Professional judgement and resolving differences' section above.

References

[1] Cardiff Partnership Early Intervention and Prevention Steering Group, “Early Help Strategy,” Cardiff Council , Cardiff , 2014.

[2] Welsh Government, “Social Services and Well-being (Wales) Act 2014,” Welsh Government, Cardiff, 2014.

[3] Public Health Wales NHS Trust , “Welsh Adverse Childhood Experiences (ACE) Study,” Public Health Wales NHS Trust , Cardiff , 2015.

[4] Welsh Government, “Well-being of Future Generations (Wales) Act 2015,” Welsh Government, Cardiff , 2015.

[5] Early Intervention Foundation, “Why early intervention matters?,” Soapbox , 2018. [Online]. Available: https://www.eif.org.uk/why-it-matters/why-is-it-good-for-children-and-families/. [Accessed 29 November 2018].

[6] Families First, “Families First Programme Guidance,” Welsh Government, 2017.

[7] NSPCC, “'We have the right to be safe' Protecting disabled children from abuse,” NSPCC, 2014.

[8] Welsh Government , “Violence Against Women, Domestic Abuse and Sexual Violence Act (Wales) 2015,” Welsh Government, Cardiff, 2015.

[9] UNICEF, “United Nations Convention on the Rights of the Child,” United Nations , 1990.

[10] Cardiff Council , “Child Friendly Cardiff Strategy,” Cardiff Council , 2018.

[11] Cardiff Partnership, “Cardiff Well-Being Plan,” Cardiff Partnership, Cardiff , 2018-2023.

[12] Children's Commissioner for Wales, “A Children's Right Approach for Wales,” Welsh Government, Cardiff, 2017.

Appendix 1: Social Services and Well-being (Wales) Act 2014

The Social Services and Well-Being [Wales] Act 2014 states:

Eligibility Criteria for Care and Support

A proportionate assessment of need is conducted which considers:

1. Personal outcomes (children):
   - Ability to carry out domestic routines
   - Ability to communicate
   - Protection from abuse and neglect
   - Involvement in work, education, learning and leisure
   - Maintenance or development of family or other significant relationships
   - Development and maintenance of personal relationships and involvement in the community
   - Achieving developmental goals
2. Barriers to achieving personal outcomes
3. Risks to meeting personal outcomes
4. Strengths and capabilities

Can the identified need be met via signposting to preventative services or in another way?

- If yes, child is not eligible.
- If no or child is in need of protection, they are eligible.

The Act defines **well-being,** in relation to a person, in relation to any of the following-

a) physical and mental health and emotional well-being;
b) protection from abuse and neglect;
c) education, training and recreation;
d) domestic, family and personal relationships;
e) contribution made to society;
f) securing rights and entitlements;
g) social and economic well-being;
h) suitability of living accommodation.

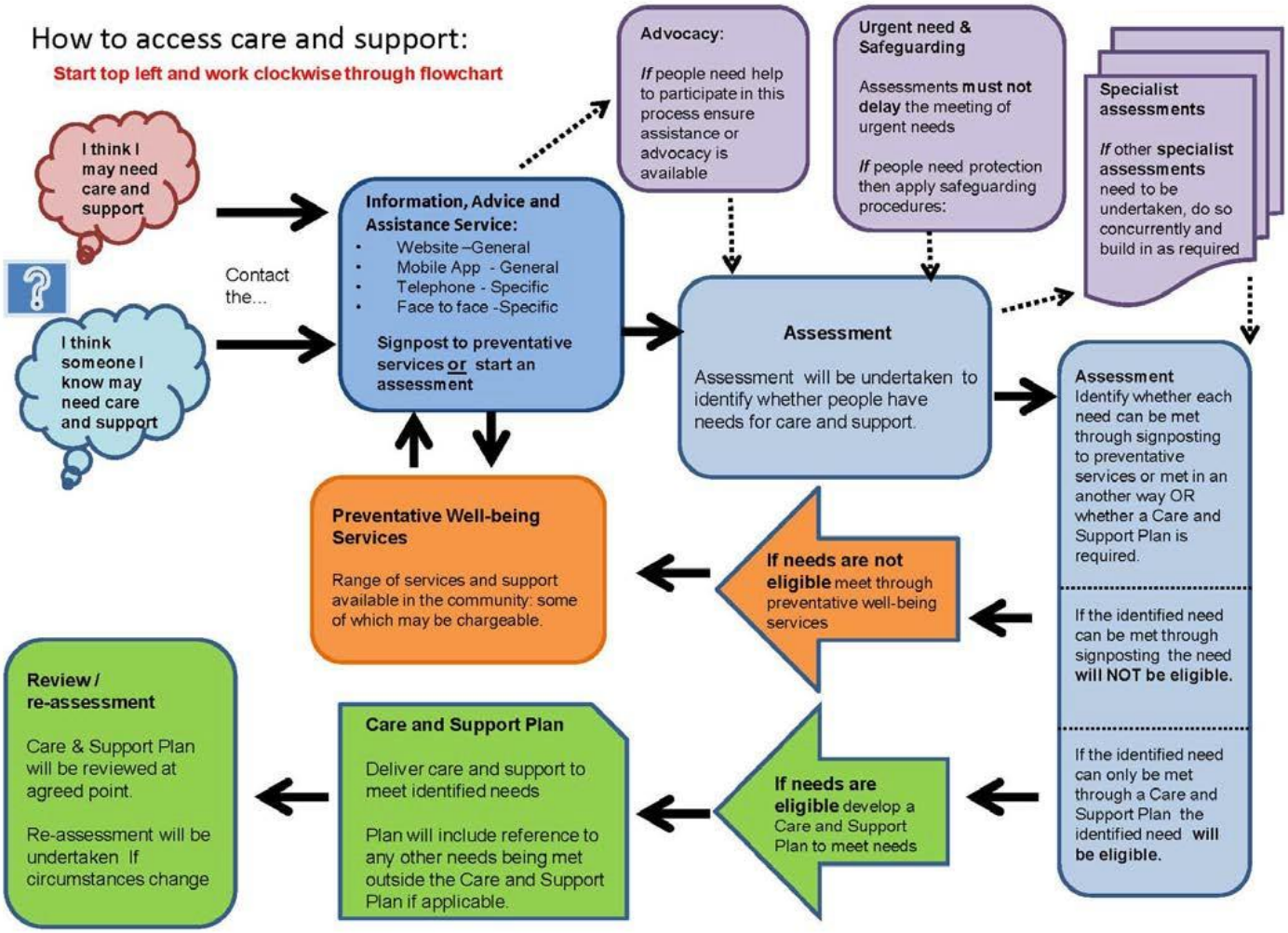
In relation to a child, "well-being" also includes—

a) physical, intellectual, emotional, social and behavioural development;
b) "welfare" as that word is interpreted for the purposes of the Children Act 1989

In relation to an adult, "well-being" also includes—

a) control over day to day life;
b) participation in work.

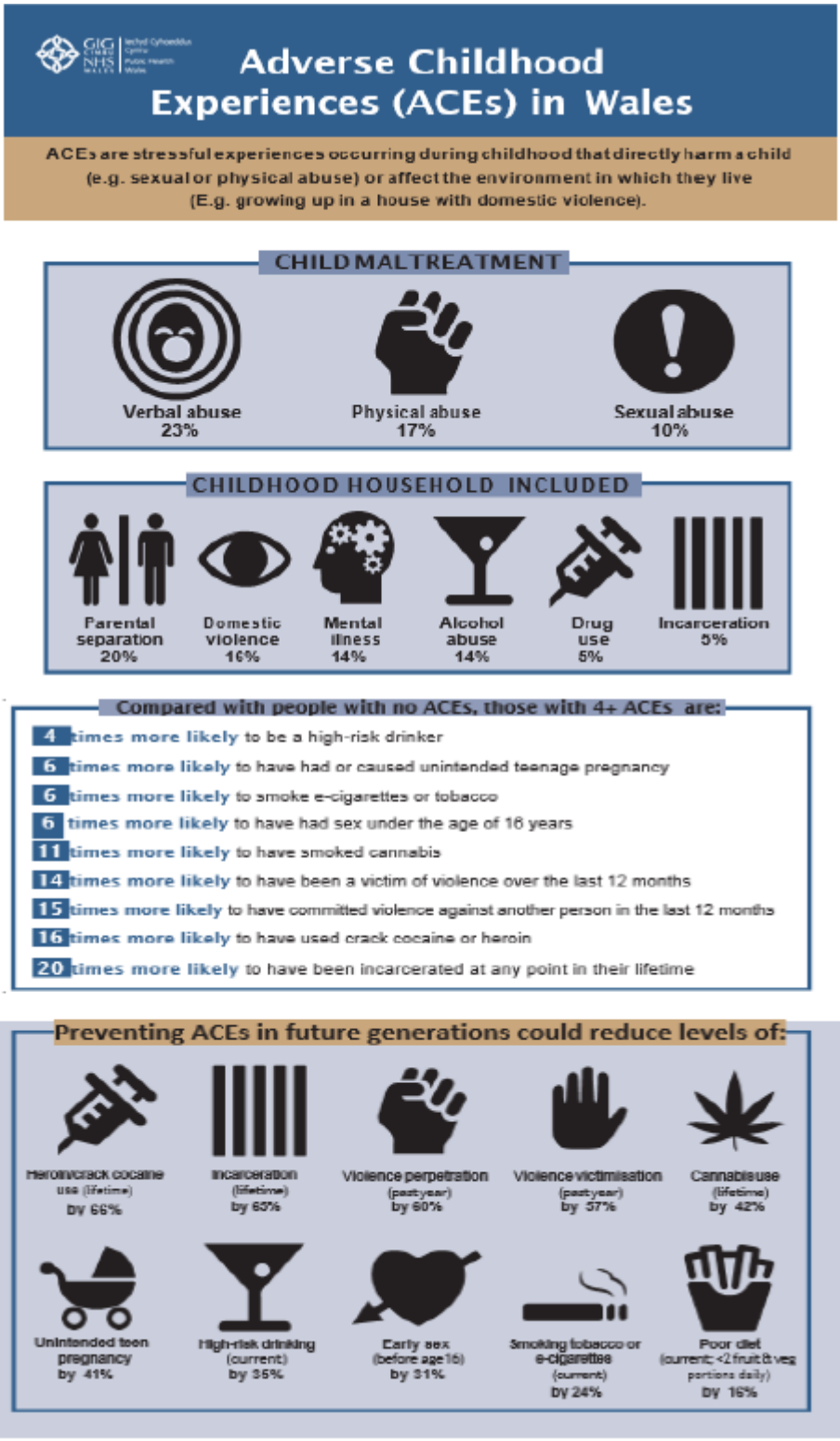
Social Services & Well-Being Act Flow Chart related to the Legislation:



Flow chart from

https://socialcare.wales/cms_assets/hub-downloads/Flowchart_____How_to_access_care_and_support.pdf

Appendix 2: Adverse Childhood Experiences



Appendix 3: Examples of services at each level

The aim of Cardiff Family Advice and Support is to provide families with the right level of support at the right time to build resilience in families and to help them to achieve their best outcomes. The following chart describes examples of services at the levels of need described in Figure 1. This is not an exhaustive list of services, only examples to help describe the levels of needs supported by these services. Some families may need to access a range of services whereas others may achieve similar benefit from interacting with a single service. The Gateway Contact Officer, Family Help Advisor or Support Worker will work with the family to determine what level or range of services are appropriate for them and their situation – every family is unique.

Universal and Universal Plus	Early Intervention	Intensive Intervention	Remedial Intervention
• Family Gateway • Hubs • Community based group parenting programmes • Health Services (GP, dentist, midwifery) • 3-4 year old Childcare Offer • Housing related advice and support • Money Advice Team • Into Work • Work Skills Training • Flying Start • Community Well-Being Service • Food banks • Adult learning courses • Citizens Advice • Childline • Veteran Support	• Family Help • Barnardos Family Well-Being Service • Youth Support (Pre/Post 16) • Right 2 • Home Start Parenting • Well-being 4U • Housing Floating Support • RISE – VAWDASV • Peer Mentoring Service • Youth Services • Action for Children • Early Intervention Team (Children's Services) • Speech and Language Therapy •	• Support 4 Families • Home based parenting interventions • Social worker support • Crisis prevention and intervention • Skills for Living • Child and Adolescent Mental Health Services (CAMHS) • Respite care • First Episode Psychosis Services • Action for Children • StaySafe • Youth Offending Service • Adolescence Resource Centre •	• Multi Agency Safeguarding Hub • Fostering • Residential • 13+ Think Safe • Adolescence Resource Centre • Child Health and Disability Team • Integrated Family Support Services • Emergency Duty Team • Special Education Needs • Youth Offending Statutory Service • Community Mental Health Team (CMHT)

Appendix 4: The Social Services and Well-being (Wales) Act 2014 National Assessment and Eligibility Tool

Common Recording Requirements for Assessments of Adults, Children and Carers

Helpful Links

Code of Practice on Assessing the Needs of Individuals (Part 3):
http://gov.wales/docs/dhss/publications/151218part3en.pdf

Code of Practice on Meeting Needs (Part 4):
http://gov.wales/docs/phhs/publications/160106pt4en.pdf

The Care and Support (Assessment) (Wales) Regulations 2015:
http://www.legislation.gov.uk/wsi/2015/1305/pdfs/wsi_20151305_mi.pdf

The Care and Support (Eligibility) (Wales) Regulations 2015
http://www.legislation.gov.uk/wsi/2015/1578/pdfs/wsi_20151578_mi.pdf

The National Minimum Core Data Set

See *the Code of Practice on Assessing the Needs of Individuals* (paragraphs 56-60) for further information.

NHS Number Title Surname Forename(s) Preferred Name Address and Postcode Date of Birth Telephone Email Address Gender GP surgery name and address School name and address (for children) Occupation	What other assessments have been undertaken by other agencies? Preferred language or communication methods Accessibility requirements Name(s) of Carer(s) / People with Parental Responsibility Relationship Contact Details for Carer(s) / People with Parental Responsibility Is this a child on the Child Protection Register?	Contact details of Lead Assessment Co-ordinator (the person doing the assessment, and who they work for) Contact details of Lead Care Co-ordinator (the person arranging any care and/or support needed, and who they work for) Information taken by (name) (if different from Lead Assessment Co-ordinator) Designation Organisation Date

Note: further core data can be collected as relevant to the circumstance and needs of the individual *e.g. Local Authority case number (if applicable), UK Visas & Immigration (UKVI) number (if applicable) and wider health related data for older people.*

Additional information to be captured

Carers	▪ Is the person being assessed a carer? ▪ The role played by unpaid carers, parents, partners and other family members in person's care ▪ If person has a carer, is the carer willing and able to contribute to their care and support? ▪ Has an assessment been offered to the carer(s)?
Children	▪ Is the child at risk of abuse, neglect or harm and action taken ▪ Is the child on the Child Protection Register? ▪ Confirmation that the child has been seen (if not set out why) ▪ Confirmation that the child has been seen alone (if not set out why)
Wider Individual Needs	▪ Is the person at risk of abuse or neglect and action taken? ▪ Confirmation that active offer of the Welsh language has been made ▪ Does the person consider themselves disabled? ▪ Do they wish to be on the relevant disability register? (include date registered) ▪ Is the person deafblind? ▪ Mental capacity of the person being assessed ▪ Deprivation of Liberty Safeguards (DOLS) considerations
Process	▪ Is this a first assessment or a re-assessment (e.g. following a review)? ▪ Who requested the assessment? (e.g. the person, the person's carer, the person's parent) ▪ Are assessments being made separately, against the wishes of families, carers and cared-for people? (If yes, explain rationale) ▪ Has the person refused an offer of an assessment of need and date? If an assessment is taking place when the person has refused please explain the reasons (See paragraphs 107-115 of the Code of Practice on Assessing the Needs of Individuals for guidance) ▪ Consent to information collected for the purposes of the assessment being shared between relevant practitioners and date – Note - The reasons for this must be clearly explained (see paragraphs 101-106 of the Code of Practice on Assessing the Needs of Individuals for guidance) ▪ Confirmation that person agrees to what is recorded (this could include a note of differing views of practitioner and person, family, etc.) ▪ Confirmation that a copy of the assessment has been offered to person or their family (**Note:** A copy of the assessment must be offered and should be provided).

Five elements of the assessment

See the *Code of Practice on Assessing the Needs of Individuals* (paragraphs 61-65 and Annex 1) for guidance. Additional guidance can be sought:

- For adults (paragraphs 66-67)
- For children (paragraphs 68-79, Annex 2)
- Carers (paragraphs 80-84)

As part of the 'What Matters?' conversation with the family, young person or child, the practitioner should:

- Assess the family's circumstances,
- Regard their personal outcomes,
- Identify any barriers to achieving these outcomes,
- Assess any risks to the family if their outcomes are not achieved, and
- Identify the family's strengths and capabilities.

Action taken to meet personal outcomes

Actions to be taken by the local authority and other persons to help the person achieve those outcomes (including actions to be taken by the person whose needs are being assessed and/or their carer).

Record a score for how the person is feeling in relation to their outcomes. The score must be stated on a scale of 1 to 10; where 1 is the worst situation the person feels they could be in and 10 is the best. This score is to be used as a baseline for reviews of the assessment and care plan.

An example template for capturing this is shown below:

Outcome	**National Wellbeing Outcome**	**Baseline Score**	**Action**	**By who**	**Date**

Statement on how the identified actions contribute to the personal outcomes

How will the identified action contribute to the achievement of the personal outcome or otherwise meet needs identified by the assessment? This applies to those needs which are to be met through the provision of care and support and those met through community based or preventative services, the provision of information, advice and assistance, or by any other means.

Results of the assessment

See the Code of Practice on *Assessing the Needs of Individuals* (paragraphs 116-122) for guidance.

The eligibility criteria for adults, children and carers are set out in the *Care and Support (Eligibility) (Wales) Regulations 2015* and the *Code of Practice on Meeting Needs*.

For each identified need, record which of these results applies:

1. there are no care and support needs to be met;
2. a more comprehensive assessment is required, which may include more specialist assessments;
3. needs can be met through the provision of information, advice or assistance;
4. needs can be met through the provision of preventative services;
5. needs can be met, wholly or in part by the individual themselves (with or without the assistance of others);
6. other matters can contribute to the achievement of the personal outcomes, or otherwise meet the needs;
7. needs can only be met through a care and support plan, or a support plan (needs are eligible);
8. the local authority considers it necessary to meet the needs in order to protect the person from abuse or neglect or a risk of abuse or neglect or, in the case of a child, other harm or risk of such harm.

Appendix 5: Indicators of children's development need

Example Indicators of Need: Level 1 – Universal

Children and young people whose needs are met by universal services or a simple single-agency response

Child's Developmental Needs				Family and Environmental Factors	Parenting Capacity
Health	**Education**	**Emotional and Behavioural**	**Identity**		
Meeting developmental milestones	Achieving expected levels appropriate to key stage	Good quality attachments / relationships	Demonstrates feelings of belonging and acceptance by family / peer group	Adequate income with resources used appropriately to meet child's needs	Protection from danger / significant harm in the home and community
Physically healthy	Satisfactory nursery / school / college attendance (90% or above)	Demonstrates appropriate responses in feelings, resilience and actions	Positive sense of self and abilities	Accessing universal services in community	Shows warmth, praise and encouragement
Medical checks and immunisations are up to date	Good links between home and nursery / school / college	Able to adapt to change	No experience of bullying or discrimination	Accommodation has all basic amenities and appropriate facilities	Facilitates cognitive development through interaction and / or play
Adequate and nutritious diet	Access to books, toys and educational materials	Able to demonstrate empathy	Good development of self-care skills	Good family networks and friendships	No alcohol / substance misuse issues
Regular dental and optical care	No evident barriers to learning	Appropriately comfortable in social situations		Good relationships between siblings	Stable, secure and caring parenting
Good mental health	No concerns about cognitive development			Access to positive, regular activities	
No misuse of substances	Parents enabled to make informed decisions			Safe and secure environment	

Routine assessments as required

Signposting to appropriate universal services, or offer of information and advice

Example Indicators of Need: Level 2 – Additional Support

Children and young people who are at risk of poor outcomes and in need of extra support from services

Child's Developmental Needs				Family and Environmental Factors	Parenting Capacity
Health	**Education**	**Emotional and Behavioural**	**Identity**		
Slow to reach developmental milestones	More than one fixed term exclusion or at risk of permanent exclusion	At risk of, or involved in, low-level offending or anti-social behaviour	Experience of bullying or discrimination	Some level of poverty or debt impacting on household and child	Inconsistent parenting / no effective boundaries
Not registered with a GP or dentist	Often late for school; tired during lessons impacting on ability to learn	Self-harming behaviours	Low self-esteem, doesn't feel valued	Home in poor repair and / or lack of some basic amenities	Lack of positive routines within the home
Disability or chronic health needs requiring additional support	Poor attendance (below 90%) or frequent Absences	Unable to regulate emotions	At risk of sexual exploitation (rating of low-medium)	Threat of eviction	Inexperienced parent in need of support
Medical checks, advice or treatment not consistently adhered to	Poor links between home and nursery / school / College	Challenging behaviour in home or community	Poor hygiene and / or poor development of self-care skills	Child's clothing regularly unwashed and frequently ill-fitting	Parents demonstrate lack of warmth, praise and affection
Inadequately nutritious diet	Often appears hungry at nursery or school	Withdrawn	Difficulties in relating to peers	Family seeking asylum or refuge	Domestic disputes
Unexplained wetting and soiling	Lack of parental encouragement to learn	Struggling with bereavement issues		Child is a secondary young carer	Concerns about alcohol or substance misuse
Early / unsafe sexual activity	SEN appropriately managed by Education, Health & Care Plan			Lack of family support or at risk of family breakdown	Significant or enduring physical or mental health issues
Experimental alcohol or substance misuse	At risk of not achieving learning potential			Returning home from a period in care	Concerns regarding attachment to child

Early Help

Initiate and follow process – identify the Lead Professional

Example Indicators of Need: Level 3 – Complex Needs

Children and young people who meet the threshold for statutory assessment

Child's Developmental Needs								Family and Environmental Factors		Parenting Capacity	
Health		**Education**		**Emotional and Behavioural**		**Identity**					
Unexplained or suspicious injury		Significant under-achievement of learning Potential		Passive suicidal ideation		At risk of rejection by parents / family		Serious poverty or debt impacting on household and child		Condones or encourages offending or antisocial behaviour	
Failure to seek antenatal or medical care for significant ailments or injuries		Persistently late for school; always tired during lessons impacting on ability to learn		Extreme anxiety or depression		Lack of positive familial relationships; no sense of belonging		Home environment highly unsuitable, exposing child to risk of injury		Own emotional or mental health needs compromise those of the child	
Multiple A&E attendances		School non- attendance or children missing Education		Behaviour beyond parental control		No sense of individuality		Homeless 16 or 17-year-old		Succession of carers or frequently leaves child in care of others	
Disability or chronic health needs requiring specialist support		Parent encourages or colludes in absence from school		Frequent offending or anti-social behaviour		At significant risk of sexual exploitation		Frequent changes of living arrangements (accommodation and household members)		Alcohol or substance misuse which has a direct impact on the child or unborn child	
Problematic substance and alcohol misuse		Persistently appears hungry at nursery or School		Often missing from home		Concerns re: honour-based violence / forced marriage		Failed asylum-seeking family with children		Domestic abuse which has a direct impact on child or unborn child	
Persistent unsafe sexual activity						Concerns around radicalisation		Private fostering arrangement		No longer wants to care for the child	
Concerns re: female genital mutilation						Feelings of self-loathing		Child is a primary young carer		Learning disabilities impacting on ability to care for child or unborn	

Child wellbeing Assessment (MASH referral:)

Consider need for specialist assessment

Example Indicators of Need: Level 4 – Protection

Children and young people who are in need of protection and require intensive support

Child's Developmental Needs				Family and Environmental Factors	Parenting Capacity
Health	**Education**	**Emotional and Behavioural**	**Identity**		
Non-accidental injury	Behaviour poses a serious risk to self and others in school environment	Active suicidal ideation or suicide attempts	Rejected by parents / family	Homeless and not eligible for temporary housing	Own emotional or mental health needs significantly compromise those of the child
Endangers own life through self-harm, substance misuse or eating disorder	Disclosure of harm or abuse to school staff	Behaviour poses a serious risk to self and others	Victim of sexual exploitation	Home environment highly unsuitable, exposing child to risk of significant harm	Inability /unwillingness to protect from sexual, physical or emotional harm
Sexual activity under the age of 13	Exhibits sexually harmful behaviour	Exhibits sexually harmful behaviour	No self-esteem or sense of self-worth	Unaccompanied asylum-seeker / victim of trafficking or slavery	Physical domestic assault witnessed by child on a regular basis
Fabricated or induced illness	Emotional disregulation	Abuses other children	Significant concerns re: radicalisation	Person who is a risk to children living in home, or visiting regularly	Misuses alcohol or substances when in sole care of child
Has suffered female genital mutilation or has a Protection Order granted		Constantly missing from home	At high risk of honour-based violence or forced marriage (or has a Protection Order granted)		Leaves child home alone (relevant to age or circumstances)
Refusing medical care resulting in risk to life					Serious neglect of primary needs
Unborn baby at risk of significant harm					Offending causing significant risk to child

Strategy Discussion / Section 47 Investigation

(MASH referral: or contact the police in an emergency)

Appendix 6: Eligibility Conditions for Care and Support

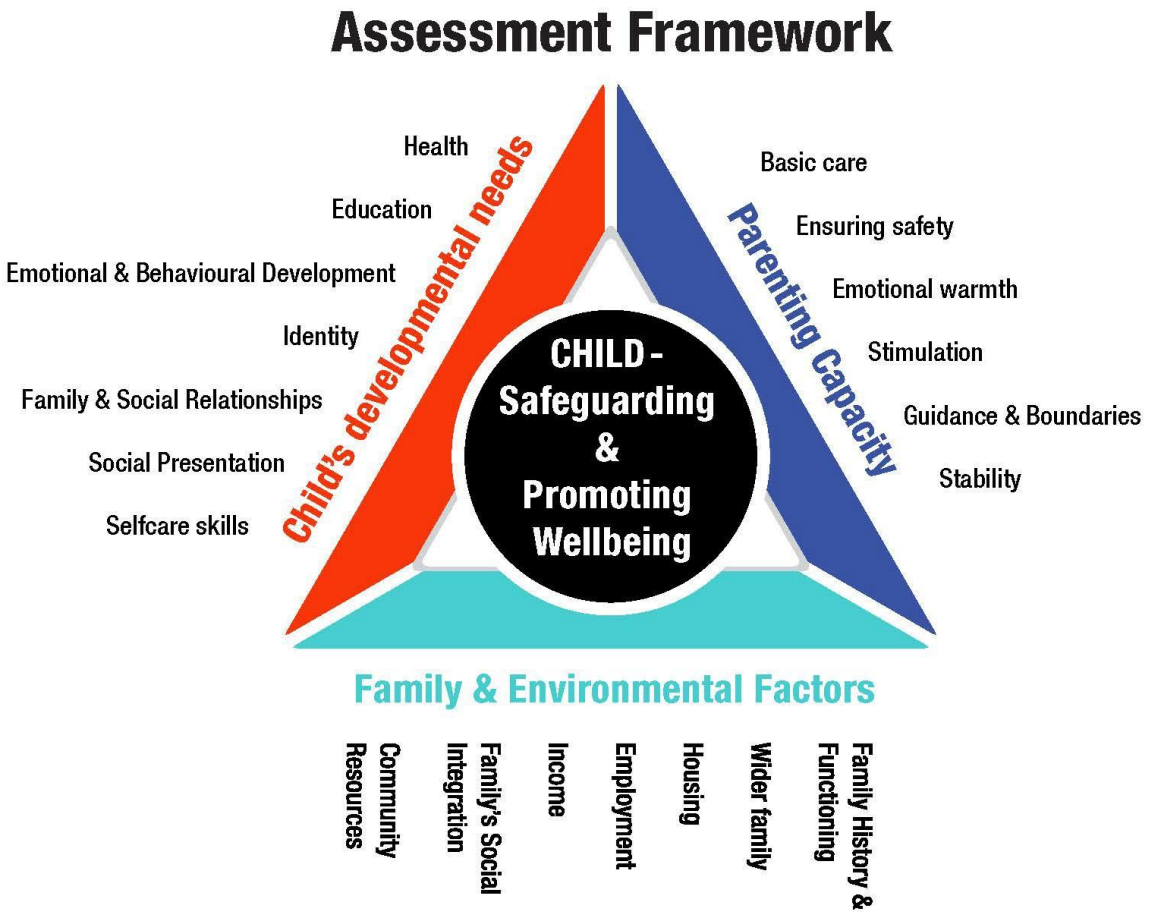
There are four eligibility conditions that must all be met in order for a family to be assessed as eligible for a care and support plan. The only exception to this is if there are safeguarding concerns, in which case the family is automatically eligible.

The four conditions are as follows:

1. If the need arises from the family's **circumstances:**
    - This could include physical or mental ill health, age, disability, dependence on alcohol or drugs as well as any need that is likely to have an adverse effect on the child's development if left unmet.
2. If the need is related to one or more of the following **outcomes:**
    - This could include the ability to carry out domestic routines, ability to communicate, protection from abuse or neglect, involvement in work, education, learning or leisure activities, maintaining family or personal relationships or achieving developmental goals.
3. If the need **cannot be met** by any of the following, either alone or in combination:
    - The child
    - The child's parents or other person/s in a parental role
    - The support of willing other
    - Community services to which the family has access
4. If the family is **unlikely to achieve** one or more of their personal outcomes unless the local authority provides or arrange care and support to meet the family's needs, or enables the need to be met through direct payments.

The family, young person or child should be treated as equal partners when working with the local authority to assess current and future care and support arrangements.

Appendix 7: Assessment Framework Triangle



All children change and develop over time. Parents have a responsibility to respond to the child's needs. The purpose of this assessment triangle is to help you to identify areas of strength and areas of developmental need, in order to assist you to determine whether this child/young person requires information, advice or assistance and/or care and support to achieve a reasonable standard of development or to prevent significant impairment of his/her health, and development.

Although the previous statements may not be concerning in isolation, the combination of factors needs to be considered in a holistic assessment. It is important to consider strengths as well as difficulties.

Taken from CYSUR: The Mid and West Wales Safeguarding Child Board document: 'The Right Help at the Right Time' for Children, Young People and their Families.

Early Help

Distance Travelled Framework

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

CARDIFF CAERDYDD

CYMORTH CYNNAR EARLY HELP

Cardiff Caerdydd

1. Document History

Date	Version	Author	Revision Summary
November 2019	1	Dr Sarah Fitzgibbon	First Draft – consultation document
February 2020	2	Dr Sarah Fitzgibbon	Incorporating feedback from reviewers
October 2020	3	Dr Sarah Fitzgibbon	Updated to reflect changes in Approaches & Interventions document

2. Reviewers

This document requires reviewing by the following individuals;

Date	Version	Reviewer Name	Reviewer Title
November 2019	1	Avril Hooper/Dan O'Keefe/ Andy Senior/ Sarah Manley/ Sion Bonett/ Rachel Raymond/ Natalie Dix	Early Help SMT
November 2019	1		Early Help Operational Group

3. Approval

This document requires approval from the following individuals;

Date	Version	Name	Title
October 2020	3	Avril Hooper	Early Help Operational Manager

Contents

1.0 Introduction

This document outlines the framework for the measurement of distance travelled in Early Help. It provides an introduction to assessment and distance travelled, which is relevant to the work of Cardiff's Early Help teams, and library of tools considered suitable for use in the measurement of distance travelled.

This document is intended for use by Early Help Managers and Data Analysts, to assist in developing the selection of relevant and robust tools for measuring distance travelled, in order to contribute to the monitoring and evaluation of Early Help service delivery. It is intended to contribute to informed decision making and ensure that Early Help is responsibly delivering effective services which can be evidenced to improve outcomes for children, families and young people in Cardiff.

This document is also intended for practitioners. With reference to the Early Help *Approaches & Interventions* document, the current document proposes how the impact of service delivery can be monitored and evaluated, with the inclusion of a library of tools from which to select.

It makes reference to the Early Help *Approaches and Interventions* document, which outlines the approaches and interventions that practitioners apply in the delivery of early intervention and prevention services for families, young people and children across Cardiff.

2.0 Definition of distance travelled

Distance travelled is a term used to refer to progress made, relevant to the individual's starting point. It is the changes that occur as people progress along a pathway; i.e. can we observe a change (positive or negative) in a certain (measurable) characteristic over a certain period of time? It can evidence the outcomes that an individual has achieved, in relation to where these were assessed at the start of an intervention.

> "The term *distance travelled* refers to the *progress* that a beneficiary makes towards …harder outcomes, as a result of the project intervention…. A consideration of distance travelled is very important in contextualising beneficiaries' achievements".
>
> (Guide to Measuring Soft Outcomes and Distance Travelled, Dewson, Eccles, Tackey & Jackson, DfEE, 2000).

3.0. Assessment: what do I want to find out and why?

Assessment is the process of documenting knowledge, skills, attitudes, and beliefs. The term "assessment" can refer to a one-off collection of information or the on-going collection of information as a process; both of which have the aim of gaining a better understanding of a situation:

- Assessment as a **one-off**: the objective measurement of a certain characteristic. It can be used to identify relative strengths and weaknesses and target areas for development. It can be used to evaluate progress by comparing the information from a different point in time e.g. repeating an assessment before and after intervention.

- Assessment as a **process**: assessment includes more than a "one-shot" evaluation. The rationale being that decisions should be based on more than one information sample. Furthermore, complex outcomes often require several assessment tasks so that individuals can demonstrate their knowledge, skills, understanding and behaviours in a variety of contexts. Ongoing assessment makes visible and values, growth over time. Instead of focusing solely on achievement, both achievement and growth are considered important. It is possible to look at progress over time.

An assessment may contribute to hypothesis testing or contribute to generating a hypothesis. A hypothesis is an idea about why something might be happening; a proposed explanation made on the basis of the evidence available, used as a starting point for further investigation.

2.1. Types of assessment

There are different types of assessment methods that can be used for different goals or purposes.

2.1.1. Standardised assessment

Users are all required to undertake the assessment in the same way, and the assessments are scored in a consistent way. These are formal assessments that have been designed to measure an individual's abilities compared to others of his or her age. These tests have been standardised on hundreds or thousands of children, which means that they have been administered to hundreds of thousands of children of varying abilities to determine the average level of ability.

As their name suggests, **standardised assessments** need to be administered in a standard way. This means that the assessor must administer the test exactly as it is written in the test manual. This ensures that they provide the same instructions to each individual that they assess, so that the results can be considered reliable and valid.

For each standardised test there will be at least one standard score. Some tests might have more than one score if they are looking at different areas. For example, a test might give a score for how well a child understands language and another score for how well they use language to communicate.

In addition to the standard score, results might be reported in terms of their *percentile rank*. This is another way of explaining where an individual's score sits in comparison to other

children their age. For example, if a child receives a standard score of 85 which is at the 16th percentile, this means that the score was better than or equal to the score of 16% of other children his or her age, or 16 out of 100 children. Another way of looking at it is that if 100 children completed this test and you lined them up from the person with the lowest score to the person with the highest score, the child would be standing in position 16.

Standardised assessments give a clear score that can be used to give a picture of where an individual sits in comparison to others of the same age. This can be helpful information to formulate a therapy plan, or to pass other professionals working with an individual.

Sometimes, results on standardised assessments are often used when applying for funding or services. These scores can also be used as a baseline for intervention by some professionals, and tests can be re-administered after the intervention to show progress.

An example of a standardised assessment is a cognitive assessment, or IQ test, which gives a standard score and percentile rank in a number of areas (such as verbal comprehension, visual spatial ability, and working memory)

2.1.2. Non-standardised assessment

A **non-standardised assessment** is an assessment that professionals might conduct to see where an individual's strengths and abilities are, as well as highlight areas for development, to target in intervention. Non-standardised assessments can still measure an individual's skills or progress, but they do not compare them to a group of age peers.

Although non-standardised, these assessments can still be structured and provide specific information about an individual's abilities. The professional will often complete specific tasks with the individual; however, these tasks can be modified according to the level of skill, comprehension and confidence. This flexibility allows the professional to gather information that may be missed in a standardised assessment as the individual is more likely to be able to participate in all activities.

Each professional may have their own set of non-standardised assessment which will provide them with information that is useful for the development and evaluation of goals. An example of a non-standardised assessment could be a professional showing a child a book of pictures and counting how many pictures they can name before therapy. They could then show the child the same book three months later and see if there was an improvement in the number of pictures the child could name.

2.1.3. Normative or norm-referenced assessment

Normative assessment refers to the process of comparing one test-taker to his or her peers. A norm-referenced test is a type of test, assessment, or evaluation which provides an

estimate of the position of the tested individual in a predefined population, with respect to the trait being measured. This type of test identifies whether the test taker performed better or worse than other test takers, not whether the test taker knows either more or less material than is necessary for a given purpose.

Norm-referenced assessment can be contrasted with criterion-referenced assessment.

2.1.4. Criterion-referenced assessment

This measures the performance against a fixed and pre-determined set of criteria. The score shows whether or not test takers performed well or poorly on a given task, not how they compare to other test takers. Many, if not most, criterion-referenced tests involve a cut-off score, where the examinee passes if their score exceeds the cut-off score and fails if it does not (often called a mastery test).

2.1.5. Ipsative assessment

Ipsative assessment is a test in which the tested individual is compared to himself/ herself in the same domain through time or in comparison with other domains. This measures the performance of an individual against previous performances from that Individual. With this method an individual is aiming to improve themselves by comparing previous results, rather than being compared to others. The term ipsative means "of the self".

2.2. Useful terms used in assessment

2.2.1. Bell Curve

A **bell curve** is the most common type of distribution for a variable and is thus considered to be a “normal distribution”. The term "bell curve" originates from the fact that the graph used to depict a normal distribution consists of a bell-shaped line (see figure below). The highest point on the curve, or the top of the bell, represents the most probable event in a series of data, while all other possible occurrences are equally distributed around the most probable event, creating a downward-sloping line on each side of the peak.

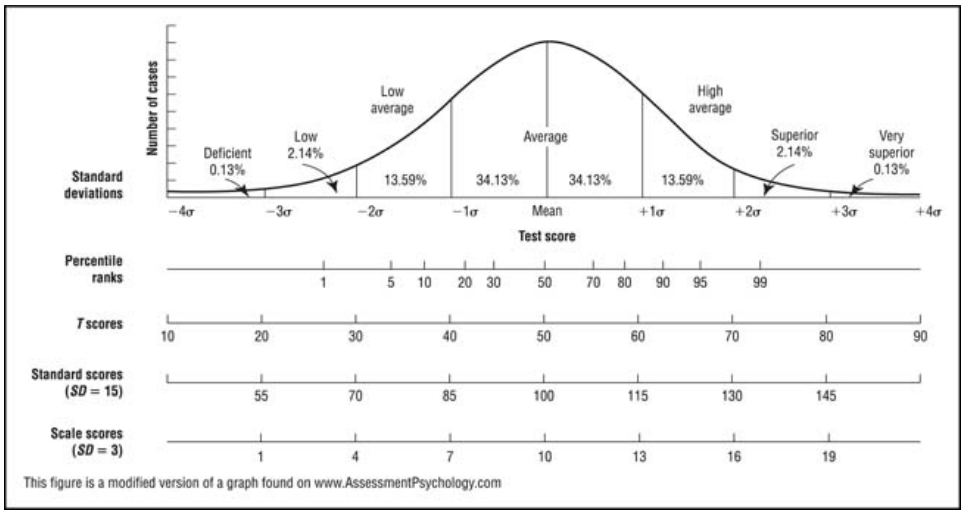


Figure 1: Bell Curve showing normal distribution, including percentile ranks and standard scores.

A bell curve uses standard deviations which are calculated after the mean is calculated, and represent a percentage of the total data collected. On a bell curve, for example, if 100 test scores are collected and used in a normal probability distribution, 68% of those test scores should fall within one standard deviation above or below the mean. Moving two standard deviations away from the mean should include 95% of the 100 test scores collected. Moving three standard deviations away from the mean should represent 99.7% of the scores.

2.2.2. Clinical range/Clinical cut-off score

The **clinical cut-off score** refers to a score that is presumed to represent the boundary between "normal" and the "clinical range" on an outcome measure. Typically, individuals scoring more than one standard deviation above the mean of a non-clinical sample (85th percentile) are said to be in the clinical range.

Jacobson & Truax (1984) describe a method for calculating the clinical cutoff score for outcome measures in psychotherapy research. The formula requires the mean and standard deviation of both a clinical and non-clinical sample, and estimates the score at which a subject has a greater probability of belonging to a clinical sample rather than a non-clinical sample. This method has been widely used and cited in research.

2.2.3. Scaling questions

Scaling questions can be used with individuals to explore their perceptions of their own statements, targets or goals, to explore a variety of elements to track performance e.g., motivation, hopefulness, depression, confidence, and progress they made. This can be used as part of a solution focussed approach and during the process of an intervention (e.g., what might be the next small steps), or it can be used at the end of the intervention to measure the perceived change.

2.2.4. Likert Scales

Rensis Likert developed the **Likert Scale** in order to assess the level of agreement or disagreement of a symmetric agree-disagree scale. It is one of the most widely used question types in a survey. Likert Scale is typically a five, seven, or nine point agreement scale used to measure respondents' agreement with a variety of statements, with each of the response points having a value allocated to it. The response categories in Likert scales have a rank order, but the intervals between values cannot be presumed equal.

2.3. Reliability and validity in assessment

The considerations of validity and reliability typically are viewed as essential elements for determining the quality of any test.

Validity will demonstrate how good a test is for a particular situation; reliability will demonstrate how trustworthy a score on that test will be.

Validity in assessment is the extent to which an assessment accurately measures what it is intended to measure. E.g. If you weigh yourself on a scale, the scale should give you an accurate measurement of your weight. If the scale tells you that you weigh 70kg and you actually weigh 100kg, then the scale is not valid. Validity is also measured by whether the scores a test produces are correlated with other variables they are expected to be correlated with and not correlated with variables that are conceptually distinct.

A **reliable** assessment where the same results are gained time after time. The reliability and validity of a measure is not usually established by any single study but by the pattern of results across multiple studies. The assessment of reliability and validity is an ongoing process or research and peer-review.

It is possible to be reliable and not valid! E.g. you can administer a test and get the same result again and again, but you may not actually be measuring what you intended to measure. It is not possible to draw valid conclusions from a test score unless you are sure that the test is reliable and valid.

Inter-rater Reliability is the extent to which two independent observers achieve the same end-point from administering a test, or the degree of agreement between administrators. If the results are similar, then the test is considered to have high inter-rater reliability. This is increased where there are clear guidelines or training for administering a test e.g. a scale has every outcome labelled so that each administrator describes it in the same way to each participant.

Test-retest reliability measures the stability of a test over time, i.e., whether an individual is likely to score/achieve the same result if the test is administered more than once on the same person. This may reflect whether the tests can provide consistent estimates of the given behaviour or skill being measured, or whether the administration of the test is completed in

a reliable way on separate occasions. Researchers measure the correlation between test at time 1 and test at time 2 to establish the level of test-retest reliability.

Internal-consistency is the consistency of individual's responses across all items on a multiple-item measure i.e., In general, all the items on such measures are supposed to reflect the same underlying construct, so people's scores on those items should be correlated with each other.

2.3.1. What can impact the validity and reliability of the assessment?

- **Test-selection for appropriate population**: When selecting as assessment, it must be ensured that the audience is included in the criteria set out by the tool e.g., a child is within the ages specified by the assessment. A child's chronological age is calculated using the date of birth and the date of the test. It is not rounded up. The age is calculated using years, months and days and any days <30 are discarded.

- **Information source**: In an assessment, it important to note what was observed first hand and what was reported by others. If we observe something, as an objective observer, it is usually more reliable than an individual reporting something from memory, particularly when answering a yes/no question about their child's abilities

- **Time taken to administer**: consideration must be given to the practical element of administration, e.g. boredom or fatigue of a respondent to a long questionnaire may affect the results

- **The point in time of administration:** consideration must be given to whether the tool is administered pre- and post-intervention to obtain a measure of distance travelled, or if it is designed to have these two pieces of information collected retrospectively. There are benefits and limitations to administering a tool at these different points in time. While pre-and post- may provide a more authentic measure of distance travelled, retrospective data collection allows for a reflection of what is now known, and was previously unknown i.e., the benefit of hindsight in reflecting upon distance travelled. Collecting data at all three points in time allows to compare the response shift. Rohs (1999) recommends that researchers collect "retrospective post-then-pre" data along with the traditional "pre-post self-ratings" and with any other objective measures if available which will help provide a more complete assessment of the effect of the intervention.

  When administering a tool pre-intervention, the responses can be utilised to contribute to the design or selection of the most appropriate intervention or plan.

When administering a tool post-intervention, the faming of the questions can usefully be used to illicit responses from the individual regarding how they were able to make positive changes and how these could be maintained following the completion of the intervention/partnership work e.g., what do you think contributed to the changes that you have described? How do you think you might be able to keep that going when faced with x?

A longer term follow up of the intervention can also provide useful data e.g., 3-6 month later. Using the same assessment tool, questions can be re-administered, to establish whether changes have been maintained. This could gain a wider evaluation of success as well as potentially reducing re-referrals being made. The "Sleeper Effect" (Hovland) also suggests that an individual can display no immediate effects from a communication, but can be impacted over a longer period of time.

- **Language**: The assessment may be completed by individuals with English as an additional language, or by individuals with varying levels of literacy. It is important to consider the language and visuals used. Language is also subjective, in that one word can mean different things to different people, based on their own life experiences.

- **Participation**: If a questionnaire is collected pre- and post-intervention, it is vital to record which family member has participated in its completion at the pre-intervention stage, so that the same person complete it post-intervention. It would not be valid to compare responses from two different participants in this situation.

- **Demand-characteristics**: This term refers to when participants unconsciously change their behaviour to meet the expectations of the researcher, which can also be relevant to service users working with practitioners. In the case of measuring distance travelled, examples could include expectancy effect (when one person expects a certain result and therefore acts in a certain way) and social desirability effect (when one person responds in a way which they think will be positively viewed by others). This can be especially true when administering self-report questionnaires. Using self-report is an effective and popular way to collect data and it can be used to collect both quantitative and qualitative data. However it can be subject to social desirability bias where people want to seem good and even leading questions in interviews. When using self-report it is important to use a variety of question types and no leading questions and make questions relevant to the topic.

  If a practitioner is observing service users, then reactivity (when individuals alter their performance or behaviour due to the awareness that they are being observed) is also a possibility.

- **Literacy and comprehension:** Whether asking an individual to complete a written or orally presented test, it is important to consider the individuals ability to comprehend spoken and written language, and to process what is being asked of them.

2.4. What qualifications are required to administer assessment tools?

Most assessment tools will come with an administration guide, which will detail the minimum user qualifications required in order to administer the assessment tool. The purpose of this is to ensure that the standardisation of the assessment is adhered to, so that the results are valid and reliable, and so that results are interpreted appropriately. Many assessment tools require the professional to provide details of their qualifications or registration number in order to purchase the materials. It is possible for some assessment tools to be administered by someone without the required qualifications provided that that individual is under the close supervision of an appropriately qualified professional.

Other assessment tools require completion of a specific training course, whilst others are freely accessible for universal administration. Some require registration in order to obtain the rights to administer. Guidelines specific to each assessment must be followed.

3.0. Ethical considerations of assessment in Early Help

Some professions are bound by codes of conduct or codes of ethics. Early Help is a collaboration of multi-professionals and while each will be guided by their own profession, as a service area, we can be guided by these following common ethical considerations when using assessments with children, families and young people:

- **"Do no harm"** – The administration of the assessment should not cause any form of upset or distress for the individuals involved. It follows the principle that professionals should not cause further damage and suffering as a result of their actions. The rationale behind the inclusion or exclusion of an assessment tool with family may form part of a wider risk assessment in considering their vulnerabilities and things which may trigger or cause distress.

- **Dangers of "within-individual" descriptions** – an assessment has the potential to define a problem as sitting within an individual rather than in a context, i.e. a medical model rather than a social model. It is not helpful to seek to assign blame for a circumstance within the context of family interventions.

- **Responsibility of providing feedback of results** – when administering an assessment, a practitioner has a responsibility to feedback any results to the respondents, and therefore should not seek to obtain any information that they are not willing to share.

- **Fact or opinion** – it is important to determine whether an assessment is measuring subjective opinions or perceptions or objective factual information.

- **Be guided by necessity** - there must be a sound rationale behind the use of any assessment i.e., a purposeful reason for its administration.

- **Service User expectations** – an assessment should not seek to obtain any information that may establish an unfair or irrelevant expectation from a service user e.g., to ask a service user to rate their personal relationship with their partner at the start of an intervention may establish an expectation that the intervention aims to improve the relationship.

4.0. Summary: selection and uses of distance travelled tools in Cardiff Early Help

Tools need to:

- Be of sound design, demonstrating reliability in their administration and collection of information.
- Be a valid measure of the construct it purports to measure.
- Measure a construct that is relevant to the intervention, i.e. be able to measure what the intervention is targeting.
- Be sensitive enough to measure changes achieved from a minimum of a 4 week intervention.
- Be able to be administered pre- and post- intervention, plus offer the opportunity to seek a retrospective score from a family and a longer term follow-up.
- Be of a valid and reliable design, so that we can be confident that we can analyse groups of responses i.e., compare responses over time from a large cohort.

5.0. Library of tools

In the Early Help *Approaches & Interventions* document, the areas of advice, support & intervention are organised under **six themes of delivery**, based on the evidence surrounding the impact of Adverse Childhood Experiences (ACEs). The six themes of delivery are:

1. **Safeguarding** – Ensuring the safety and wellbeing of families, young people and children, ACES may include domestic violence, being the victim of abuse or exploitation (physical, sexual and/or emotional), being the victim of neglect (physical and emotional).

2. **Attachment, Parenting & Family Relationships** – – Promoting secure attachments from birth. ACES may include parental abandonment through separation or divorce, a member of the household being in prison, relational trauma due to a parent not being able to meet the developing child's needs

3. **Child Health & Development** – Ensuring that children and young people are physically healthy, mentally alert, emotionally sound, socially competent and ready to learn.

4. **Finance, Benefits & Housing** – Promoting financial stability and housing. ACES may include experiencing financial difficulty or potential homelessness due to a change in circumstances such as unemployment.

5. **Mental Health & Wellbeing** – Supporting pathways to good mental health and wellbeing. ACES may include a parent with a mental health condition, growing up in a household in which there are adults experiencing alcohol and drug use problems

6. **Education & Childcare** - Providing access to quality childcare and supporting engagement with education and learning.

The table below describes tools which can be used to measure distance travelled in the advice, support & intervention services delivered by Early Help.

Key for table:

- Green = currently in use by one or more teams.
- Orange = intended for future use by one or more teams.
- No colour = additional option.

5.1. Safeguarding

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
Signs of Safety tools	Tool include: • Eco-mapping • Family networking • Danger / worry / Harm statements • 3 Columns • Family Safety Circles • Three Houses • Words and Pictures • Safety House • Future House • House of Dreams / Worries • Objectives / Goals setting and scaling • SFBT • Motivational Interviewing	Any family member	How worried are we? Safety/Wellbeing Scale - After completing what is working well, what we are worried about and what needs to happen, a judgement needs to be made to determine the current level of concern/need for the child. The judgement is undertaken using a safety/wellbeing scale, family members and agencies are asked on a scale of 0 to 10, where they rate the situation right now? 10 is the worst-case scenario and 0 is best case scenario	The SOS model is used for every case in Support 4 Families and by Family Help. Not all the tools are needed, but SOS give practitioners a varied tool kit to implement the model		Every assessment and all case work will be approached under the SOS model
Proportionate Assessment	Assessment used by Family Help and Support 4 Families that is based on the SOS model. Strengths based assessment that uses: • An assessment that is contributed by the views and worries of all family members and professionals within the families network to develop a 'whole family approach' • Reflection on past, present and future to help identify strengths and areas for support. • Eco-mapping • Family networking	Family members	As above	A proportionate assessment is completed with every new family that has been referred to Support 4 Families.		Every allocated referral to Support 4 Families

	• Danger / worry / Harm statements • 3 Columns • To assess the needs of families and formulate a family plan • The child's voice is central to the assessment					
Wellbeing Assessment	Is a Statutory assessment completed by Children's Services. Based on a strength-based approach under SOS Assess wellbeing, as specified in the Social Services and Wellbeing Act Wales (2014) The child's voice is central to the assessment	Family members	As above	Assessment used by Statutory Children's Services		Every case referred to Children's Services
Scaling	Scaling is used with service users for them to rate against personal goals and objectives at the beginning of an assessment. These are then reviewed throughout the invention with a closing scale at the end.	Family members	Team often use a 0-10 scaling tool consistent with signs of safety model by creating a 'Worry Statement' and a 'Wellbeing Goal'. Family Help utilise these in all six themes of delivery. 0 - Worry Statement 10 - Wellbeing goal A typical statement in relation to **'Finance, Benefits and Housing'** for example, can be the following…. Worry Statement *"Due to longstanding rent arrears, we have been evicted from our*	A subjective, solution focussed rating by a service user against personal objectives.		

			current property leaving us intentionally homeless" Wellbeing Goal *"We have a secure tenancy agreement with a realistic repayment plan agreed by the housing association"* Both the 'Worry Statement' and 'Wellbeing Goal' is created with the service user to ensure we are led by them and what they want to achieve.			
The national outcomes framework for people who need care and support and carers who need support (WG, 2019)	The national outcomes framework is for all people who need care and support and carers who need support, their families and friends, and for all services undertaking social services functions under the Act; e.g. local authorities, social enterprises, co-operatives, user led services, the third sector and the independent sector.	For all service users engaging in social services functions under the Act	To provide greater transparency on whether services are improving well-being outcomes for people who need care and support and carers who need support in Wales using consistent and comparable indicators. This will allow the sector to scrutinise its performance and will shine a spotlight on what needs to be done to improve people's well-being rather than focussing on the processes involved in delivering social services. The national outcomes framework will be the key driver for identifying evidenced based national priorities for improvement. This information will be used effectively to focus improvement resources in the most important areas, identify and	The national outcome indicators will evidence whether the national well-being outcomes are being achieved, and will provide a measure of the well-being of people who need care and support and carers who need support at a national level.	English & Welsh.	

			extend best practice and identify where new policies are required.			

5.2. Attachment, Parenting and Family Relationships

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
Parent Problem Checklist (Dadds and Powell, 1991)	• 16 item questionnaire measuring inter-parental conflict over child rearing issues • Yes/no format with Likert-scale to describe the extent • 6 items on rules and disciplining misbehaviour, 6 items focus on over conflict relating to child rearing practices, and 4 items measure the extent to which the parents undermine their partner's relationship with the children	Parents self-report	Established clinical cut-off is 5 or more areas of conflict	https://researchingparents.wordpress.com/2013/02/20/parent-problem-checklist-ppc/ Free to use, devised by Mark Dadds as a part of the Triple P programme.	English	Parental disagreement on how to discipline a child.
Pianta's Child-Parent Relationship Scale (Pianta, 1992)	• The CPRS (Pianta, 1992) is a self-report instrument completed by mothers or fathers that assesses their perceptions of their relationship with their son or daughter. • Self report instrument to assess parents perception of their relationship with their child • 15 items rated on 5 point Likert scales Ratings can be summed into groups of items for conflict and closeness	Parent self report (with children aged 3-12)	Includes scoring. The 15 items are rated on 5-point Likert scales and the ratings can be summed into groups of items corresponding to conflict and closeness subscales. Scoring guide available for free online. Scores can be compared to means for boys and girls of different ages.	Download for free here https://curry.virginia.edu/faculty-research/centers-labs-projects/castl/measures-developed-robert-c-pianta-phd	English	To compare mother, father and child perceptions of their relationship. For a parent wanting to focus on their relationship with their child.
Karitane parenting Confidence Scale (Črnčec, Bryanne Barnett &	The Karitane Parenting Confidence Scale has been developed to assist in the support and development of parenting skills for parents of children 0-12 months of age. The tool has been developed in the Australian context and has been shown to be appropriate in a	The KPCS is a self-report instrument. Minimal instruction is required on the part of the	Each item on the KPCS is scored 0, 1, 2, or 3, with scores summed to produce a total score. The general rule is that a high score indicates the parent is feeling confident on that item. Items have a common scoring order	Download for free https://plct.files.wordpress.com/2019/01/karitane-parenting-confidence-scale-manual-copy.pdf	At this stage, no translations of the KPCS are available.	To measure a new parents feelings of self-efficacy.

Matthey, 2008)	range of client-professional relationships. The rating scale and scoring is simple and user friendly for both client and professional. The KPCS was designed to measure 'perceived parenting self-efficacy' PPSE in the parents of children aged 0-12 months.	clinician / researcher during administration. Validation data for the scale were gathered from mothers; however, the scale is also suitable for administration to fathers.	(that is, the first response option is always scored 0, the second always scored 1 etc.). Two items on the KPCS can be endorsed not applicable, for instance when the infant is exclusively fed by the partner (item 1), or where the respondent does not have a partner (item 9). These items are scored 21. The final version of the KPCS contains 15 items with a possible range of scores of 0-45.	Permission is granted to use the scale in clinical and research contexts, provided the scale is not altered from that included in this manual, and full reference to the scale is included on all copies.		
The Parenting Scale (Arnold, O'Leary, Wolff and Acker, 1993)	A rating scale was designed to measure dysfunctional discipline practices in parents of young children. Three stable factors of dysfunctional discipline style were identified: (a) Laxness, (b) Over reactivity, and (c) Verbosity. The Parenting Scale exhibited adequate internal consistency and test–retest reliability.	30-item self report questionnaire for parents. Statements are rated against a 7-point Likert scale. Whilst it is designed for families with a child under four years it could be used with parents of older children as it is seeking to measure laxness/permissive parenting, over-reactivity and verbosity.	Each item receives a score 1-7; with 7 represents the most ineffective response. Responses are averaged on all items. Scores for the 3 subscales can also be calculated.	Free to download http://www.first5scc.org/sites/default/files/Parenting%20scale%20-%20English.pdf	English	When working with one or two parents, to see how they approach parenting their child and how they each tend to react.

Parenting Daily Hassles Scale (Crnic & Booth, 1991)	Aims to assess the frequency and intensity/impact of 20 potential parenting 'daily' hassles experienced by adults caring for children.	20-item self report questionnaire for parents.	Scoring instructions and guide available with questionnaire.	Free to download https://www.oscb.org.uk/wp-content/uploads/2019/07/Parenting-daily-hassles.pdf		A parent who is feeling stressed with parenting a young child and managing the household.
Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978)	– 17-item self-report scale to examine parents' anxiety, motivation, competence & problem solving. There are 2 subscales. Each item is rated on a 6 point Likert scale anchored by 1 = "Strongly Disagree" and 6 = "Strongly Agree".	Parents rates against statements on a 6 point Likert scale. For parents with children birth-17 years of age	Includes scoring guide. A higher score indicates a higher parenting sense of competency. There are no average scores or 'cut-off's' for this tool.	For use with parents; a self-reporting instrument that measures and assesses parent self-efficacy. Open access.	English	To measure parents' own perceptions' of their self-efficacy as a parent.
Parenting Tasks Checklist (Sanders & Woolley, 2001)	2 subscales (setting-self-efficacy and behavioural self-efficacy)measure parental confidence in dealing with tricky child behaviors. Designed to measure how confidence parents feel in dealing with their child's behaviors in various settings.	Parent rates 28 items on scale 0-100	Includes scoring guide	Free to download http://www.first5scc.org/sites/default/files/Parenting%20Tasks%20Checklist%20-%20English%20(2%20pp).pdf https://portal.ct.gov/-/media/DCF/ParentingSupportServices/PDF/ParentingTasksChecklistpdf.pdf?la=en	English.	Parent not feeling confident in managing child's behaviour.
Kansas Parenting Satisfaction Scale	This is a 3-item instrument designed to measure an individual's satisfaction with themselves as a parent, the behaviour of their children, and their relationship with their children.		Scores are added and a clinical cut-off is provided. Scores of 15 or less indicate low parental satisfaction (DeCato	For scale and research papers email Dr Schumm. Contact: schumm@humec.ksu.edu Parenting	English	Parent engaging in a parenting change process.

(James et al., 1985)	It is answered using a seven point scale, ranging from 1= Extremely dissatisfied to 7= Extremely satisfied. It correlates well with other very robust measures such as the marital satisfaction scales and the Rosenberg Self Esteem Scale.		Murphy, Donohue, Azrin, Teichner, & Crum, 2003). The scale has good concurrent validity.	Can also be accessed for free online.		
Mothers Object Relations Sale and Baby MORS (Short Form)	A fourteen item scale developed as a screening tool with subscales of warmth and invasiveness.	Self-report questionnaire. MORS (baby) is used with parents with a child 0-2 and MORS (child) is used with parents of children aged 2-4	The scale taps into mothers' psychodynamic processes but the questions describe aspects of infant behaviour, so limiting the social desirability response bias.	Free online https://hqlo.biomedcentral.com/articles/10.1186/1477-7525-11-49	English	Designed to identify potential problems in the early mother-infant relationship; particularly in a mother's working model of attachment.
WEMWBS (The Warwick-Edinburgh Mental Wellbeing Scales)	The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 14-item scale WEMWBS has 5 response categories, summed to provide a single score. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible.	Self-report scale to monitor mental wellbeing. WEMWBS has 2 scales: the original 14-item scale and the short 7-item scale.	The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing	WEMWBS is protected by copyright. Should you wish to use WEMWBS you will require a license appropriate to your intended use. Uses include: - mental health education programmes e.g. mental health literacy, social and emotional learning or mindfulness, typically delivered in groups and often in educational settings	Over 25 languages.	

				- programmes to promote wellbeing in the workplace including within business, public and third sector organisations - evaluating interventions which aim to change health-related behaviour - evaluation of the effect of community projects and parenting programmes - psychotherapeutic interventions, usually delivered in a clinical setting one on one. - clinical settings within the NHS where patients are treated for both mental and physical illness		
Strengthening Families Programme Before and After Survey	Self-report questionnaire for individuals completing Strengthening Families Programme (SFP).	Parents and young people completing SFP.	Soring in SFP Manual.	Use only with SFP.		Parents and young people completing SFP.
Conflict Behaviour	The Conflict Behavior Questionnaire (CBQ) is a 20-item true/false scale that assesses general conflict between parents and their children. 2 parents complete independently in relation to	Self-report questionnaire for parents and adolescent to complete	The CBQ has been used extensively in the literature and has adequate internal consistency (Robin & Foster, 1989). Robin and Foster (1989)	The instrument taps two potential sources of complaints: dissatisfaction with the other person's behavior and evaluations		When working with a parent and young person

Questionnaire	their own relationship. It is considered as a measure of perceived communication-conflict behavior at home and it gives a general estimate of how much conflict and negative communication the family experiences.	regarding their relationship.	have found that the CBQ discriminates between distressed and non-distressed families.	of the interactions between the two members.		together, on relationship.
TOPSE – A Tool to measure Parenting Self Efficacy	TOPSE is a tool to measure a change in parenting self-efficacy. It can be used to evaluate the effectiveness of parenting programmes. It can also be used to help identify specific problem areas that individual parents may be experiencing.	Parents of children under the age of six years. Self-report - parents' perceived ability to manage their children, based on their own views and experiences (Bloomfield, Kendall et al. 2005).	Scoring template available on website to complete with the scores from Time 1 and Time 2. Carries out the calculations and provides before and after scores. Can also be scored manually. Booklets may be completed several months following the end of the programme to identify if changes in parenting self-efficacy have been maintained.	**https://www.topse.org.uk/site/** No charge provided that no changes are made to either the style or content of the tool. We ask that all logos and references to the University of Hertfordshire are retained. We request that full acknowledgment is given in any published findings.		Parenting programmes. Parents should complete the TOPSE booklet at the beginning of, or before, the first session of the parenting programme (Time 1 or T1). A second booklet should be completed at the end of, or following, the final session (Time 2 or T2).
Family Attachment and Changeability Index 8 (FACI8) (McCubbin, Thompson,	For use with parents. It is helpful in measuring overall family functioning and has good predictive ability of successful adaptation after interventions have taken place. 16 questions; measuring how things are now and how the respondent would like them to be in the future, each column is	Used with parents and young people to rate family functioning.	Includes scoring. Within the 16 questions are two blended sub-scales; attachments and the capacity to change or changeability. This makes is a useful tool for use with families where such issues are sustaining problems. These two scales may be used separately or in	This instrument can be found at: http://www.mccubbinresilience.org/measures.html	Availble in multiple languages. Source: Family Assessment Resiliency, Coping and Adaptation.	It has useful questions for anyone undertaking a family assessment, such as, "It is difficult to get a rule

Elver & McCubbin)	answered with a five point scale, from 'Never' to 'Always'.		combination to create a family typology.		Inventories for research and practice. Madison University of Wisconsin pp725 - 751	changed in our family" or "In our family everyone shares responsibility. "
Family Pressure Scale-Ethnic (McCubbin, Thompson and Elver)	64 question with a four point scale answer system ('Not a problem' through to 'Large problem'). The questionnaire includes information seeking on couple conflict, children's racial or ethnic identity and life changes such as moving house. One of the few (American) tools designed specifically for use with families from minority ethnic community backgrounds.	To be undertaken with parents	Includes scoring. The total score for FPRES-E is obtained by simply summing the number circled by the respondent (i.e., 1=Not a Problem, 2=Small Problem, 3=Medium Problem, 4=Large Problem) for all 64 items.	This instrument can be found at: http://www.mccubbinresilience.org/measures.html	Availble in multiple languages.	
Family Problem Solving Communication (McCubbin, Thompson, Elver, & McCubbin)	10 questions and four point answers. The measure is seeking information on the quality of family communication, both positive and negative. Questions include the 'incendiary' communications ones such as 'We yell and scream at each other' and the positive, 'we work to be calm and talk things through. It correlates well with other family functioning and well being devices so, despite a fairly small sample it seems to offer good reliability and validity.	To be undertaken with parents. How families communicate seems to play a major part in how families cope with hardships.	Includes scoring. The instrument consists of two five· item subscales, Incendiary Communication and Affirming Communication.	This instrument can be found at: http://www.mccubbinresilience.org/measures.html	Available in multiple languages.	
Parental reflective functioning questionnaire	An 18 item questionnaire designed to assess the caregiver's capacity to reflect upon his/her own internal mental experiences as well as those of the child.	Designed for parents with a child aged 0-5.	Parental reflective functioning (PRF) refers to the caregiver's capacity to reflect upon his/her own internal mental experiences as well as those of the child . PRF	Available online. 18 items and scoring syntax in English, and translations of the 18 items in the various	18 languages: English Chinese •Danish •Dutch	Designed to assess Parental reflective

(PRFQ) (Fonagay) PRFQ-Adolescent Version	The Parental Reflective Functioning Questionnaire (PRFQ) has been developed to provide a brief, multidimensional assessment of parental reflective functioning that is easy to administer to parents with a wide range of socioeconomic and educational backgrounds.	Adolescent version for aged 12-18.	is assumed to play a key role in fostering the developing infant's own capacity for mentalizing, which in turn is important for the development of emotion regulation, a sense of personal agency, and secure attachment relationships.	languages that are currently available. Free online https://www.ucl.ac.uk/psychoanalysis/research/parental-reflective-functioning-questionnaire-prfq	•English •French •German •Italian •Portuguese •Spanish •Spanish (MX) version •Swedish •Turkish	functioning (PRF). There is increasing evidence of intervention programmes that are rooted in the mentalizing approach, and a focus on improving mentalizing may be a common factor in all effective psychosocial interventions.
Systemic Clinical Outcome and Routine Evaluation SCORE-15	• One of a group of self-report measures of family processes derived from the original SCORE-40 (Stratton, Bland, Janes, & Lask, 2010). • These measures are designed to indicate crucial aspects of family life that are relevant to the need for therapy and for therapeutic change. • 15 Likert scale items and six separate indicators, three of them qualitative, plus demographic information. It records perceptions of the family from each member over the age of 11 years.	• Should be administered to each family member individually at or just before the start of the relevant sessions. Arrangements should be made so that each person fills it in privately and their completed	The potential range of scores is 15 to 75, with a lower score indicating higher family functioning. At this time clinical cut off points are not available because the questionnaire is still being evaluated.	• If you are planning to use this measure for the delivery and improvement of health and/or social care, a license to incorporate it into electronic systems can be obtained from NHS Digital. Please note that licenses obtained via this route may be restricted to particular territory (e.g. England, UK). If planning to use the measure outside of	• Finnish • Polish • French • German • Hindi • Greek • Norwegian • Italian • Hungarian • Spanish • Turkish More translation being done.	When some degree of intervention with a family unit. To highlight different viewpoints of family members.

		SCORE is not seen by others.		England, you may wish to contact NHS Digital to clarify the geographical scope of the license.		
Evaluation Form (Child's behaviour) from Neville, D., King, L. and Beak, D. (1995)	Designed by the programme developers, informed by other baseline behaviour checklists. Describes 15 'problem behaviours' and asks parent(s) to rate the frequency (or intensity) with which they perceive those behaviours occur on a 5 point likert scale from 'never' to 'always'. Asks parent (s) to answer 'yes' or 'no' to whether those behaviours are a problem for them.	To make an assessment of the frequency of behaviours that are a 'problem' for the parent.	Parent self-report. Can obtain a score/average for frequency/intensity of problem behaviours and the number of behaviours which are problematic for parents. Promoting Positive Parenting: A Professional Guide to Establishing Groupwork Programmes for Parents of Children with Behavioural Problems.	Can be used as a baseline measure and to compare change in terms of frequency/intensity and the extent to which behaviour pose a problem for parents.	None ,	To assess the frequency and intensity of child behaviours, as perceived by parent and provide comparison following group/individual intervention

5.3. Child Health &Development

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
Strengths and Difficulties Questionnaire (Goodman)	The Strengths and Difficulties Questionnaire (SDQ) is a brief emotional and behavioural screening questionnaire for children and young people. The tool can capture the perspective of children and young people, their parents and teachers. There are currently three versions of the SDQ: a short form, a longer form with an impact supplement (which assesses the impact of difficulties on the child's life) and a follow-up form. The 25 items in the SDQ comprise 5 scales of 5 items each. The SDQ can be used for various purposes, including clinical assessment, evaluation of outcomes, research and screening.	• Children and young people aged 11-17 years old. • Parent or teacher of CYP aged 2-17 years old. • May be appropriate to use with CYP with mild learning difficulties, but not with more severe learning difficulties (Law & Wolpert, 2014). • The questionnaire takes 5-10 mins to complete. • The questionnaire can be completed on paper or online and can all be found on the	Computerised: Paper versions of the SDQ can be scored on the SDQ website. If CYP, parents or teachers fill out the SDQ online, the Youth in Mind website produces a technical and readable report with a description of the scores. By hand: Instructions for scoring SDQ's by hand can be found on the SDQ scoring website. •Computerised: After entering paper versions of the SDQ on the SDQ website, a report designed for professionals will then be generated. If CYP, parents or teachers fill out the SDQ online, the Youth in Mind website produces instant feedback reports including a technical report designed for professionals as well as a readable report with a description of the scores, the level of concern, an overall impression as well as suggestions about what to do if the child or	• If you are planning to use this measure for the delivery and improvement of health and/or social care, a license to incorporate it into electronic systems can be obtained from NHS Digital. • Please note that licenses obtained via this route may be restricted to particular territory (e.g. England, UK). If planning to use the measure outside of England, you may wish to contact NHS Digital to clarify the geographical scope of the license.	Translated into more than 80 languages including Spanish, Chinese, Russian, and Portuguese. **Translated versions are available here**. Information on normative SDQ data from the United Kingdom, Australia, Denmark, Finland, Italy, Germany, Japan, Spain, Sweden and the United States can be **found here**.	

		Youth In Mind website. Can also be administered directly by the clinician who can ask follow-up questions.	young person, their parent/teacher still has concerns. •By hand Instructions for scoring the SDQ by hand can be found on the SDQ scoring website and instructions for interpreting the SDQ when scored by hand can be found here. Instructions in other languages are also available here.			
Eyberg Child Behaviour Inventory	This is a well-respected and well-used measure for assessing conduct-problem behaviours in children and young people. For age two years to under 17 years identifies change due to intervention over time Examples of question areas include refusing to eat food presented to the child, arguing, fighting and verbal aggression.	• 36-point self-report scale for parents. &-poiny Likert Scale and Yes/No response to indicate whether parent considered this a problem.	The measure, its reliability and application is described in detail in Burns, G. and Patterson, D.R. (1990) Conduct problem behaviors in a stratified random sample of children and adolescents: New standardization data on the, Psychological Assessment, Number 2, 391–397	It is available from the author, Dr Sheila Eyberg, Department of Clinical and Health Psychology, University of Florida, Box J-165 HSC, Gainesville, FL 32610 • https://clas.uiowa.edu/sites/clas.uiowa.edu.nrcfcp/files/Eyberg%20Instrument.pdf		
Sheffield Learning Disabilities Outcome Measure	• A measure of parents' perception of their child's symptoms and their ability to cope with their child's symptoms. • The SLDOM questionnaire has three parts. Part 1 is designed to be completed at Time 1 and Time 2, and then the whole measure (Parts 1-3) should be completed at discharge.	The SLDOM is to be completed by parents/carers of children aged 3-16 years old. It is designed to be completed by individuals either on paper or on a computer.	• Part 1: includes eight items which relate to understanding the child's behaviour, and looks at the relationship between carer/parent and child, level of confidence and views about the future. The questions use a 5 point likert scale (1 = strongly disagree, 5 = strongly agree, and 0 = not applicable) • Part 2: includes 10 items which ask about how the team works	The SLDOM is free to use. The name of the author should be displayed on all paper copies of the form as follows: Dr. Evette Girgis consultant child and adolescent Learning Disability Psychiatrist, Sheffield Children NHS Foundation Trust and CORC.		

			and how the service is delivered. It is useful for services that offer an outreach provision into people's homes and are not necessarily clinic based. The questions use a 5 point likert scale (1 = strongly disagree, 5 = strongly agree, and 0 = not applicable) • Part 3: this is a free text section which allows the respondent to put down their views about what they found helpful about the care they received, whether there was anything they did not like or needs improving, and suggestions for improving the service they received.			
Health of the Nation Outcome Scales for Children and Adolescents	A recently developed measure of outcome for use in child and adolescent mental health services focusing on general health and social functioning. 15 item questionnaire, to be completed by practitioners, to indicate the severity of each problem, on a scale of 0-4.	The practitioner and parent tool can be used in relation to children aged 5-18 years Self-rated HoNOSCA is for children and young people aged 13-18 years old.	Manual scoring: • Section A: 13 items rated 0-4 which are added together to create a Total score. • Section B (optional): 2 items rated 0-4 which are added together to create a total score.	The HoNOSCA is free to use. The measure is made up of two sections. The first section consists of 13 items relating to different types of problems; the second consists of two items relating the parent or young person's knowledge of the nature of the young person's difficulties and their information about the services available.		

Outcome Rating Scale (ORS), Children's Outcome Rating Scale (CORS) and Young Child Outcome Rating Scale (YCORS)	• The Outcome Rating Scale (ORS) and Child Outcome Rating Scale (CORS) are measures that can be used to monitor children's, young people and their families or carers feedback on progress. • Simple, four-item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention. • These include: symptom distress, interpersonal well-being, social role, and overall well-being. • The ORS translates these four dimensions of functioning into four visual analogue scales which are l0cm lines, with instructions to place a mark on each line with low estimate to the left and high to the right. • The ORS is designed to be accessible to a child with a 13-year-old's reading level, making it feasible for adolescents and adults.	• The CORS was developed for children age 6–12. It has the same format as the ORS but with more child friendly. For children 5 or under there is also the Young Child Outcome Rating Scale (YCORS), which has no psychometric properties, but can be a useful way of engaging young children regarding their assessment of how they are doing	• Scoring is done in front of the client using a ruler. Each of the four visual analogue scales is 10cm, so the score for each of the four visual analogue scales is the measurement length on the ruler (e.g. 3.3cm = score of 3.3) with 10 being the highest score for each scale. • The score is written in the right margin, and the four scores added together for the overall score. The total possible score is 40. Next, each person's overall score is plotted on a graph or entered into an electronic database to monitor the trajectory of progress. The ORS (ages 13 and over) cut-off scores are: Cut off for 13–17 year olds = 28 Cut off for 18 and over = 25 The CORS (ages 12 and under) cut-off scores are: Child Self Reporting = 32 Carer Reporting on Child = 28	The ORS, CORS and YCORS measures are licensed by Scott D. Miller and ICCE. Free to use. A license to incorporate it into electronic systems can be obtained from NHS Digital.		
Children's Global Assessment Scale	The Children's Global Assessment Scale (CGAS) is a rating of functioning aimed at children and young people aged 6-17 years old. The child or young person is given a single score between 1 and 100, based on a clinician's assessment of a range of aspects related to a child's	The CGAS is aimed at children and young people under 18 years old and is completed by clinicians. The	Ratings can be at ten increment points or as an actual score (e.g. 53). The following score ranges are defined: •0-10: Extremely impaired (24 hour care)	Free to use. A license to incorporate it into electronic systems can be obtained from NHS Digital.	The CGAS has been translated into English, Spanish, and Swedish.	

	psychological and social functioning. The score will put them in one of ten categories that range from 'extremely impaired' (1-10) to 'doing very well' (91-100).	CGAS has been modified for use with children with developmental disabilities (DD-CGAS). Scientific investigators and licensed clinicians may print and copy this instrument as needed. There is also a version of the CGAS for parent-infant relationships, the **PIRGAS**.	•11-20: Very severely impaired •21-30: Severe problems •31-40: Serious problems •41-50: Obvious problems •51-60: Some noticeable problems •61-70: Some problems •71-80: Doing all right •81-90: Doing well •91-100: Doing very well			
Hawaii Early Learning profile (HELP)	HELP is a comprehensive, on-going, family centered curriculum based assessment process for infants and toddlers (ages 0-3) and their families. It is used when creating goals and tailoring developmentally-appropriate interventions to meet the specific needs of children.	For use with parents of children 0-3 or 3-6.	Manual based. Can use combination of observation of developement and parental report. By identifying developmental stages, next steps can be planned for in targetted development.	To identify areas of strength and development across 6 domainds of development. Used t set tarhets and make progress with specific tasks provided.		Concerns with a child's develop ment.
Wellcom Toolkit	Screening tool to identify children needing speech and language support.	For use with children 6 month plus.	Manual scoring.	Following screening, there are play-based activities to promote speech and language development.		Screenin g tool. Concerns with develop ment of communi

						cation skills.
Evaluation Form (Child's behaviour) from Neville, D., King, L. and Beak, D. (1995)	Designed by the programme developers, informed by other baseline behaviour checklists. • Describes 15 'problem behaviours' and asks parent(s) to rate the frequency (or intensity) with which they perceive those behaviours occur on a 5 point likert scale from 'never' to 'always'. • Asks parent (s) to answer 'yes' or 'no' to whether those behaviours are a problem for them.	To make an assessment of the frequency of behaviours that are a 'problem' for the parent.	Parent self-report. Can obtain a score/average for frequency/intensity of problem behaviours and the number of behaviours which are problematic for parents. Promoting Positive Parenting: A Professional Guide to Establishing Groupwork Programmes for Parents of Children with Behavioural Problems. Ashgate	Can be used as a baseline measure and to compare change in terms of frequency/intensity and the extent to which behaviours pose a problem for parents.	**None**	To assess the frequency and intensity of child behaviours, as perceived by parent and provide comparison following group/individual intervention.

5.4. Finance, Benefits and Housing

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
The amount of benefits claimed	Captured via Council's Money Advice Database		n/a	An alternative to distance travelled, this measure how much/how many.	n/a	
Amount of savings made by a family for one-off payments.	Captured via Council's Money Advice Database		n/a	An alternative to distance travelled, this measure how much/how many.	n/a	
Number of people saved from homelessness & eviction.	Numbers included in Core Data.		n/a	An alternative to distance travelled, this measure how much/how many.	n/a	
Number of families and children benefitting from Building Blocks grants	Save The Children Building Blocks grants target early play development in the home and practical needs relating to this.	Parent who is pregnant or who has a child under 6.	Grants are provided according to criteria set. We can monitor number of children and number of families benefitting.	A grant can provide white goods, furniture and early learning resources.	n/a	
Number of families benefiting from Foodbank vouchers	Numbers included in Core Data.		n/a	An alternative to distance travelled, this measure how much/how many.	n/a	
Scaling	Scaling is used with service users for them to rate against personal goals and objectives at the beginning of an assessment. These are then reviewed throughout the invention with a closing scale at the end.	CFAS	Team often use a 0-10 scaling tool consistent with signs of safety model by creating a 'Worry Statement' and a 'Wellbeing Goal'. Family Help utilise these in all six themes of delivery.	A subjective, solution focussed rating by a service user against personal objectives.		

			0 - Worry Statement 10 - Wellbeing goal A typical statement in relation to **'Finance, Benefits and Housing'** for example, can be the following…. Worry Statement *"Due to longstanding rent arrears, we have been evicted from our current property leaving us intentionally homeless"* Wellbeing Goal *" We have a secure tenancy agreement with a realistic repayment plan agreed by the housing association"* Both the 'Worry Statement' and 'Wellbeing Goal' is created with the service user to ensure we are led by them and what they want to achieve.			

5.5. Mental Health and Well-being

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
Patient Health Questionnaire Pfizer, 2017	• A diagnostic tool for mental health disorders used by health care professionals (Pfizer 2017a). It consists of 5 scales covering depression, anxiety, somatoform, alcohol and eating. • The PHQ is part of a family of related measures, including the PHQ-9, which is the depression scale from the PHQ, and the PHQ-15, which is the somatic symptom scale from the PHQ (Kroenke 2014). • Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ (Kroenke 2014). • The PHQ-A is a substantially modified version of the PHQ developed for use in adolescents (Kroenke 2014). Richardson et al. (2010) investigated the original version of the PHQ-9 in an adolescent population an found that a slightly higher cut-off (11 instead of 10 for adults) better distinguished between adolescents with a depressive disorder and those without.	• Self-administered. Can be completed in session with a clinician and used to discuss how treatment is going.	See instruction manual in pack.	• Free to download. • Free for download and use as stated within the PHQ Screeners site (Pfizer 2017b). The text at the bottom of the PHQ form states that "No permission is required to reproduce, translate, display or distribute" (PHQ 2010).	•French •German •Polish •Spanish •Chinese •Malay •Korean •Italian •Hungarian •Russian •Portuguese •Norwegian •Czech •Danish •Dutch And more	Monitoring diagnosed depression in a mother. Diagnosing depression in a young adult.

Revised Children's Anxiety and Depression Scale (RCADS) Parent version RCADS-P	• 47-item questionnaire that measure the reported frequency of various symptoms of anxiety and low mood. They produce a total anxiety and low mood score and separate scores for each of the follow sub-scales: separation anxiety; social phobia; generalised anxiety; panic; obsessive compulsive; total anxiety; and, low mood. • RCADS and the RCADS-P can be used for tracking symptoms as well as providing additional information for assessment. The tool can be useful in highlighting specific issues, such as separation anxiety or obsessive compulsive disorder, where the initial difficulty seems to be a more general one, such as generalised anxiety or low mood. There is also an adapted version of the RCDAS to accommodate characteristics of Young People with Autism Spectrum Disorder. The Anxiety Scale for Children (ASC-ASD) has Parent and Child versions, which are available **here.** (free to download).	• 5-10 mins to administer. • Can be self-administered Or administered by clinician who can ask follow up questions	• RCADS and the RCADS-P can be scored using spreadsheets available from the developer. • The young person's equivalent US School Grade must be entered, which is grade one below the UK school year. • A "t-score" of 65 means that the score is roughly in the top 7% of scores of un-referred young people of the same age (described as borderline clinical by the developer) and a score of 70 means that the score is roughly in the top 2% of scores of un-referred young people of the same age (described as the clinical threshold by the developer). The measures can also be scored by hand following the instructions on the Scoring Aids for the RCADS and RCADS-P (https://www.childfirst.ucla.edu/resources/)	• The RCADS and its derivative works (inclusive of translations) are copyrighted by its developers (Chorpita, Ebesutani). They are available for use through Dr. Chorpita's **UCLA resource page**. • Any use of these instruments implies that the user has read and agreed to the terms of use.	RCADS •French •Spanish •Chinese •Dutch •Danish •Korean RCADS-P •Spanish •Dutch •Danish •Korean Currently, norms and scoring programs for both the RCADS and RCADS-P are based on English versions. Use of norms and interpretation of T-scores should be done cautiously with non-English versions.	
WEMWBS (The Warwick-Edinburgh Mental Wellbeing Scales)	The Warwick-Edinburgh Mental Wellbeing Scales were developed to enable the measuring of mental wellbeing in the general population and the evaluation of projects, programmes and policies which aim to improve mental wellbeing. The 14-item scale WEMWBS has 5 response categories, summed to provide a	Self-report scale to monitor mental wellbeing. WEMWBS has 2 scales: the original 14-item scale and the	The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing	WEMWBS is protected by copyright. Should you wish to use WEMWBS you will require a license appropriate to your intended use. Uses include:	Over 25 languages.	

	single score. The items are all worded positively and cover both feeling and functioning aspects of mental wellbeing, thereby making the concept more accessible.	short 7-item scale.		- mental health education programmes e.g. mental health literacy, social and emotional learning or mindfulness, typically delivered in groups and often in educational settings - programmes to promote wellbeing in the workplace including within business, public and third sector organisations - evaluating interventions which aim to change health-related behaviour - evaluation of the effect of community projects and parenting programmes - psychotherapeutic interventions, usually delivered in a clinical setting one on one. - clinical settings within the NHS where patients are treated for both mental and physical illness		
Child Revised Impact of Events Scale	• The Children's Revised Impact of Event Scale (CRIES) is a brief child-friendly measure designed to screen	Self-completed	There are 8 items that are scored on a four point scale: Not at all = 0	Free to use, though the Children and War Foundation request copies of the results for continued	Translation apparently available here http://www.childr	Potential for PTSD

	children at risk for Post-Traumatic Stress Disorder (PTSD) • Monitor the phenomena of re-experiencing the traumatic event and of avoidance of that event and the feelings to which it gave rise • Developed by the Children and War Foundation. • It has been applied in a variety of cultures as post-traumatic stress symptoms in children are more similar than they are different from one culture to the other • CRIES-8: designed for use with children aged 8 years and above who are able to read independently. It consists of 4 items measuring Intrusion and 4 items measuring Avoidance. • CRIES-13: As above with 5 items added to evaluate Arousal (haven't found a copy of this yet). The CRIES-8 performs equally as well and is recommended for use over CRIES-13 as a screening tool.		Rarely = 1 Sometimes = 3 Often = 5 There are two subscales: Intrusion = sum of items 1+3+6+7 Avoidance = sum of items 2+4+5+8 The lay-out has been designed so that scoring can be easily done in the two columns on the right hand side. The total for each sub-scale can be entered at the bottom of each column.	improvements to the measure.	enandwar.org/projectsresources/measures/ Though website does not work for HT.	
Systemic Clinical Outcome and Routine Evaluation SCORE-15	• One of a group of self-report measures of family processes derived from the original SCORE-40 (Stratton, Bland, Janes, & Lask, 2010). • These measures are designed to indicate crucial aspects of family life that are relevant to the need for therapy and for therapeutic change. • 15 Likert scale items and six separate indicators, three of them qualitative, plus demographic information.	• Should be administered to each family member individually at or just before the start of the relevant sessions. Arrangements should be made	The potential range of scores is 15 to 75, with a lower score indicating higher family functioning. At this time clinical cut off points are not available because the questionnaire is still being evaluated.	• If you are planning to use this measure for the delivery and improvement of health and/or social care, a license to incorporate it into electronic systems can be obtained from NHS Digital. Please note that licenses obtained via this route	• Finnish • Polish • French • German • Hindi • Greek • Norwegian • Italian • Hungarian • Spanish	When some degree of interventio n with a family unit. To highlight different viewpoints of family members.

	It records perceptions of the family from each member over the age of 11 years.	so that each person fills it in privately and their completed SCORE is not seen by others.		may be restricted to particular territory (e.g. England, UK). If planning to use the measure outside of England, you may wish to contact NHS Digital to clarify the geographical scope of the license.	• Turkish More translation being done.	
Child and Youth Resilience Measure	• A screening tool to explore the resources (individual, relational, communal and cultural) available to individuals, that may bolster their resilience. • The measure was designed as part of the International Resilience Project (IRP), of the Resilience Research Centre, in collaboration with 14 communities in 11 countries around the world. • CHILD - Designed for ages five through nine years old. • YOUTH - Designed for ages ten through 23 years old. • Person Most Knowledgeable About Child (PMK) – The CYRM-PMK is designed for use by primary caregivers or people who play a significant role in the participant's life. All come in 12 and 26 item versions http://cyrm.resilienceresearch.org/how-to-use/	• It is recommended that researchers complete the questionnaire with children individually. • All questions to be read to participants as they work through to ensure the children understand each question. • Researchers should also record the answer for the participant but take care to ensure that participants are engaged. CYRM-26 takes approximately 20 minutes, the	The CYRM-28 has three sub-scales: individual capacities/resources, relationships with primary caregivers and contextual factors that facilitate a sense of belonging. Certain questions in the survey provide insight into certain sub-scales. To score each subscale, simply sum responses to the relevant questions – please read the CYRM Manual for more information.	There is no cost to reproduce the CYRM-28 and the CYRM-12 including versions of the CYRM adapted for use with younger children, for research purposes as long as (a) no changes are made other than those authorised by the RRC, (b) the author's are credited (see Ungar & Liebenberg, 2011), and (c) the measure is not sold. Obtain permission on the Resilience Research Centre website (www.resilienceresearch.org).	Not necessarily for all versions of the CYRM: • Arabic • Chinese • English • French • Hindi • Portuguese (Brazil) • Spanish (Puerto Rico) • Spanish Urdu	

		CYRM-12 takes less time.				
The Eating Disorder Examination	Provides a measure of the range and severity of eating disorder features. Researchers have developed community norms and an amended scoring structure for use of the EDE for adolescent boys and girls aged 14+, the EDE-A.	Self-reported		The EDE-Q is under copyright, but freely available to use for non-commerical research use only and no permission need to be sought.	The EDE-Q is widely used and available in many languages.	
Clinical Outcomes in Routine Evaluation (CORE)	This is a client self-report questionnaire designed to be administered before and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: • Subjective well-being • Problems/symptoms • Life functioning • Risk/harm Two practitioner-completed forms complement the CORE-OM by providing contextual information.		The responses are designed to be averaged by the practitioner to produce a mean score to indicate the level of current psychological global distress (from 'healthy' to 'severe'). The questionnaire is repeated after the last session of treatment; comparison of the pre-and post-therapy scores offers a measure of 'outcome' (i.e. whether or not the client's level of distress has changed, and by how much).	The CORE Outcome Measure (CORE-OM) was conceived as a non-proprietary measure of psychological distress. Crucially, it was informed by feedback from practitioners as to what they considered to be important to include. Since its development the CORE-OM has been validated with samples from the general population, NHS primary and secondary care, and in older adults. **The Therapy Assessment Form** helps to profile the client, their presenting problems/concerns and their pathway into therapy. **The End of Therapy Form**		

				helps to chart the client's pathway through and out of therapy, alongside a range of subjective outcome assessments		
Rosenberg Self-Esteem Scale (Rosenberg, 1965)	The scale is a ten question tool with answers on a four point scale, from strongly agree to strongly disagree. The 10 statements related to overall feelings of self-worth or self-acceptance.	Parents and young people.	Scale and scoring instructions at www.yorku.ca/rokada/psyctest/rosenbrg.pdf The scale may be used without explicit permission.	To measure individual self-esteem.		
Mood thermometers (Tuckerman, Bruce, 1988)	An easy to use measure comprising fi ve thermometers designed to measure mood as a child or young person's awareness of well-being. The areas covered are depression, tension, confusion, fatigue and anger.	Undertaken with child/young person	Some of the descriptors are complex (melancholy, tranquil, civil, dejected etc) and would require a child or young person to have a fairly sophisticated grasp of language for the measure to be appropriate. The other issue to bear in mind is that moods, as a state rather than a personality trait, fluctuate and are highly influenced by external conditions.	The measure is available by paying for a journal subscription. Further information: The Scaling of mood. Educational and Psychological Measurement Number 48, 419–427		
Children's Percieved Self-Control Scale (Humphreys, L.)	This short 11 question measure looks at children and young people's perceptions of their control over themselves, and is good for children where you are concerned about impulsiveness and the child's capacity to reflect on their behaviours. Question areas include a child or young person having no idea about what will happen next after they do something and distractibility.	Undertaken with children and young people There is a parallel questionnaire for teachers	It has the benefit of a yes/no answer system and provides a good deal of information from a short measure.	It is available by writing to the author. Contact: Dr Laura Humphreys, Department of Psychiatry, Northwestern University Medical School, 320, E.Huron, Chicago, IL. 60611		

Children's Belief's About Parental Divorce Scale (Kurdek, L. A. and Berg, B., 1987)	There is a very comprehensive USA compendium of assessment measures that are specifically focused on violence, selected to measure changes in beliefs, behaviours and attitudes of young people in young people's services. Some of the measures in the compendium are not at all suitable for UK-based services but others might be helpful. Some are very short, four questions measures, for example, Beliefs About Hitting (Orpinas) some six questions, Attitude Toward Violence, which measures attitudes toward violence and its acceptability, particularly in relation to fighting, it has been used with school years six to eight and was created by the Houston Community Demonstration Project, 1993 and adapted by Bosworth & Espelage, 1995.	Undertaken with children and young people	All the measures have their provenance or reliability cited, some are not clinically reliable but included in the hope that by use they can be improved so pick carefully, some are excellent in terms of reliability and validity, well known and widely used. Avoid printing the whole document as it runs to 373 pages. Look for tools that interest you and print them specifically.	Children's Beliefs about Parental Divorce Scale; Psychometric characteristics and concurrent validity, Journal of Consulting and Clinical Psychology, 55, 712-718.		
Hare Self-Esteem Scale (Hare, Bruce)	This questionnaire covers three areas (peers, home and school) and has ten questions in each area. It is a tool that can be given to groups of children as well as individuals. To use the scale children and young people have to be able to discriminate their place on a 4 point scale (strongly disagree, disagree, agree, strongly agree). Examples of questions include wishing that the child or young person was different in order to have more friends, parents feeling proud of the child or young person and teachers	Undertaken with children and young people over 10 years old.	Subscales of: - Peer Self-Esteem - Other people wish that they were like me - School Self-Esteem - My teachers are usually happy with the - kind of work I do - Home Self-Esteem - My parents are proud of the kind of person I am	It is available online or by contacting the author. Contact: Dr Bruce Hare, 115 Nottingham Rd, Syracuse, NY. 13210		

	expecting too much from the child or young person.					

5.6. Education and Childcare

Name	Description	Who	Interpretation/Scoring	Use	Translation	Examples of when to use it
ITERS – Infant/ Toddler Environment Rating Scale	Designed to assess center-based child care programs for infants and toddlers up to 30 months of age. Scale consists of 39 items organized into 7 subscales: - Space and Furnishings - Personal Care Routines - Listening and Talking - Activities - Interaction - Program Structure - Parents and Staff	To make an assessment of the environment offered by a childcare setting.	Carried out through observation, a score in given in each subscale and allows targets to be set for development.	The ITERS is a classroom assessment tool designed to measure the quality of group programs for infants and toddlers (birth to age 3) by collecting data through classroom observations and a staff interview.		To assess a childcare environment.
SSTEW – Sustained Shared Thinking and Emotional Wellbeing Scale	An observation scale to measure the quality of provision and practice related to Sustained Shared Thinking and the Emotional well-being of children. The focus is on how the adults – practitioners and teachers – support children's language for thinking and social and emotional well-being. It brings together the crucial message that children's early learning is secured through their personal, social and emotional development. Using a self-evaluation scale it covers the following; - Building trust, confidence and independence - Social and emotional well-being - Supporting and extending language and communication	Needs to be used by someone with knowledge of child development and appropriate practice	Considers high quality interactions with and between children.	SST is an episode in which two or more individuals "work together" in an intellectual way to resolve a problem, clarify a concept, evaluate activities, extend a narrative etc. Both parties must contribute to the thinking and it must develop and extend" (Siraj-Blatchford et al., 2002)		To assess a childcare environment

	- Supporting learning and critical thinking - Assessing learning and language					
The Leuven Scale – Wellbeing and Involvement Screening Tool	Laevers has created a 5 point scale to measure both wellbeing and involvement. The procedure is simple and can be compared to 'scanning': observe the children for about two minutes to ascertain the general levels of wellbeing and involvement using the five-point scale. The observation can focus on groups of children or can be used to focus on a particular individual. Unless a child is operating at 4 or 5, learning will be limited. However, children cannot peak at levels 4 or 5 all the time and levels will fluctuate throughout the day.	Needs to be used by someone with knowledge of child development and appropriate practice	The evaluation starts with assessing the levels of wellbeing and involvement using the tables.	If there is a lack of wellbeing and or involvement, it is likely a child's development will be threatened. The higher the levels of wellbeing and involvement we can achieve for the child, the more we can add to the child's development. When there are high levels of wellbeing and involvement, we know that deep level learning is taking place.		To assess a childcare environment
School attendance Records	An alternative to distance travelled, this measure how much/how many.	Children on-roll at Cardiff schools.	n/a	Able to look at school attendance and monitor changes before and after intervention.	n/a	When school attendance is a cause for concern.
Wellcom Toolkit	Screening tool to identify children needing speech and language support.	For use with children 6 month plus.	Manual scoring.	Following screening, there are play-based activities to promote speech and language development.		Screening tool. Concerns with development of communication skills.

Early Help

Thinking Together Conversations:
A Framework for Practice

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

CARDIFF
CAERDYDD

CYMORTH CYNNAR
EARLY HELP

Cardiff
Caerdydd

Document History

Date	Version	Author	Revision Summary
3.9.2020	1	Dr Nicola Canale & Dr Sarah Fitzgibbon	First Draft with contributions

Reviewers

This document requires reviewing by the following individuals;

Date	Version	Reviewer Name	Reviewer Title
16.9.202	1	Avril Hooper/Dan O'Keefe/ Andy Senior/ Sarah Manley/ Sion Bonett/ Rachel Raymond/ Natalie Dix	Early Help SMT
			Early Help Operational Group

Approval

This document requires approval from the following individuals;

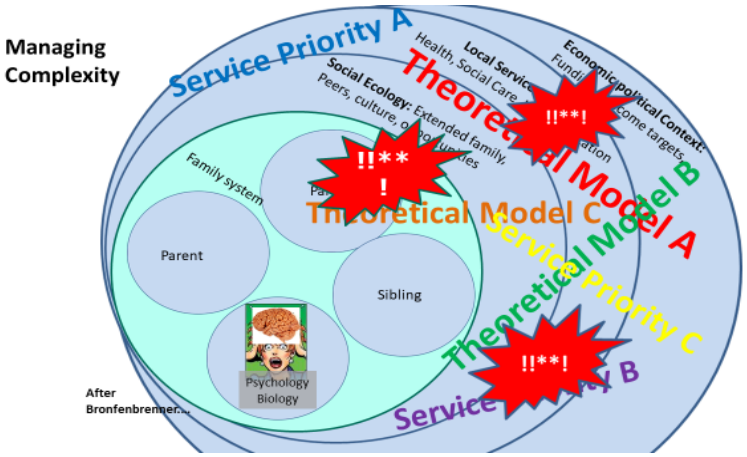
Date	Version	Name	Title
		Avril Hooper	Early Help Operational Manager

Contents

Contents

1.0 Introduction

Many of the families we work with in Cardiff Early Help experience co-occurring difficulties (e.g. financial worries, housing issues, safeguarding concerns, difficulties with parenting, etc.) and attract the involvement of multiple teams or agencies who all have a desire to facilitate some type of positive change for the family. *See Early Help: Approaches & Interventions.*



Involvement from professionals often multiply in the face of such problems, so that a child, young person or family is approached by multiple workers, from different agencies within 'the system', who are often working towards different goals and using different models. This can be overwhelming and may actually be experienced as unhelpful by the child, young person or family, despite the best intentions of practitioners. Failure to provide effective help, at the right time, is not only unhelpful for families but can also be costly to society (effective early intervention in conduct disorder alone is estimated to save £150,000 per child; Friedli, 2007).

We have therefore adopted a Thinking Together Conversations Framework For Practice, to provide us with us a framework for supportive and collaborative professional conversations to take place between two (or more) professionals from different teams/agencies/disciplines to explore thoughts, feelings and plans for casework and to respond collaboratively to family need, utilising the relationship that a practitioner has already developed with a family and the resources that are available from colleagues within a multi-agency service.

The current document outlines the rationale behind adopting the Thinking Together Conversations Framework for Professional Practice, the psychology which underpins the model, the structure of a Thinking Together Conversation, how the Framework will be operationalised in Cardiff Early Help and the Process for requesting and recording Thinking Together Conversations in Practice.

2.0 'Thinking Together'

'Thinking Together' (Bevington et al, 2017) is a tool that forms a part of a wider whole-team approach (AMBIT model), designed by practitioners at the Anna Freud Centre London, to develop better systems of care and support around people with complex and co-occurring difficulties. The AMBIT model is underpinned by psychological theories such as mentalisation, attachment theory and systemic ways of thinking.

Cardiff Early Help have decided to utilise this particular tool (Thinking Together) to begin to facilitate a more joined up and collaborative approach to the way we work with families. Professionals will all bring their own knowledge and expertise to these conversations and they should be used to enhance, rather than replace, existing structures and processes e.g., supervision, multi-agency meetings, etc.

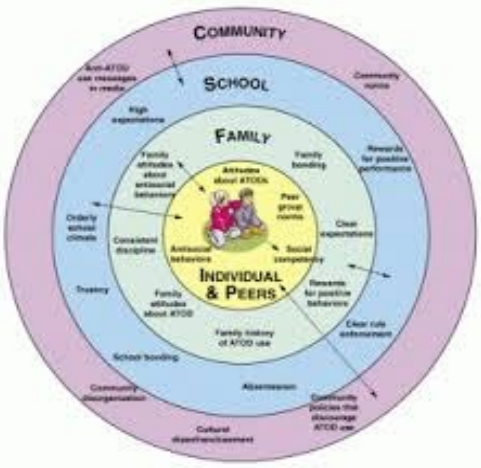
2.1 The Psychology Underpinning the AMBIT model

Attachment Theory can be defined as the "enduring emotional bond that connects one person to another across time and space" (Ainsworth, 1973; Bowlby, 1969). From an attachment perspective, the AMBIT model emphasises the importance of building safe and trusting relationships between people and how this is necessary before any new learning/changes can take place.

Mentalisation can be defined as "the imaginative activity of making sense of the actions of oneself and others on the basis of intentional mental states such as desires, feelings and beliefs" (Fonagy 2018). From a mentalising perspective, the AMBIT model places an emphasis on developing strong professional relationships around the worker who has formed a strong relationships of trust with the child, young person or family with whom they work. This improves a family's openness to receive help both immediately and in the future.

Systems thinking can be defined as "the process of understanding how things influence one another within a whole" (Rogers, 2020). From a systems thinking perspective, the AMBIT model recognises the interconnectedness between the family system, the team system and wider networks and the significant role that relationships and communication (or lack of) plays in the process of change.

One particularly helpful theory from this area of psychology, commonly used when working with children and young people and their families, is Bronfenbrenner's Ecological Systems Theory.



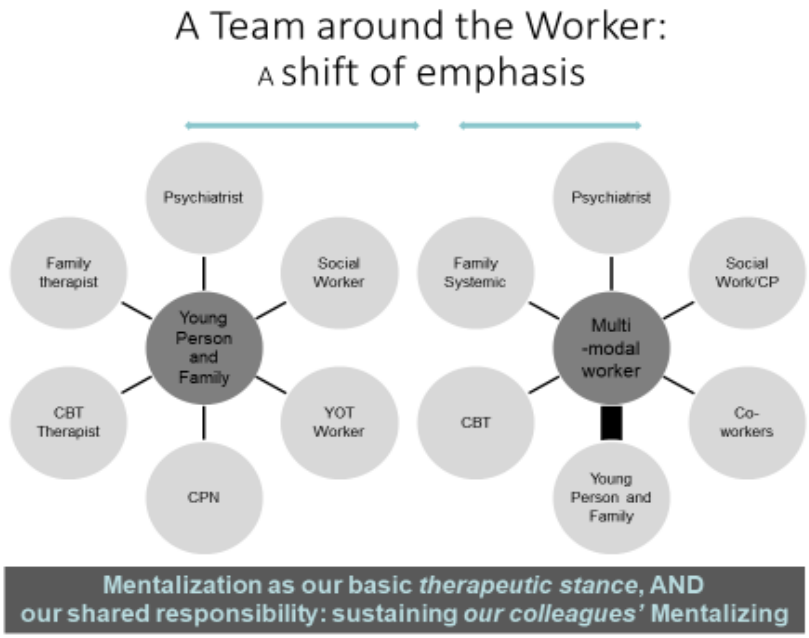
According to Bronfenbrenner (1979), children typically find themselves enmeshed in various systems, from the most intimate home system to the larger school system and then to the most expansive

system which includes society and culture. Each of these systems inevitably interact with and influence each other in all aspects of the children's lives.

2.2 'Thinking Together Conversations'

Thinking Together Conversations offers us a framework or structure for supportive and collaborative professional conversations to take place between two (or more) professionals from different teams/agencies/disciplines to explore thoughts, feelings and plans for casework (see Section 2.0 for process for Practice). Within the Thinking Together Conversations Framework, a range of practice and supervision models, familiar to the practitioners taking part in the conversation (e.g., Signs of Safety, COMOIRA, etc.), can be drawn on and applied.

The benefits of Thinking Together Conversations are twofold; as well as colleagues having the opportunity to learn from each other whilst thinking about a piece of casework, they also provide a possible alternative to referring families on to yet another agency which, as mentioned above, can feel overwhelming and unhelpful to families. If, however, a referral to another agency is felt to be necessary as an outcome of the Thinking Together Conversations, then this can be made in a thoughtful and structured way.



These conversations therefore seek to help begin to make a shift from the dominant "Team around a Child/YP/Family" approach, towards a "Team around a Worker" approach - so that the wider Early Help team can focus on supporting the worker who has already successfully formed a secure and trusting relationship with the chid/young person/parent.

2.3 The Structure & Recording of the Thinking Together Conversation

Conversation requested by:	
Names of others involved:	
To think about work with (Name and Date of birth):	

1. Mark the Task and Decide the Purpose

Agree on how long both parties have, and what is the purpose of the conversation.
Is there a key issue that needs a decision? Is there an area of confusion that needs a better framework for understanding it? Is the task... to work out what the task is? Etc.

2. Stating the Case

It is important for the person seeking the TTC to clarify in his or her mind what are the simple bones of the story or problem that they wish for help in thinking about.

3. Thinking Together (Mentalising)

The helper helps the person requesting the TTC to **think through and reflect on the situation** rather than to leap straight in to giving advice or making suggestions. The intention is to allow and foster a more curious and exploratory kind of thinking. This step allows for a range of models to be applied to support this important step (e.g., Signs of Safety, COMOIRA, Coaching, etc.).

4. Outcome of the conversation

Return to the purpose of the conversation and clarify what **decision**, **intervention**, new **understanding**, etc. was agreed and will be **offered to** the child/YP/family as a result. Record a brief summary of this outcome below (other more detailed records of the conversation can be attached).

Signatures of all present

2.4 How will Thinking Together Conversations be operationalised in Cardiff Early Help?

Thinking Together Conversations was initially be piloted between Cardiff Parenting and Family Help, and the feedback from practitioners in both teams was positive in reporting:

- Individuals feel better able to work with families right away on the needs they have identified
- Collaborative thinking resulted in new ideas being generated
- Families are able to continue working with the person that they know and with whom they have developed a trusted relationship
- Colleagues have an improved understanding of each other's role

The result is that we have adopted a staged approach to include an increasing number of teams with the Framework for Practice. There is scope to broaden the application of Thinking Together Conversations between other teams both within Cardiff Early Help (e.g., FS Advisory Team, FS Inclusion Team, and Support 4 Families) and with partner agencies (e.g., Primary Mental Health, Violence Protection Unit, and Cardiff Resilience Project Workers). This will require planning with team leaders and managers regarding how these systems are able to interact with one another for the benefit of families, and how the impact of the work is recorded for reporting purposes.

Table 1: The staged approach to Thinking Together Conversations

Stage	**Reason for Thinking Together Conversation**	**Teams Involved in the Thinking Together Conversation**
1	Families where there are co-occurring difficulties/needs with an element of parenting*. **Parenting will be one of the many needs that exist for the family but will not be the primary need identified with the family.*	Cardiff Family Advice & Support and Cardiff Parenting Service
2	Families expecting/with a child aged 0-2 where a concern in the parent-infant relationship has been identified.	Parents Plus & Flying Start Health Visitor
3	Families with a child aged 4-17years 9months where there are concerns around emotional wellbeing and mental health.	Primary Care Mental Health Specialist Practitioner and Family Advice & Support and Cardiff Parenting Service
4	Families where partners are aware of behaviours where a policing response may be appropriate.	Early Help PCSO and Primary Care Mental Health Specialist Practitioner and Family Advice & Support and Cardiff Parenting Service

3.0 Processes for Practice

Process to arrange and record Thinking Together Conversations will vary between teams. Different teams have different systems for, and requirements of, case recording. Please consult the appropriate section below, relevant to the team the Thinking Together Conversation is being requested from.

3.1 Families where there are co-occurring difficulties/needs with an element of parenting

For Cardiff Parenting Services, the Thinking Together Conversation Framework is not intended as a way to "gate keep" any referrals into Cardiff Parenting Services, and therefore the Thinking Together Conversation is independent of the referral process. The Conversation is intended to offer an opportunity for supportive and collaborative professional conversations to take place.

In the event that a future referral is made, it would be useful to include in the referral that a Thinking Together conversation has taken place, so that the content of this can be used to inform the next steps with the family.

Practitioner and line manager/supervisor have identified a plan, which involves an element of parenting, through supervision e.g., there is an identified parenting need, which is not the primary need, and the Practitioner would like to discuss ideas with another professional.

↓

FHA & line manager/supervisor consults diagram below to ascertain which parenting team would be best placed to arrange the 'Thinking Together Meeting'. Colleagues providing Thinking Together Conversations will benefit from a request being made in advance, as case holding practitioners do not hold a space open in their diary for the conversations to take place, and therefore are working to accommodate requests as they are received.

↓

FHA contacts the lead of the identified parenting team to arrange a one-hour 'Thinking Together' conversation to discus and agree on parenting focused actions.
This might take place with the team lead or with another member of the team, as identified by the manager.

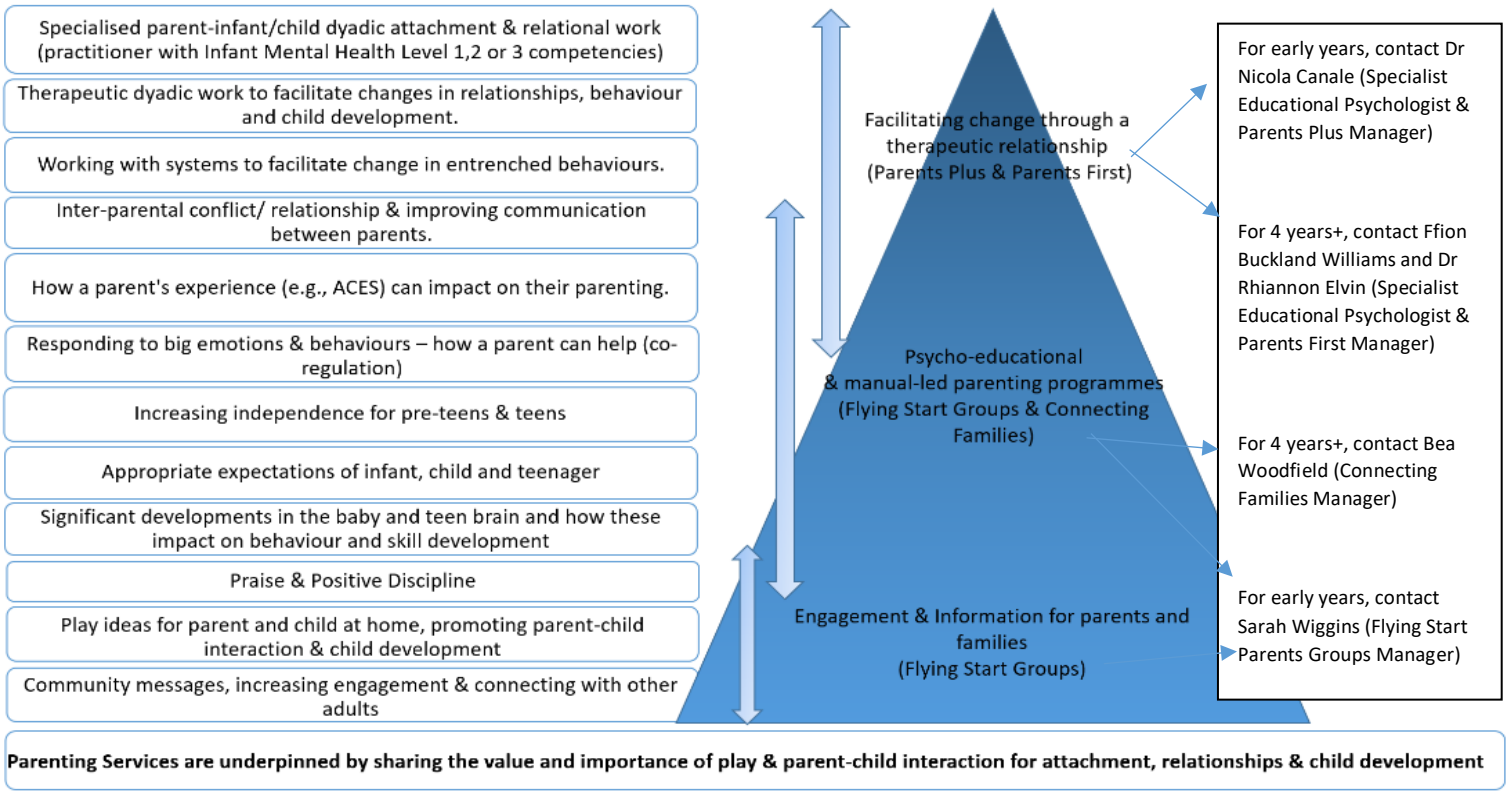
↓

If parents have consented to the sharing of information, then Practitioner completes the *Name, Date of Birth* and *Mark the Task and Decide the Purpose* section of the recording form and sends to the Helper in advance, so that the "helping" colleague can look at the service case management system in advance and establish whether there has been any previous or current involvement with the family, or if they are on a waiting list.

↓

Brief record of the conversation and agreed actions recorded by case-holder and shared with all involved with the Thinking Together Conversation. It would be expected that these actions would formulate part of the case-holder's family plan/next steps. Case-notes relating to the child and family remain the responsibility of the case holder.

Parenting Services (Dr Sarah Fitzgibbon, Cardiff Early Help)



2.1.1 Review Process

Following a Thinking Together Conversation, Cardiff Parenting Services will follow up to ask their collaborators:

On a scale of 0-10 with 0 being not confident and 10 being extremely confident, how confident are you in addressing the parenting element of your piece of casework?:

Prior to conversation:

0 1 2 3 4 5 6 7 8 9 10

After conversation:

0 1 2 3 4 5 6 7 8 9 10

3.2 Thinking Together Conversations to Support Parent-Infant Relationships and Infant Mental Health during the First 1000 Days

3.2.1 Defining Infant Mental Health (IMH)

Infant mental health describes the social and emotional wellbeing and development of children in the earliest years of life. Crucially, infant mental health relies on the healthy functioning of the nurturing relationship between caregiver and child. In other words, infant mental health reflects whether children have the secure, responsive relationships that they need to thrive.

3.2.2 Early Intervention: Improving infant mental health by strengthening parent-infant relationships

Although children's futures are not determined by the age of two, wellbeing in the early years is strongly linked to later outcomes. By protecting and promoting babies' emotional wellbeing and development (i.e., *improving infant mental health and strengthening parent-infant relationships)* we have an opportunity to put children on a positive developmental trajectory and take advantage of the opportunities that lie ahead.

It is more ethical and cost-effective to act early, rather than pick up the pieces when problems occur. Without taking early action, we risk exposing children to unnecessary suffering and increase the need for later mental health support. Effective early action also leads to accumulated savings by preventing other services being required later in the child's life, it also improves the child and family's participation in the economy.

Promoting infant mental health and strengthening parent-infant relationships is not about 'perfect parenting'. Children don't need perfect parents - they need 'good enough' ones. Pregnancy and early parenthood is a life changing experience which brings with it a wide range of stressors and conflicting emotions. The goal in these formative years is to enable as many attuned interactions between the baby and caregiver as possible, and to try and find a way of repairing and reconnecting when things go wrong.

3.2.3 Applying an Infant Mental Health Framework to help parents to meet the challenges of parenthood.

A parent-infant mental health framework draws from psychology, genetics and neuroscience. It offers us a framework to understand the challenges of becoming a new parent and helps us to find a way forward in supporting both the parent and infant during this time. An infant mental health framework can inform a full range of support from universal and targeted, to more specialist support for parents and their infants.

In her book 'The Developmental Science of Early Childhood', paediatrician Claudia Gold posits that a parent-infant mental health paradigm can be characterized by the four key components below:

- **Relational** – Human's develop in the context of caregiving relationships. Rather than seeing a problem as residing 'within' a child or 'within' a parent we focus on the difficulty as being

'between' the parent and child and support the relationship. Work is therefore dyadic in nature (i.e., with the parent and infant together).

- **Developmental** - Whether a person is 3 months, 3 years, or 13 years old, and infant mental health framework helps us to understand how early experiences have far-reaching effects over our lifespan. However, effective support lies in an understanding of this early development.
- **Multidisciplinary** – Professionals from a wide range of clinical fields e.g., psychology, nursing, health visiting, occupational therapy, etc. can apply an infant mental health framework to inform their practice.
- **Reflective** – The *meaning of behaviour*, rather than just *treating the behaviour* is key. Behaviour is viewed as a form of communication. When we discover the meaning of the behaviour the way to support becomes clear.

3.3.4 Beyond ACES and a 'medical model' of disease and disorder

The ACEs study has provided abundant evidence of the long-term negative effects of early exposure to a range of adverse early childhood experiences. An infant mental health framework shows us how to make use of this knowledge in a model of prevention and intervention for families.

The current dominant 'medical' model of mental health focuses primarily on the question *'what is it?'* In contrast, an infant mental health paradigm focuses on answering the question *'why is this happening is and what can we do about it?'*

Regardless of our profession, by thinking together, through an Infant Mental Health framework, we can think less about the of the former question and focus on the latter as this gives us a way forward in offering the best support possible to parents during this extremely important period of their child's development.

3.3.5 The Process to Support Parent-Infant Relationships and Infant Mental Health during the First 1000 Days

Concern for infant development and/ or the parent-infant relationship 0-2 years:

- Parental anxiety regarding wellbeing of healthy infant leading to pursuit of medical diagnosis, e.g. 'colic', reflux, 'ADHD' etc.
- Difficulty in soothing infant
- Parental anxiety regarding feeding and/or weaning.
- Infant's ongoing night time waking (8-12 weeks).
- Parent's inappropriate expectation of infant relative to development.
- Unresponsive, intrusive or hostile care.
- Poor parental mind-mindedness/ mentalising.
- Parent's poor self-regulation.
- Parent is negative towards baby 'he hates me/ she's doing it to get at me'.
- Hostile home environment/ lack of safety.

Midwife or HV identifies risk difficulties/risk factors with the parent-infant relationship in first 1000 Days.

↓

HV Requests a Thinking Together Conversation with Practitioner/s from ARTIS Forum with specialist knowledge around Parent-Infant relationships (Infant Mental Health competencies level 2-3).

↓

HV applies approach agreed during this meeting to support the parent-infant relationship. Clinical supervision received from agreed Specialist Practitioner.

↓

A decision is also made during the meeting as to whether it is felt that the family would benefit from any input from other teams/services.

Risk factors for parental poor sensitivity and the parent-infant relationship:

- History of risk in extended family.
- Parental Mental Health difficulties.
- Parents with difficult childhood experiences (ACES) Family conflict / violence.
- Parents with learning difficulties.
- Traumatic delivery or loss during ante natal period.
- Substance or alcohol abuse
- Adolescent parents.
- Unwanted / unplanned pregnancy.
- Baby premature / significant health needs.
- Safeguarding history involving infant's siblings.

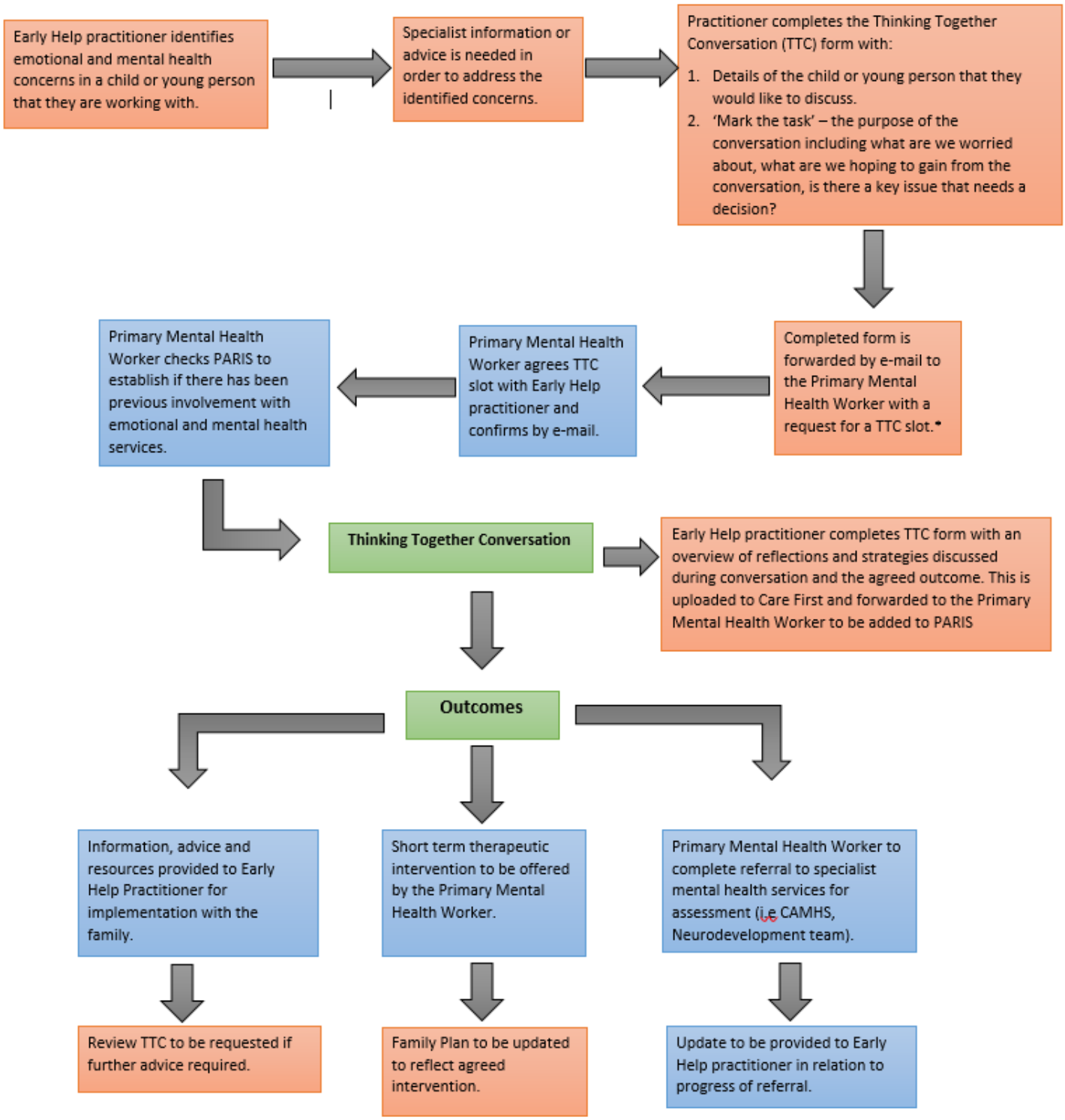
Universal
Support and intervention managed by HV in the home

Targeted/Enhanced Support
Parents Plus/Parents First (Psychology-Led short-term intervention to support the Parent-Infant Relationship - Watch, Wait, Wonder, VIG, etc.).
+
Universal

Specialist Support
ARTIS 1:1 intervention, Children's Services, Perinatal Mental Health Team, etc.).
+
Universal

3.3 Thinking Together Conversation involving Primary Mental Health & Young people

Early Help and Primary Mental Health referral process



* Two consultation sessions will be offered each week in both the east and the west

3.4 Thinking Together Conversations with Police Community Support Officers

PCSOs are employed to work with Early Help partners to ensure that families get the right help they need through Police and partners working together more effectively. Their role is to discuss with partners potential opportunities for intervention with children and families utilising a problem solving based approach. Where a policing response is appropriate, PCSOs will carry out follow up visits to children and families with the relevant partner agency.

Further information to follow.

Appendix 3:

1. **Perinatal/ Parent-Infant Relationships Collaborative working**

ARTIS Group: The establishment of the Attachment and Relational Trauma Informed Service (ARTIS) Group. The ARTIS group is a special interest learning community led by Cardiff Flying Start & Early Help practitioners who have enhanced skills, knowledge and expertise in relation to attachment, and trauma informed approaches and early child development.

Projects led/run by the ARTIS group:

Workforce Development/Training: The ARTIS group have put together a suite of Attachment, Relational and Trauma Informed Training that has been mapped onto to Association for Infant Mental Health Competencies Framework. Around 200 Cardiff Early Help and partner agencies currently benefit from the training per year. The ARTIS group are now working with Heath Education in Wales (HEIW) and other Parent-Infant teams across Wales, to further develop training in Parent-Infant work with the view to rolling this out as a Wales wide qualification for the wider workforce at different levels e.g. perinatal teams, CAMHS, parenting, childcare, etc.

Community of Practice Sessions: Bi-monthly sessions that support practitioners from Cardiff and the Vale in the application of attachment, relational and trauma informed approaches to their work with families and children during the first 1000 days. These sessions have focused on topics such as:

- Development of empathy in young children
- Fear of childbirth
- Video Interaction Guidance
- Maternal mental health & mood

Thinking Together (1st 1000 days) Pilot: Fortnightly group discussion/co-formulation session, led by the ARTIS leads (psychologist and health visitor) that is requested by a HV when they identify a risk/difficulty within the parent-infant relationship. The HV applies the agreed approach to casework and brings back to the group for further discussion/reflection. Evidence: The TTC Framework Document?

2. UHB Perinatal Team & Cardiff Parenting

Thinking Together Conversations (TTC) Pregnancy Pilot: Monthly group discussion/co-formulation sessions co-led by; the lead Educational Psychologist from Cardiff Parents Plus, the lead Social Worker for the Cardiff Pre-birth team and the Clinical Psychologist from Cardiff Perinatal team. The conversation is requested by a social worker within the pre-birth team. Evidence: The TTC Framework.