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Motivational Practice

Evaluation report

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Key messages

Systemic change takes time:

- The rollout of an organisation-wide training programme has taken time and will continue to take time before certain changes are visible.
- This evaluation does not provide sufficient evidence to justify wider dissemination of the Motivational Practice programme at this stage, but the evidence does suggest the programme merits further research following further embedding.

Embedding new approaches require ongoing practice by staff:

- Social work theories and techniques such as motivational interviewing (MI), dyadic developmental practice (DDP) and trauma informed practice (TIP) require ongoing support and experiential learning to be successfully embedded.
- Provision must continue to be made for formal support structures to be available, and for them to be consistent, to give staff opportunities to reflect on their practice with managers and peers.
- Embedding of key training concepts can be provided using informal routes, as trained staff are able to teach others, however this may also be burdensome for trained staff who may require more support.

Relationships between social workers and families underpin positive outcomes:

- Open and supportive communication channels between social workers and families were a key mechanism in engendering confidence and emotional support within the home environment.
- The proximal outcome of placement stability for CLA and CIN case stability was attributed to the development of families' trust in their social worker, as they felt heard and understood.

Evaluating Children's Social Care innovations requires further capacity-building:

- Local Authorities have data necessary for evaluations. Preparing these data in a way which enables robust evaluations is time-consuming for boroughs and therefore requires sufficient dedicated resources to ensure that evaluations are supported.
- Evaluating interventions often relies on comparing outcomes between evaluated and comparison boroughs. Such comparisons are often made challenging within Children's Social Care due to many boroughs simultaneously engaging in innovative programmes. The selection of appropriate comparison boroughs would therefore be enabled by having an easy way to identify the nature and timing of any changes across all boroughs to rule out changes that may have occurred due to involvement in other programmes.

Executive summary

Introduction

This report details the evaluation of two project phases undertaken by Islington Children's Social Care (CSC) as part of the Department for Education's (DfE) Children's Social Care Innovation Programme (Innovation Programme hereafter). The first phase was launched in a previous Innovation Programme, with the new phase building on the previous.

The project

In 2015, Islington CSC launched a training programme to help social workers (SW) improve their practice when working with Children in Need (CIN) and their families. SWs learned new skills which were intended to allow them to build more collaborative and supportive relationships with CIN and their families, and to encourage more stability in these families, who were selected as they represent the largest proportion of children and young people (CYP) involved with social care. In 2017, Islington CSC adapted the training programme to include workers in the Children Looked-After (CLA) team, including foster carers (FC) working with CLA. Again, this phase was designed to improve worker skills, and improve relationships between CLA, their carer and the CLA team at Islington CSC, ultimately resulting in more stability in the foster home.

The evaluation

Both project phases were evaluated using an impact evaluation, supported by implementation and process evaluation (IPE) and cost evaluation. For the CIN phase, the impact evaluation sought to understand whether the project decreased re-referrals that resulted in CIN status and escalations to a Child Protection Plan (CPP), as this was seen to indicate more stability in the home. For the CLA phase, the impact evaluation sought to understand whether the project decreased the number of placement moves and residential care placements for CLA, as this was seen to indicate more stability in a placement. The IPE for both phases focussed on understanding processes of implementation and mechanisms of change. The cost evaluation focused on outlining the spend and the unit cost of each phase for staff and CYP.

The impact evaluation for both phases consisted of a difference-in-differences (DiD) analysis, where changes in Islington stability outcomes before and after the intervention were compared with changes in stability outcomes in two other comparison boroughs to identify the effect of introducing the intervention. The IPE was a mixed method design and primarily consisted of qualitative interviews with a sample of SWs, supervising social workers (SSW), CIN families, CLA families and a focus group with Young People Advisors

(YPA)¹. The IPE also utilised an online survey for a deeper understanding of the experience of foster carers.

Key findings

The impact evaluation demonstrated fluctuating stability outcomes for both CIN and CLA phases in relation to the same outcomes for comparator boroughs. The process and implementation evaluation demonstrated that across the CIN and CLA phases, consistency in training and embedding practice was associated with proximal outcomes of stability for families, although this did not consistently translate into impact on outcomes in the quantitative evaluation.

Implementation: Motivational Practice (MP) required staff to adopt a model integrating motivational interviewing (MI) and trauma informed practice (TIP) into core safeguarding skills, which led to new perspectives on social work practice. The addition of DDP in CLA provided a framework and skills for working with FC's in their care of CLA. Interviews with staff indicated that support, reflection and experiential learning allowed staff to feel more confident and refine their new skills, although due to the limitations in the sample size, there may be details or experiences missing from the dataset:

- Staff motivation was directly linked to engagement with training activities, which were essential to adopting MP as a new way of working.
- As training was run quarterly, there were periods of time where new staff remained untrained. Despite being supplied with induction packs, new staff also sought out drip down methods from trained colleagues to improve their knowledge of TIP.
- The training gave staff new perspectives on ways they could approach their practice through a trauma-informed lens, which aligned with social work values.
- Embedding MP relied on staff having opportunities to practice the new approaches in informal ways, and support from key stakeholders to reinforce the new practice model through more formal structures, such as training courses.
- Staff discussed four key elements of the model impacted embedding: (1) Supervision, (2) Coaching and observations, (3) Innovations team and Practice champions support, and (4) Support from new processes and existing networks.

Impact: The evaluation found that there were variations in stability outcomes for families:

¹ All eligible, relevant and former relevant children and young people must have a Young Person's Adviser (referred to in the Act as a personal adviser) who will help to draw up the Pathway Plan and to make sure that it develops with the young person's changing needs and that it is implemented. When the young person leaves care and until they are at least 21 the Young Person's Adviser will be responsible for keeping in touch with them and ensuring that they receive the advice and support to which they are entitled. Regulations may provide that children in other groups might also have Young Person's Advisors.

- MP initially increased CIN re-referrals occurring within 12 months of referral opening in the first two years, but subsequently decreased such re-referrals in the third year after implementation.
- There was no impact on CIN re-referrals occurring within 24 months of referral opening in either year after MP was introduced.
- MP was associated with an increase in CIN escalations to CPP or CLA within 12 months of referral opening, but interpretation of this finding is limited by differences in escalation trends between Islington and the comparison borough in the year before MP was introduced.
- MP was associated with a marginal decrease in the number of placement moves that CLA experienced, but had no impact on the number of residential care placements.
- Conclusions are limited by uncertainty around the comparability of data across years and boroughs, and a limited number of post-intervention years for analysis.
- According to the implementation component of this evaluation, perceptions of increased emotional burden and workload among social workers, as well as MP's gradual implementation and embedding within Islington, may potentially explain why MP decreased CIN re-referrals only in the third year, and had only a limited impact on CLA.

Lessons and implications

There were several important lessons and implications that emerged from both the process of conducting the evaluation and the evaluation findings themselves. The project lessons and implications included:

1. **Combat innovation fatigue.** We recommend motivating staff for changes to practice by showing them how the new practice aligns with their work values, such as relationship building.
2. **Ensure consistent embedding.** We recommend that managers be encouraged to commit to regular supervision to avoid the drop-off in supervision described in the qualitative data, and that teams be briefed on the purpose of a practice champion, and the ways to go about accessing this service.
3. **Leverage informal knowledge pathways.** Depending on resourcing and schedules, Islington CSC could leverage informal support such as peer to peer learning in a more structured way, building on the coaching, supervision and practice championship models to include something similar for training delivery.
4. **Address practical and emotional burdens.** This evaluation recommends that staff be supported in peer-to-peer knowledge sharing. We also recommend that additional support services for debriefing, or additional training on coping with trauma stories may help staff in their new practice.

Evaluation lessons and implications:

1. **Local Authorities should have resources dedicated to supporting evaluations.** Boroughs have data necessary for evaluations. Preparing these data

in a way which enables robust evaluations is time-consuming for boroughs and therefore requires sufficient resources to ensure that evaluations are supported.

- 2. During evaluation design, it should be easy to identify the nature and timing of any changes within boroughs that may impact evaluation-relevant outcomes.** Evaluating interventions often relies on comparing outcomes between evaluated and comparison boroughs. Such comparisons are often made challenging within CSC due to many boroughs simultaneously engaging in innovative programmes. The selection of appropriate comparison boroughs would therefore be enabled by having an easy way to identify the nature and timing of any changes across all boroughs.

1. Overview of the project

1.1 Project context

Islington is the most densely populated borough area in England and Wales with 15,818 people per square kilometre, triple the London average and more than 37 times the national average². 35% of children under 16 live in low-income households, the third highest proportion in the country, and in 2018-19, 47% of primary school pupils in Islington schools were eligible for the deprivation pupil premium. Furthermore, as of March 2018, there were almost 1000 children in temporary accommodation in Islington, reflecting the great burden placed on families and (CSC) services.

Prior to Phase 1, in a scoping phase (2012-2014), the University of Bedfordshire conducted exploratory research in Islington to look at the effectiveness of Motivational Interviewing (MI) as a social work intervention. MI operates by way of a guiding interview style, asking questions that elicit the interviewees own motivation for change and increasing autonomy in that change process. MI training was rolled out across the Child in Need (CIN) team to develop social workers' (SWs') relationship-based practice skills with the aim of improving outcomes for children.

Funded by the first round of DfE innovation projects, the first phase of Islington CSC's Doing What Counts: Measuring What Matters (DWC:MWM) project involved the CIN team and ran from 2015 to 2017. Phase 2, which started in 2017, expanded motivational social work (MSW) into the CLA team, building upon the learning from the first phase of the project and incorporating TIP into the model. Overall, the two projects are known as Motivational Practice (MP) and were the result of a process of iteration, review and further development.

1.2 Project aims and intended outcomes

The aim of MP is to support Islington CSC professionals in becoming more effective in supporting families and improving outcomes for children. By learning new skills and building their understanding of new approaches, the project aims to improve social work practice, and increase collaborative working between parents or foster carers (FCs) and supervising social workers (SSWs) and social workers (SWs). As outlined in the Theory of Change (ToC) (see Appendix 1), it is hoped that an improvement in social work practice will facilitate greater stability in the home for both CIN and CP and improve placement stability for CLA by increasing the skills of FCs.

The project was seen by the Islington CSC team as a whole systems change. As well as the direct training, Islington CSC committed to increasing business support while reducing bureaucracy and caseloads to free up SW time for more direct work. Whole systems change also involved the development of a recruitment and retention strategy with

² State of Equalities in Islington, *A Fairer Islington*, 2019

improved career progression for SWs, the development of a leadership and supervision programme, and the development of systems enabling the review of data in real time and to respond to children's needs and safety.

1.3 Project activities

Phase 1: Children in Need

The first phase of the project, DWC:MWM, which involves working with CIN and CP, and was funded as part of the DfE's first round of Innovation Programme projects. The project was a collaboration between Islington and the University of Bedfordshire, which developed the MSW methodology. It was evaluated by the University of Sussex using qualitative interview methods and sought to provide feedback on the success of the embedding approach on supporting practice for SWs³. MSW is based upon the MI counselling method, which focuses on working together with the counsellor to achieve goals in a specified time period (Miller & Rollnick, 2012). It aims to bring about change through eliciting a person's personal drive by setting clear goals that are developed collaboratively. Practitioners are trained to be non-judgmental, affirmative and empathetic, as well as purposeful, child-focused and able to clearly articulate their concerns about children's safety and wellbeing.

The practice was embedded by senior leaders in Islington and Bedfordshire⁴, who augmented the practice through a combination of feedback, coaching and observations of SWs practicing the methodology. CSC used findings from the previous evaluation to refine project activities for MP, with frameworks and training materials designed for use in both phases. By early 2018, the DWC:MWM programme had been finished; systemic changes had been embedded or were being integrated into "business as usual" service development plans.

Phase 2: Expansion into children looked-after and care leavers

Reflecting on the learning from Phase One, questions emerged regarding SWs' confidence and skill in working with children's lived experiences with traumatic histories. Phase Two aimed to address this by integrating TIP into the practice model and to extend the model and training to all parts of the service. This phase of the programme started in 2017 and sought to improve the model of care for CLA and CL (Care Leavers), building on Phase One. The model employs three main resources: MSW, the existing expertise that SWs, families, and children already possess, and the incorporation of trauma-focused social work approaches. Furthermore, senior SWs were created in each team to lead practice and coaching, and clinicians were deployed in each team to support ongoing development of SWs and FCs. The innovation team at Islington CSC noted that this

³ <https://www.gov.uk/government/publications/islington-doing-what-counts-measuring-what-matters-evaluation>

⁴ The University of Bedfordshire evaluated the scoping phase prior to the commencement of Phase 1

restructure may have initially caused some anxiety for CLA teams as they adjusted to a new way of working.

The programme was implemented in three stages. In the first stage, practitioners in CLA, which includes fostering and care leaver services, were trained in MP, including trauma-informed practice (TIP). In addition, they were trained in Dyadic Developmental Practice (DDP) as a trauma-informed intervention to support foster carers to work with children in their care. In parallel, foster carers were offered “Nurturing Attachments”, a trauma-informed training to help FC’s understand the behaviour and needs of CLA. In the second phase, these approaches are embedded into practice and are reinforced through observations, feedback, coaching, practice champions, sharing case studies in group supervision with the participation of a clinician, and adopting skills-focussed supervision for SWs. In the final phase, practice is assessed by supervisors against a framework jointly developed by the University of Bedford and the Innovations team, the outcome of which is incorporated into SW quality assurance, against which SWs performance is measured.

2. Overview of the evaluation

2.1 Evaluation questions

The evaluation sought to answer questions related to project implementation, project impact and the mechanisms of impact. Specifically, the evaluation questions included:

Implementation: how was the intervention implemented and how did its delivery vary across workers and between families?

1. Map the ways in which MP was implemented by identifying stakeholders and relationships, describing different delivery models and the nature and range of interactions between Islington CSC and families and FCs.
2. Identify factors that supported or limited programme implementation including logistics, relationships and training.
3. Identify factors which supported or limited family and FC engagement including relationships, meetings and strategies.
4. Identify expectations of the programme for staff, parents and CIN and CLA.

Impact: how and to what extent did the intervention improve staff practice and impact stability in the home for CIN and CLA families?

1. Did the intervention reduce CIN re-referrals and escalations to CPP or CLA?
2. Did the intervention increase the stability of CLA placements and reduce residential care placements?
3. Map the range and diversity of outcomes for families and for staff.
 - a) Describe satisfaction with the programme for families including whether expectations and care needs were met.
 - b) Describe the range of programme impacts on families including changes in support, relationships, attitudes to social care, education, family dynamics, educational behaviour and social care behaviour.
 - c) Describe satisfaction with the programme for staff including whether expectations and training needs were met.
 - d) Describe the range of programme impacts for staff, including any changes to knowledge, skills, workload, confidence and support structures.

Mechanisms of impact: what were the barriers and facilitators to change for families and staff?

1. Identify factors that supported or limited change for families including relationships, meetings and strategies.
2. Identify factors that supported or limited change for staff including relationships and training.

2.2 Evaluation methods

The evaluation began in January 2018 and ended in March 2020. The overall evaluation consisted of a quantitative impact evaluation, an implementation and process evaluation, and a cost evaluation. Below is a summary of the evaluation methods included:

- Difference-in-differences (DiD) analysis to evaluate impact on CIN referral- related outcomes in each of the three years after MP was introduced (2015-2018).
- DiD analysis to evaluate impact on CLA placement- related outcomes in each of the two years after MP was introduced (2017-2019)
- 8 post semi-structured interviews with CIN SWs to explore implementation and perceived outcomes of the innovation (September-December 2019)
- 5 post semi-structured interviews with CIN families to explore experiences of the innovation and self-reported outcomes (September 2019-January 2020)
- 8 post semi-structured interviews with CLA SWs to explore implementation and perceived outcomes of the innovation (September-December 2019)
- 7 semi-structured post interviews with CLA SSW to explore implementation and perceived outcomes of the innovation (September-December 2019)
- 6 semi-structured post interviews with FCs and five CLA to explore experiences of the innovation and self-reported outcomes (September-December 2019)
- 1 post focus group with 6 young person advisors (YPAs) to explore implementation and perceived outcomes of the innovation (September 2019)
- 14 (out of a possible 30) survey responses from FCs to explore their experience of training and support (December 2019)
- Unit cost analysis of fixed and variable costs for CIN and CIN staff, CLA and CLA staff, and for all CYP and all staff. (March 2020)

Quantitative impact evaluation⁵

The quantitative impact evaluation covered the CIN and CLA phases of the programme. To evaluate the impact in each phase, a quasi-experimental method known as Difference-in-Differences (DiD) analysis was employed. This method estimates the impact of the MP intervention by comparing the change in outcomes among CIN and CLA in Islington before and after the intervention with the equivalent change in outcomes among CIN and CLA in a comparison borough over the same time period. For the CIN evaluation, the comparison borough was Southend-on-Sea (referred to as Southend from here out). For the CLA evaluation, this was Barnet. Different comparison boroughs were selected for each evaluation due to the differences between the CIN and CLA populations and the difficulty of identifying a single borough that matches well across all outcomes.

For a borough to serve as a valid comparison for Islington, it is important that its time trends for the outcomes of interest (for example, percentage of re-referrals) are parallel to those in Islington up to when MP is introduced. This “parallel trends assumption”

⁵ For further details of the quantitative evaluation methods, see Appendix 4.

enables the evaluation to infer that any change in the outcomes after MP is caused by the programme itself, and not any other factors which differently affect Islington and the comparison borough. For the same reason, the comparison borough should not have introduced any intervention of its own during the evaluation period. For details on how the comparison boroughs were identified and limitations, see Appendix 3-4.

Individuals were not matched between Islington and the comparison boroughs as the exclusion of individuals in the matching process would have considerably reduced our power for the DiD analysis. For the CIN evaluation, the final sample size consisted of 10,339 referrals in Islington and 7,283 referrals in Southend. For the CLA analysis, the final sample size consisted of 857 CLA cases (1765 placements) in Islington and 845 CLA cases (2235 placements) in Barnet. For the evaluation of CIN outcomes, three outcome indicators were analysed in each of the years after intervention onset available for analysis (see Table 1), with 2012-13 used as the pre-intervention reference year. Additionally, as an exploratory DiD analysis, all post-intervention years were compared with all pre-intervention years for each of the outcome indicators.

Table 1. CIN quantitative impact evaluation outcome indicators

Outcome	Indicator
Reduce CIN re-referrals	1. Probability of CIN re-referral within 12 months of referral opening, in each of the three years after intervention onset (March 2015-2018) (Primary outcome indicator)
	2. Probability of CIN re-referral within 24 months of referral opening, in each of the two years after intervention onset (March 2015-2017) (Secondary outcome indicator)
Reduce CIN escalations to CPP or CLA	3. Probability of CIN escalations to CPP or CLA within 12 months of referral opening, in each of the three years after intervention onset (March 2015-2018) (Secondary outcome indicator)

For the evaluation of CLA outcomes, two outcome indicators were analysed in each of the years after intervention onset available for analysis (see Table 2), with 2016-17 used as the pre-intervention reference year.

Table 2. CLA quantitative impact evaluation outcome indicators

Outcome	Indicator
Increase stability of CLA placements	1. Number of placement moves CLA experienced in each of the two years after intervention onset (August 2017-2019) (Primary outcome indicator)
Reduce residential care placements	2. Number of residential care placements CLA experienced in each of the two years after intervention onset (August 2017-2019) (Secondary outcome indicator)

Placement moves were defined as any placements occurring after the initial one, with placements encompassing all possible types (for example, foster care, residential care etc.). Residential care placements were defined according to the approach taken in the Children’s Commissioner’s Stability Index 2019 (Clarke, 2019; see Appendix 4 for details). Lastly, as an additional exploratory DiD analysis, the two post-intervention years were together compared to the two pre-intervention years, for each of the two outcome indicators.

For the CIN and CLA evaluations, certain non-intervention-related factors that might impact outcomes (e.g., age and primary need code) were controlled for in the analysis by including them as covariates in the DiD regression specification (see Appendix 4 for details).

The results are presented by comparing the change in outcomes in Islington and in the comparison boroughs in each year after MP was introduced, relative to a reference year before the intervention. These changes are reported as *average marginal effects*, derived from the DiD analysis. These are changes in outcomes in a given year relative to a reference year, averaged across the unit of analysis (i.e., CIN referrals or CLA cases) and controlling for other factors (e.g., age and primary need code; see Appendix 4 for details). Additionally, time trends are presented for each outcome indicator in Islington and the comparison boroughs.

Implementation and process evaluation

The IPE explored the process of implementation, the range of outcomes and the mechanisms of change. The IPE primarily used qualitative methods to address the research objectives. Qualitative research allowed the exploration of perspectives and experiences of participants in their own words. Multiple perspectives were sought for both phases, triangulating practitioner, parent and FC and CIN and CLA responses on the same topic, providing rich descriptions of key aspects of the intervention as well as explanations for divergent perspectives and experiences. Semi-structured interviews were used with CIN families and FC and CLA cases for an in-depth exploration of their individual intervention experiences. Semi-structured interviews were used with CIN and CLA staff to provide an understanding of the intervention across multiple family cases,

and a focus group was used with YPAs to compare and contrast practitioner perspectives on implementation and impact.

Interviews and the focus groups were audio recorded and transcribed, and transcripts were managed using the Framework Approach (Ritchie et al., 2013). This involved summarising verbatim transcripts into a matrix organised by themes and sub-themes (columns) as well as by individual cases (rows). The managed data were then interpreted with the aim of identifying and categorising the range of themes present in each of the sampling groups.

In addition to qualitative methods, an online survey was distributed to FCs over a two-week period in December 2019. The survey aimed to learn more about FC experiences of the intervention, particularly to provide a deeper understanding of training modules, barriers to engaging in the intervention training and their perceived outcomes of the intervention.

Cost evaluation

A unit cost analysis was conducted for each phase of the intervention. The analysis outlined the cost of the intervention per staff member and per CYP. This involved collecting fixed and variable costs for each time period and dividing total costs by the number of staff who participated in the intervention, and the by the number of CYP who were reached by trained staff. This approach was useful in determining where funding was distributed, and identifying setup costs and ongoing costs.

2.3 Changes to evaluation methods

After engaging in early stage research activities and completing the interim report, it was concluded that it was sensible and necessary to modify the approach to the MP evaluation. The key changes are set out below (see Appendix 2 for details).

- The primary modifications to the qualitative aspects of the evaluation were:
 - a change from longitudinal to longer, more in-depth single-time point interviews;
 - unmatching SWs and SSWs from the case studies in order to discuss multiple cases and better capture the diversity of experiences families may have in the programme;
 - the addition of a focus group with personal assistants.
- The modifications to the quantitative evaluation of CIN outcomes were:
 - specifying outcome indicators to be at the level of referrals rather than participants (participants can have multiple referrals);
 - as a result of the above change, excluding one of the secondary outcome indicators concerning re-referrals due to redundancy with another outcome indicator

- combining escalations to CPP and CLA into a single outcome indicator due to the relative rarity of CLA escalations in the dataset.
- The modifications to the quantitative evaluation of CLA outcomes were:
 - extending the range of data for analysis until the end of 2019;
 - changing the primary outcome indicator to consider all placement moves;
 - analysing outcome indicators in both the first and second year after intervention onset (August 2017);
 - changing the secondary outcome indicator to measure the *number* of residential care placements rather than whether such a placement occurred;
 - deciding not to evaluate outcomes relating to Not in Education, Employment, or Training (NEET) status, absenteeism, or fixed-term and permanent exclusions due to data unavailability.

2.4 Limitations of the evaluation

- Several factors introduce uncertainty around the comparability of outcome trends between Islington and the comparison boroughs, limiting the quantitative impact evaluation's ability to attribute changes in outcomes specifically to MP⁶:
 - Barnet launched its own CLA intervention in January 2017, around the same time as MP
 - Although Southend was a suitable comparison borough for analysing CIN re-referrals, there was evidence of differing trends between Islington and Southend in CIN escalations to CPP or CLA before the introduction of MP
 - Potential differences in decision-making and/or data recording practices may exist across years and boroughs
- Given MP's focus on training and embedding of practices and the potentially delayed impact on CIN and CLA outcomes, the quantitative impact evaluation may be limited by the number of post-intervention years available for analysis
- Difficulty meeting qualitative sample quotas in the CIN parent and child cases has limited the confidence in capturing the range and diversity of family experience in the programme.
- Analysis of survey findings beyond basic descriptive statistics was limited by the overall low numbers of eligible FCs at Islington CSC.
- The scoping evaluation of CIN: MSW by the University of Surrey did not include a ToC. It was therefore not possible to discuss mechanisms of proximal indicators of impact in relation to hypothesised mechanisms.

⁶ Given the challenges of identifying a suitable comparison borough (e.g., many boroughs are simultaneously innovating), it was decided that, on balance, having imperfect comparison boroughs is preferable to potentially having no comparison boroughs for analysis.

3. Key findings

This section sets out the key findings of the evaluation. In the first subsection, the implementation of the model is described, including the process of introducing staff to a new way of working and the borough's approach to embedding the programme. The second subsection focuses on the impact of the model on the key outcomes for CIN and CLA cohorts. The third subsection discusses the mechanisms of impact and the factors influencing the effectiveness of the programme, while the final subsection presents the findings of the cost evaluation.

3.1 Implementation

The MP model represented a departure from the CSC service's traditional way of working, and therefore presented several challenges in terms of it being adopted by practitioners. The process of implementation therefore involved introducing the model to staff and training them to use it (stage 1, discussed in the first subsection), and then embedding it into practice (stage 2, discussed in the second subsection).

Stage 1: A new way of working

Key findings from Implementation Stage

1. **Motivation:** Staff participating in the interviews expressed greater motivation to engage in innovation once they could see how the approach aligned with their social work values.
2. **Training:** Scheduled timing gaps in training provision led to inconsistencies in expertise and knowledge for staff joining between quarterly training, despite the provision of induction materials. Staff learnt about new concepts through informal peer-to-peer channels, which were perceived as burdensome for trained staff interviewees.
3. **New perspectives:** The MP training gave staff new perspectives on ways they could approach their practice. However, interviewed staff were concerned about balancing high caseloads with the additional demands of the MP model.

Key stakeholders interviewed considered the MP project to be a new way of working. The various components that made up the new approach required significant changes to practice for CIN and CLA staff and FCs, and relied on staff being motivated to adopt new theories. Staff motivation was important in preliminary engagement with the innovation, which consisted of a series of training activities for all stakeholders. Being motivated and feeling that MP, compared to other working methods which were described as 'tick boxing exercises', aligned with their values and allowed staff to gain new perspectives on their existing practice as they implemented these improvements with families.

Motivation

The staff interviewed highlighted motivation as an important consideration for training provision, as it was directly related to staff engagement. For this sample of staff, prior experience with Islington innovations affected their motivation for the new way of working. In the interviews, longstanding Islington CSC staff members expressed that they were sceptical about MP, which fostered reservations towards implementation. Staff expressed feeling fatigued by what they perceived to be regular innovations, questioning whether MP was simply a repackaged version of previous models, and this led to questions around the long-term sustainability of implementing another innovation.

“I think initially, because we had done some training in Islington in the CLA team and in fostering on motivational interviewing. I think the initial reaction was, oh DDP. How is that different and how are we going to use both approaches together?”

(CLA-SSW-03)

Previous experience for staff was particularly important for their motivation to learn new things and to change their practice. The staff interviewed remembered other innovations that were initially adopted but later dropped as practice returned to the status quo. This meant that these staff members entered training without enthusiasm and needed to be convinced of the value of the new model.

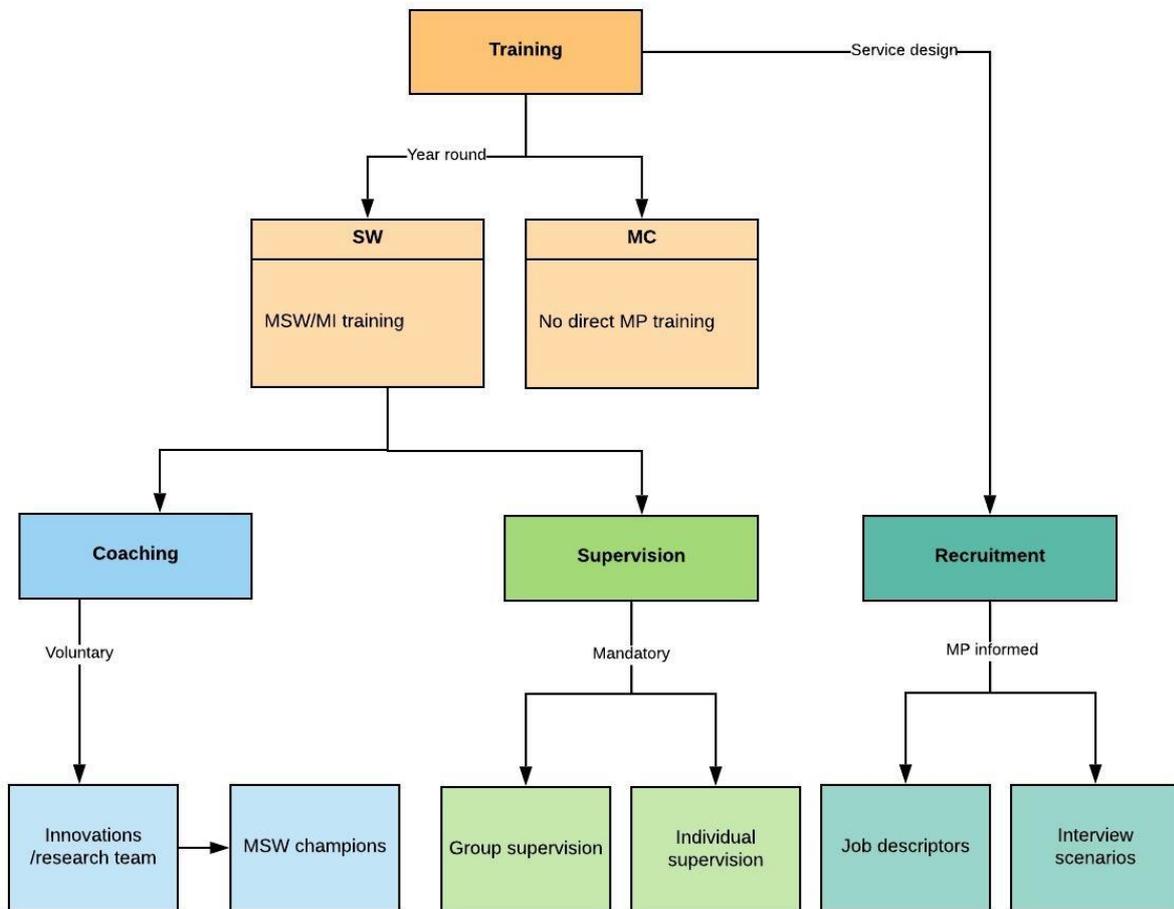
Despite varying levels of motivation to attend training, staff reported in the interviews that they were motivated to learn about the new model as it transparently aligned with their social work values of collaboration and empathy. Staff who understood the purpose of the training reported changing their attitudes once they realised the approach would emphasise collaboration with families and that the training would help them learn new ways to demonstrate empathy.

“I think it sits, for me, I think it just sits quite well with my values. I think with MI, Motivational Interviewing, the original thing, one of the aspects it took was the spirit of MI, which is where the collaboration side comes from and, yes, the working together aspect. For me, I like it.” **(CIN-SW-05)**

Training activities

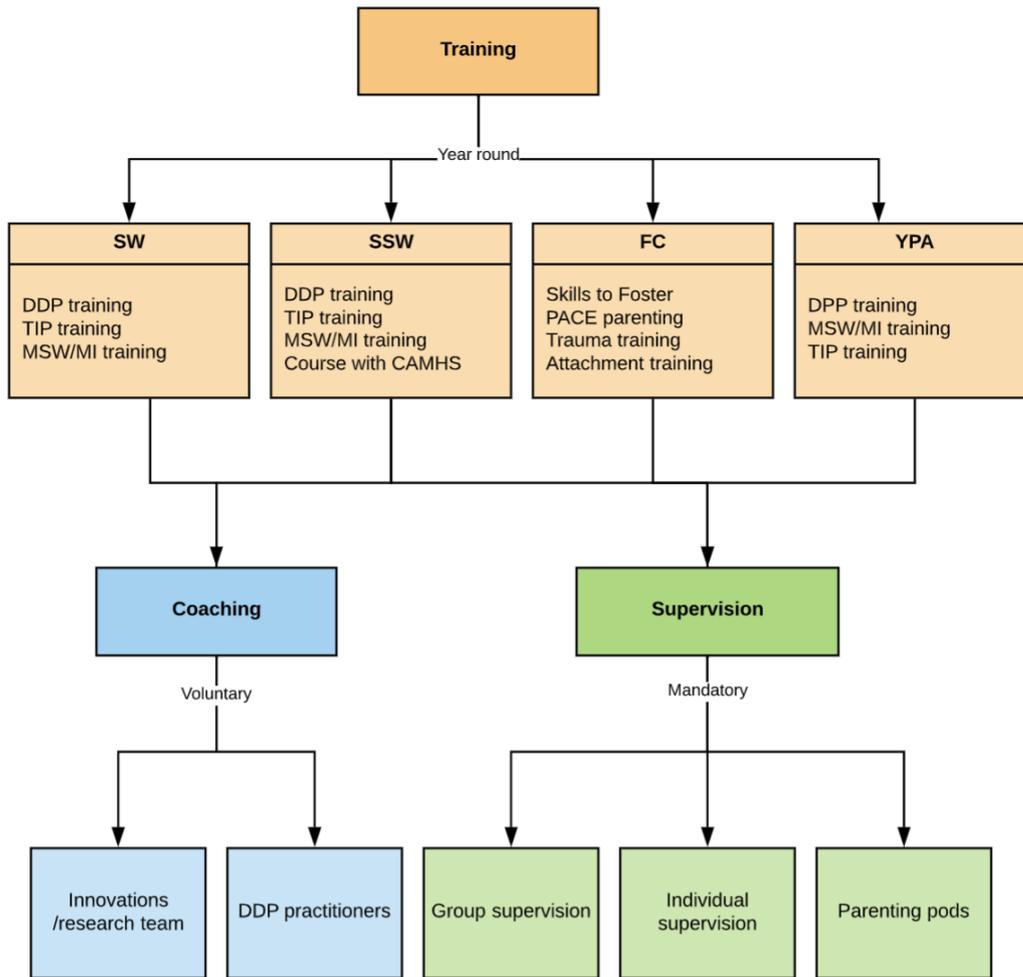
According to staff interviewed, for both CIN and CLA teams, the new way of working was primarily communicated through training. The training model of CIN was to deliver MSW and MI training to SWs, who would then receive ongoing support and in turn, support parents and main carers (MC) of CIN. The model below outlines the structure of formal training as well as ongoing support.

Figure 1. CIN cascade model



The MP CLA training package was delivered as intended. CLA staff received the appropriate training content and subsequent support as designed by the Islington CSC team. Under the CLA model, SSWs attended four-day DDP training, three-day MI training, two-day TIP training, and a two-day training course with child and adolescent mental health services (CAMHS) workers. SWs also attended MSW training and moved through level one to level two of DDP training. According to FCs interviewed, FCs received a range of training and were required to select a minimum of four or five further training sessions to attend during the year. FCs attended ‘Skills to Foster’, (lasting three days), ‘PACE parenting’, ‘Trauma training’, the eight-week training course and had ‘LGBTQ training’ upcoming. The model below outlines the formal training, as well as ongoing supports which will be explored in the subsequent section on embedding.

Figure 2. CLA cascade model



Staggered delivery

The quarterly rollout of the training programme meant that at the time of interviews, there were gaps in training, and therefore inconsistencies in expertise among staff. The training gaps were evident for FCs, as findings from the survey showed that attendance varied (see Appendix 5 Table 18). Staff attendance across CIN and CLA teams was similarly inconsistent, with some staff attending no MP courses and others reporting that they had completed multiple courses. Some staff reported not being able to fit the training around their schedules, which was consistent with data from the FCs survey where time restraints were listed as the main reason for non-attendance (see Appendix 5).

Given the quarterly rollout and the ambition to influence systemic change, staff joining between training modules waited to attend training. As staff, both untrained permanent and agency staff, were working with families, they were provided with induction packs which referred to the concepts presented in training. Based on the interviews with a sample of permanent staff, it was clear that untrained staff used informal, or unintended, learning pathways to overcome gaps in their expertise while they waited for training. In

the interviews, SWs stated that untrained staff sought knowledge from trained staff, having read their packs and having overheard their colleagues talk about key concepts and ideas around embedding.

‘I haven’t done my DDP training yet, I’m due to do that ... since coming into this team and being around, I’ve talked about it a lot with other social workers and other teams, and a lot of my foster carers have done the training as well. So I’ve got a good understanding of what it is.’ **(SSW06)**

According to the staff interviewed, practitioners were gaining valuable and unexpected knowledge through informal pathways and were proactively overcoming barriers associated with a staggered training rollout, however these unintended informal learning pathways were considered burdensome for the sample of trained staff interviewed for the evaluation. SWs stated in the interviews that agency SWs were open to the DDP approach but did not receive the training and as a result, SWs found they were putting time and effort into teaching or convincing agency staff to learn about the MP approach, and recommending relevant reading to get them thinking about the approach.

“What I found myself doing was trying to support those agency workers, to start thinking or doing a bit of reading, pointing them to some reading about what my approach was. Generally, they were quite open to that ... but they didn’t have the same level of training, so I felt like perhaps I was pulling them along a bit. I find that quite a lot with agency social workers, so if we’re not looking, if we’re not all thinking in the same way, there is a bit of handholding and trying to convince people.”

(CLA-SW-02)

New perspectives

SWs stated in their interviews that the training gave them new perspectives on ways they could approach their practice through a trauma-informed lens. Attending the training allowed staff to see the value of the new practice model and helped alleviate some of the initial resistance about the application of new models in practice. CIN staff realised that the new practice model aligned with how they liked to work with families, actively encouraging collaboration with families and the devotion of time to relationship building which they had previously felt weren’t prioritised in traditional social work practice. This included an emphasis on relationship building, which staff acknowledged as important but often difficult to prioritise due to workloads and expectations. As a result, by implementing the new way of working, staff were given permission to practice in a way that emphasised the development of relationships and moved beyond the procedural approach of former models.

“I have become more of the social worker I wanted to be when I came into the job... I didn’t just want to be tick-boxy and saying ‘Oh, yes, okay, well I’ve seen the child, my job’s done’, and more about actually trying to help support the family.” **(CIN-SW-07)**

In their interviews, staff in the CLA team said the training had changed their perspectives on trauma and its relevance to their work. They attributed the change in perspective to the intensity of the training, which was delivered over a shorter period of time than the CIN training, allowing them to engage fully in the content without the distraction of their work. This immersive approach allowed staff to recall aspects of the content, specifically scientific approaches and the impact of trauma on a young person's brain, which they stated were new concepts not previously covered in their social work training. It engaged staff and highlighted the importance of trauma informed approaches, challenging staff to consider how they can interpret and respond to difficult behaviour. Staff reported that the use of case examples, videos and role plays allowed them to gain a better understanding of how the approach worked in practice.

Even with changes in perspectives, the training did not allay all staff concerns around the practicalities of implementation. Staff anticipated that there would be tension between wanting to invest time into relationship building with families while at the same time managing high caseloads, as both of the new practice models (MSW and DDP) were associated with the expectation that staff would need to spend more time doing direct work with families. The staff interviewed felt that they already had intense workloads and viewed the new approach as idealistic in the context of the realities of existing time constraints.

“Each case becomes a much bigger time commitment per worker, and people got that and could see why it was a good thing. But it's always, can we actually deliver that you know, is it a bit utopian but actually is it realistic?” **(CIN-SW-01)**

Overall, for the sample of staff interviewed for the evaluation, there was a lack of understanding about how the new practice model could feasibly be implemented within existing caseloads, which fostered resistance and unease towards the implementation of MP, even when staff were convinced about the potential benefits of the model. This was not displayed by staff already familiar with the model, suggesting that clear communication about new practice models is critical to staff engagement and smooth implementation.

Stage 2: Embedding practice

Key findings: Embedding Phase

- 1. New skills:** The training gave SWs more confidence in their work. Increased empathy and improved listening skills allowed SWs to provide tailored and non-judgemental support to families. SWs also felt upskilled in conversational techniques to help families work through interpersonal conflict.
- 2. Emotional burden:** Due to the trauma-focused approach of MP, the SWs' role became more emotionally demanding. SWs felt they needed more supervision and debriefing opportunities, and more time for self-care and reflection.
- 3. Formal and informal support:** Formal embedding practices were facilitated or hindered by variations in supervision, coaching, observation and feedback as well as availability of practice champions and support networks. Staff also engaged in informal practice channels with friends and colleagues to embed the MP model into their daily work.

Embedding MP required staff to move from understanding the theory to developing an entirely new approach to their day-to-day practice. This needed to be internalised as a way of working with a specific theoretical mindset and was particularly important for the CLA team because the trauma-informed practice model was very different from their old way of working. While one YPA described the importance of the risk adverse nature of the old model, they noted this sometimes felt like a box-ticking exercise which created barriers to forming more therapeutic relationships.

“But now, it's like it's changed, where it's more therapeutic. I think in terms of that wall, and for me, the risk is still there, but I'm still able to now know what the risks are, but at the same time build a relationship with them, because it's incorporated that therapeutic touch, and that's what I like about the model.” (CLA PA6)

In the interviews and focus group, both CIN and CLA staff linked the training package to a development in their skills and subsequent practice.

New skills

Following the training, SWs felt more confident in their ability to deliver discrete pieces of work with families which increased the more they practised the approach and became familiar with it. Specifically, SWs felt more skilled in having conversations with families

and finding new ways to overcome hurdles that had previously hindered case progress. For example, the DDP training gave one SW more confidence in carrying out life story work (in which the child explores their past, present and future), which was an element of social work they had previously found challenging, due to its complexity and their concern around having a detrimental effect on the child if they did not get it right. From the SWs perspective, the life story work informed by the DDP training brought about a new level of understanding of the child's life.

“[Life story work is] a piece of work that I’ve always found quite scary throughout my career, but using DDP has really helped me to have confidence in carrying out that piece of work. One of my children’s FC has said that that changed her behaviour, almost overnight, that real understanding of what her story is. I got another compliment from a CAMHS professional about the other piece of life story work, that it was really considered and reflective. I don’t think I would have that understanding of the impact of early childhood experiences on behaviour and how to remedy that... without DDP training.” **(CLA-SW-02)**

FCs and CYPs appreciated how SWs and SSWs implementing the new approach were much better listeners, non-judgemental, respectful, and provided more regular support that was tailored to their needs. In their interviews, CLA SWs discussed the importance of focussing on the CYP and sitting with their feelings, however uncomfortable. SW’s highlighted their role in giving CYP a voice, acknowledging that this can still remain difficult when SWs may have to make decisions on the CYP’s behalf.

“With the children I suppose it’s about sitting with their feelings, isn’t it, and listening to what they’re saying, giving them more of a voice, maybe, but, obviously, there is a conflict of sometimes we have to listen to them but still make decisions that they don’t particularly agree with. It’s giving them an understanding.” **(CLA SW05)**

The above quote demonstrates the principles of MP where the SW made the time to ensure the CYP understood the decisions being made with a focus on relationship building, as opposed to making decisions on the CYP’s behalf without communicating the reasons. In their interviews, FCs similarly described a noticeable change in SW practice, specifically in their improved communication and listening skills. One FC highlighted the humanising effect of these changes, moving away from more procedural interactions to feeling heard and understood.

“It’s like she’s listening and that’s what I mean, that’s why you feel that kind of connection with them [the SW] and that they’re listening. You can feel them applying it [the training], you can hear the difference ... It makes me feel like they’re humanised, you know, rather than this thing about the box-ticking.”
(FC04)

In CLA staff interviews, it was clear that the training package had helped staff be more conscious of their approach, allowing them to actively work on displaying empathy and giving CYP a voice through listening. One CLA SW discussed a case where the CYP was being physically abused by their brother, and how the SW had to consciously stop themselves from interrupting and offering actions and solutions. Instead, the SW realised they had been speaking over the CYP, in their effort to help, and that they needed to provide a space for the CYP to talk about their experience.

“I'd spent more time trying to elicit how she was feeling about it and what she thought about it, and how we could work together. I did catch myself, and I over talked and was like, 'That's okay, you can do that too', la, la, and I actually stepped back from that a little bit to allow her the space”. (CLA SW07)

This example demonstrates the importance of listening, but also the level of conscious effort required for staff to practice the new model.

Emotional burden

One of the unanticipated impacts of the new approach was that it led to new burdens for staff. Because the MP approach was trauma-focused, the SW's role became more emotionally demanding as it elicited more information about trauma-related experiences. To counterbalance the emotional impact of this, staff felt they needed more supervision and debriefing opportunities with a counselling or therapeutic element, with staff recommending this support be provided by CAMHS clinicians because they are experienced in this field. This was consistent with SW descriptions of helpful line management and supervision, where staff felt able to discuss the secondary trauma they were exposed to. SWs also said that practising self-care and having time to reflect and distance themselves from their work helped them to process the trauma they were absorbing. The emotional burden also highlighted the importance of support structures, such as supervision, when helping staff embed theory into practice.

Support

Embedding MP relied on staff having opportunities to practice the new approaches in informal ways, and support from key stakeholders to reinforce the new practice model through more formal structures. Embedding MP allowed staff to develop new skills in their work with families. While staff improved their confidence and their ability to consider family perspectives, the increased focus on trauma led to a concomitant increase in the emotional burden they carried.

Informal opportunities

CLA staff took the initiative to practice the DDP approach in their interactions with their colleagues, their friends and even their own children. When talking to colleagues who had

taken the training courses, they took a collaborative approach by learning from each other, discussing any challenges and providing mutual encouragement.

“I definitely think that we support each other, and sometimes, one of us will be on the phone to a carer and we’ll be trying to use all of the good practice that we’ve been learning, and we’ll come off the phone and my colleague might say, ‘That was really good conversation’; and that’s really good and helpful.” **(SSW02)**

CLA staff also emphasised the value of CAMHS staff in developing their skills because they were experts in working in a more therapeutic way and were familiar with DDP. CAMHS staff provided opportunities to practice DDP in various ways, including having ad-hoc conversations and consultations with CLA staff.

Formal support

For the new way of working to become automatic, staff felt they needed to have ongoing support to practice the skills after training. Embedding was positively influenced by having a dedicated team whose primary responsibility was to implement the new models. While the CIN team initially had an embedded research team who conducted coaching and observations, for the CLA team, it was expected that senior staff and the innovations team would do this when the research team left. This was not fully realised and meant that work to embed practices became more inconsistent over time. Four key elements of the model provided either opportunities or challenges to embedding: supervision; coaching and observations; innovations team and practice champions support; and support from new processes and existing networks.

1. Supervision

According to the staff interviewed, supervision served as a regular, formal way for new approaches to be reinforced. The practice model was well reflected in group supervision, but less consistently emphasised in one-to-one supervision, which was manager dependent. In terms of the former, staff found group supervision helpful because they were able to bring a case to discuss with others using a DDP lens. Staff felt that it was important in these sessions to have a facilitator who knew the new practice model well, as it allowed them to facilitate and create a safe space for an honest and fruitful discussion.

“We are all kind of united specifically by the use of PACE and DDP. We’ve managed to create a healthy safe space where we can be curious without being judgemental and without being critical.” **(SSW01)**

2. Coaching, observations and feedback

Coaching, observations and feedback sessions helped the staff interviewed for the evaluation to develop their skills for working with FCs, CYPs and colleagues. Staff reported having received one or more sessions, which were facilitated by the research

team when they were embedded in Islington CSC. However, since then, the staff interviewed reported that they would've appreciated more encouragement to take up coaching sessions and expressed some confusion about who was responsible for delivering them. The expectation had been that the innovations team would initially act as coaches, after which the responsibility would be passed on to the senior SWs. According to the interviewed staff, this proved difficult as the innovations team was not well integrated in some teams, and senior and management staff were considered to be new to the practice model and perceived as lacking confidence in their ability to be a coach. In addition, despite interviewed staff acknowledging the value of observation sessions, the process of being observed could be uncomfortable, leading to lower-than-expected requests for coaching support.

3. Support from innovations team and practice champions

The innovations team and practice champions group were set up to support embedding the new practice models. Initially, the practice champions were self-selected members of the team, who were enthusiastic about the new practice model and this support was well received by the CIN team. They reported receiving monthly newsletters, participating in workshops and generally feeling like they were supportive and available to answer questions. The intention was to replicate this structure in the CLA team and it was planned that senior SWs would take on this role alongside their coaching responsibility. This replication was viewed by the interviewed staff as challenging as the senior SW role had only recently been created within the team, which meant that it was evolving and changing. As such, interviewed staff reported that they often did not approach their practice champion as they lacked awareness that they had been integrated into their team. The interviewed staff acknowledged that more stability in the senior SW role and better communication of the role to SWs would likely facilitate this support being used to better effect.

4. Support from process and networks

The staff interviewed for the evaluation reported benefiting from the support offered through the changes to recruitment processes, through supervisors and through wider networks. For successful embedding, all stakeholders needed to be on board with MP from initial recruitment through to training and wider professional networks such as schools. The interview process for all staff was changed to reflect the new practice model principles, screening potential candidates for whether they have a willingness to learn and practice in line with the new model.

Alongside these changes, CLA staff identified challenges in collaborating with related organisations, such as schools, that did not have an understanding of the new way of working. As a result, YPAs, who worked with CYP over the age of 16, sometimes felt like they were fighting against the system in trying to balance doing what was best for the CYP from a trauma-informed view and maintaining relationships with external agencies.

One SW discussed the issue of applying trauma-based approaches to CLA, when schools continued to view behaviour through a more traditional and punitive lens.

“[The school] is not thinking, actually, what needs to be put in place to ensure that that young person feels nurtured ...for them to feel they can be open enough to tell them, actually, they’re quite anxious, they’re quite frustrated ... but they’re not seeing that, they’re just seeing the detentions and their response is quite - as a school, I guess, very clean-cut.” **(SSW05)**

Limitations due to caseloads

High caseloads limited opportunities to practice the more intensive work required by the new model. CLA staff reported that their caseloads were not reduced to allow for the additional training and supervision required, nor the additional time to conduct and integrate this more intensive work into their everyday practice. This was noticed by carers and CYPs who sometimes felt they had a ‘tokenistic’ relationship with their SW, which undermined trust and engagement. They felt that some SWs were excellent and went above and beyond to support them, while others did the bare minimum. Equally, staff felt tired and resentful due to limited headspace, and argued that they needed more time to build relationships and apply the new skills consistently for the new practical model to reach its full potential.

3.2 Impact

The impact of MP was quantitatively assessed using a DiD analysis. This section sets out the findings of that analysis for outcomes among CIN and CLA.⁷ The results are presented by comparing the change in outcomes in Islington and in the comparison boroughs in each year after MP was introduced, relative to a reference year before the intervention. These changes are reported as *average marginal effects*. These are changes in outcomes relative to a reference year, averaged across the unit of analysis (i.e., CIN referrals or CLA cases) and controlling for other factors such as age and primary need code. Further details on methods, results, and additional analyses are provided in Appendix 4.

⁷ The figures presented here (e.g., number of re-referrals and placements) are not directly comparable with official DfE statistics due to the specifics of the evaluation design.

Key findings from quantitative impact evaluation

- 1. MP initially increased then decreased CIN re-referrals occurring within 12 months:** MP initially led to a statistically significant increase in the probability of CIN referrals being re-referred within 12 months, but subsequently led to a statistically significant decrease in this probability in the third year after implementation.
- 2. MP did not impact CIN re-referrals occurring within 24 months:** There was no statistically significant impact on the probability of CIN referrals being re-referred within 24 months.
- 3. Ambiguous evidence around MP and escalations to CPP or CLA:** MP was associated with a statistically significant increase in the probability of CIN referrals escalating to CPP or CLA within 12 months in the third year after implementation, but interpretation of this analysis is severely limited by differences in outcome trends between Islington and Southend (the comparison borough) before the introduction of MP.
- 4. Limited evidence for link between MP and a decrease in CLA placement moves:** MP was associated with a marginally statistically significant decrease in the number of CLA placement moves when considering both post-intervention years together. However, the evaluation of CLA outcomes is limited by uncertainty around the comparability of outcome trends in Islington and Barnet (the comparison borough).
- 5. No link between MP and residential care placements:** There was no statistically significant association between the programme and the number of residential care placements.

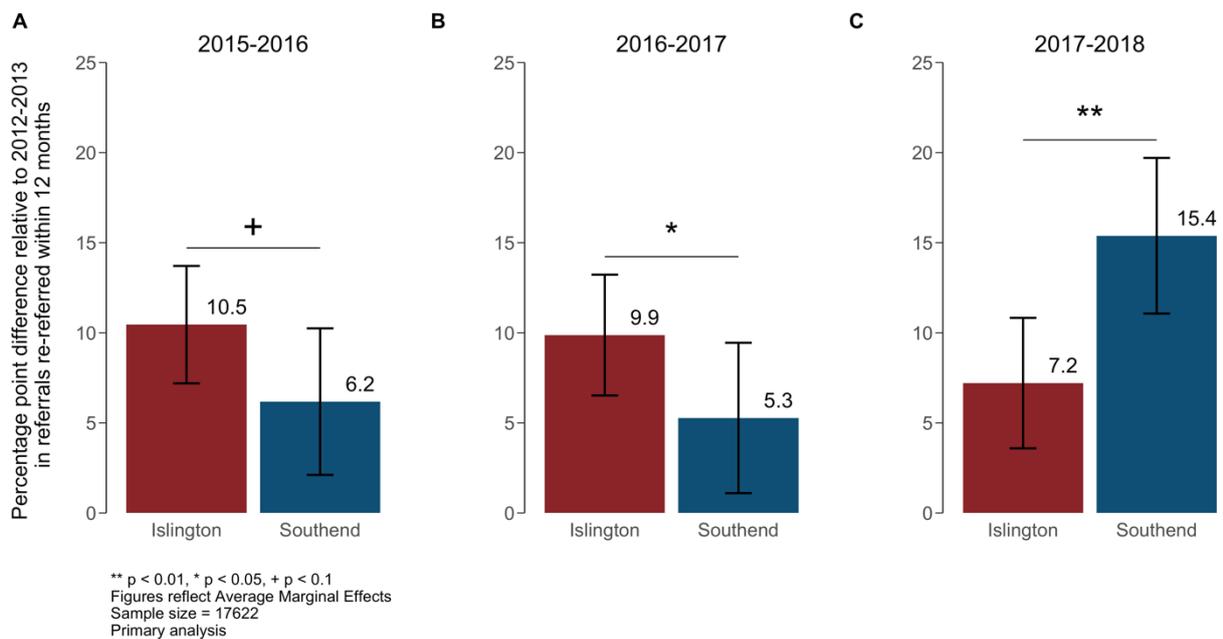
Outcomes for CIN

Probability of CIN re-referral within 12 months

In the first two years after the intervention started (2015-16 and 2016-17), the analysis shows that, when compared to Southend, MP led to an increase in the probability of CIN referrals in Islington experiencing a re-referral within 12 months. Relative to 2012-13, in 2015-16 there was a 10.5 percentage point (pp) increase in CIN referrals in Islington experiencing a re-referral within 12 months, whereas in Southend this was only a 6.5 pp increase. The difference between these figures was just above the conventional statistical threshold ($p = 0.08$). In 2016-17, there was 9.9 pp increase in CIN referrals leading to a re-referral in Islington, whereas in Southend this was only a 5.3 pp increase, a statistically significant effect ($p = 0.04$).

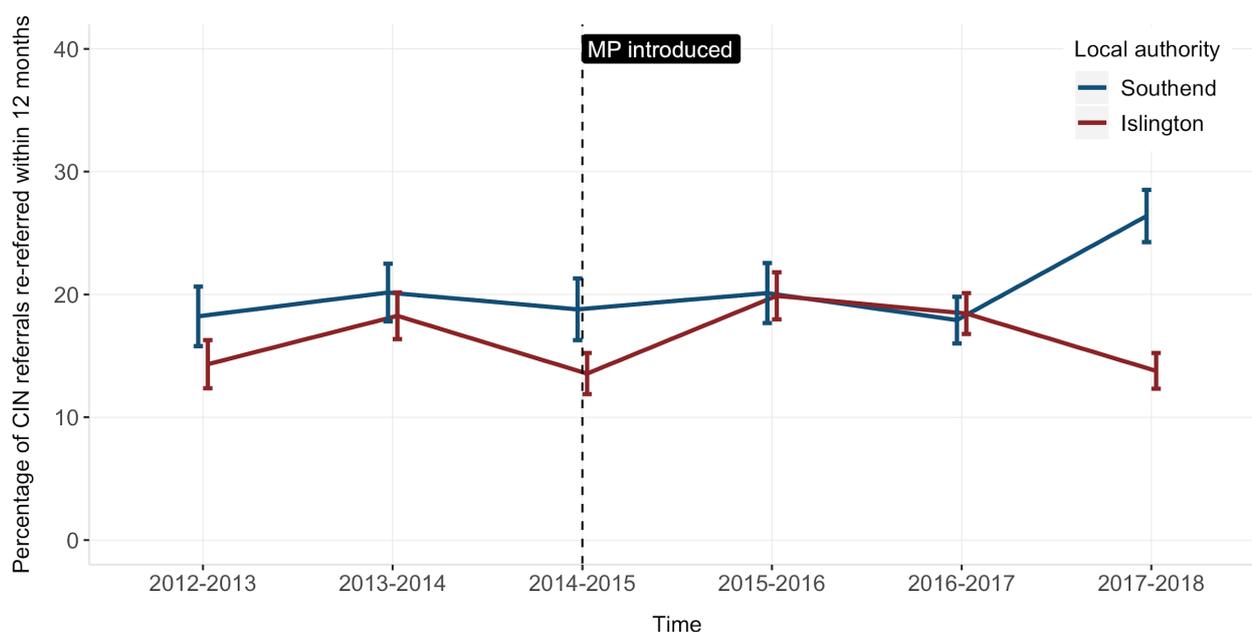
In contrast, in the third year there was evidence that, when compared to Southend, CIN referrals in Islington experienced a significant decrease in the probability of a re-referral within 12 months. Relative to 2012-2013, in 2017-18 there was a 7.2 pp increase in Islington in CIN referrals leading to a re-referral within 12 months, whereas Southend experienced a 15.4 pp increase in this figure, a statistically significant difference ($p < 0.01$). Figure 3 shows the observed changes in Islington and Southend for all three years (reported as average marginal effects).

Figure 3. Percentage point differences in CIN referrals re-referred within 12 months in Islington and Southend in the three years after MP onset



Importantly, the effect in 2017-18 is partly driven by an increase in the probability of re-referrals in Southend, rather than solely due to a decrease in the probability of re-referrals in Islington. This is evident in Figure 4, which shows the time trends in CIN re-referrals for both boroughs. The cause of this increase in Southend is unclear. However, based on the observed parallel trends between Islington and Southend before the intervention, it can be inferred that Islington would have experienced a similar increase in the probability of re-referrals if MP had not been introduced. These results are therefore interpreted as the causal impact of MP in Islington.

Figure 4. Time trends for the percentage of CIN referrals re-referred within 12 months



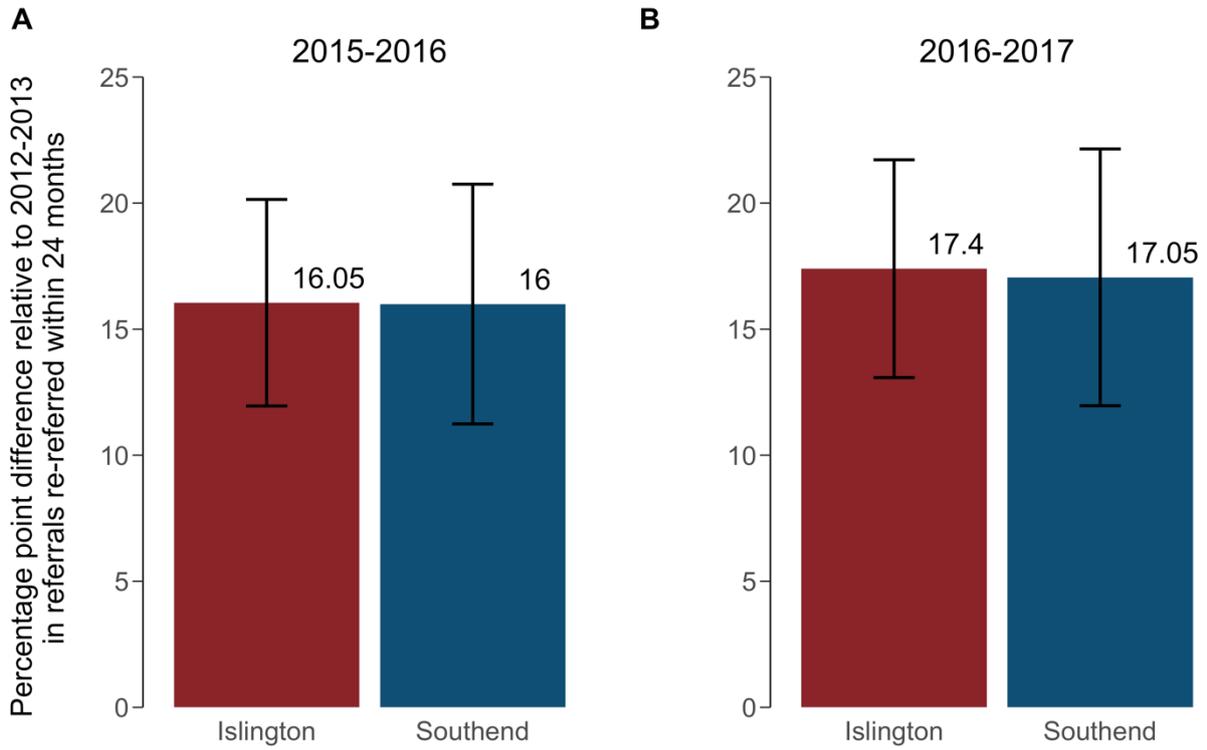
Lastly, a DiD analysis was performed to test whether there was an overall impact when comparing all the three post-intervention years to all the three pre-intervention years in Islington and Southend, but there was no statistically significant effect ($p = 0.38$). When considering the analyses of the individual years together, this overall null result can be explained by the increases in re-referrals in the first two years being numerically cancelled out by the decrease in the third year.

Probability of CIN re-referral within 24 months

A similar analysis was performed to test whether there was any impact on the probability that CIN referrals led to a re-referral within 24 months. This indicator aims to capture any impact that MP may have had on longer term outcomes for CIN referrals in Islington. The analysis found that, when compared to Southend, in the two post-intervention years there was no significant impact of MP on the probability of a re-referral within 24 months.

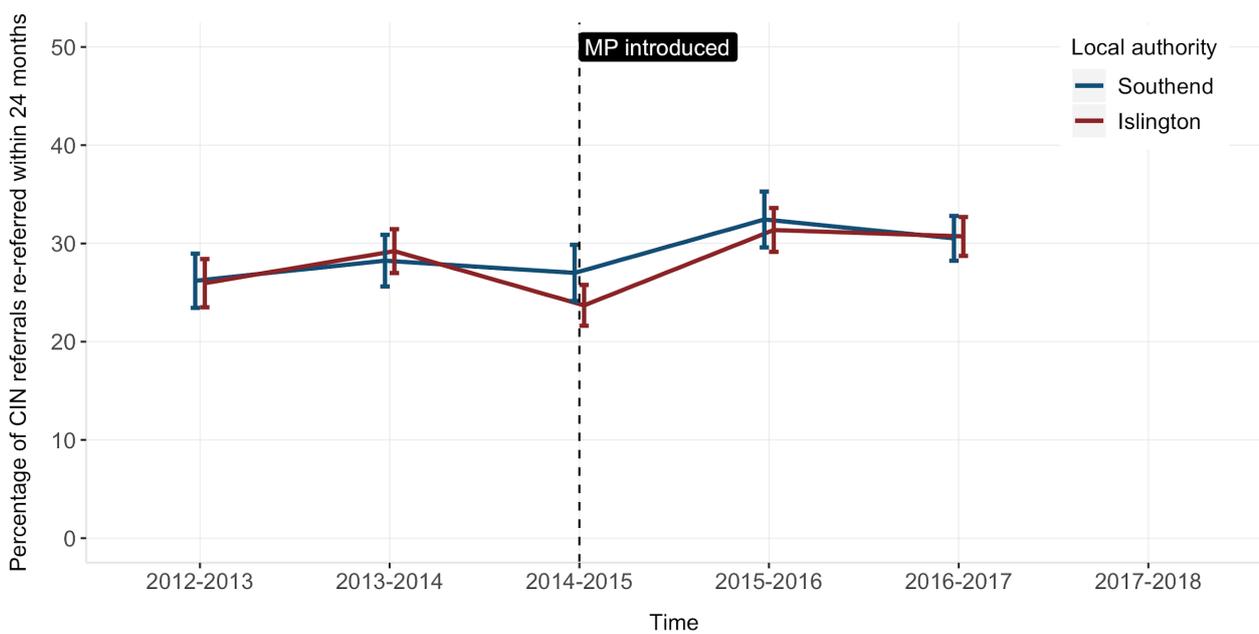
Relative to 2012-13, in 2015-16, there was a 16.1 pp increase in Islington in CIN referrals experiencing a re-referral within 24 months, whereas in Southend there was a 16 pp increase, a difference that is not statistically significant ($p = 0.98$). Similarly, in 2016-17, there was a 17.4 pp increase in Islington in CIN referrals leading to a re-referral within 24 months, compared to a 17.1 pp increase in Southend ($p = 0.9$). There was also no significant effect when comparing both of the post-intervention years to all the three pre-intervention years in Islington and Southend ($p = 0.61$). Outcomes for both years are shown in Figure 5. Time trends for the percentage of CIN re-referrals within 24 months were very similar for Islington and Southend (Figure 6).

Figure 5. Percentage point differences in CIN referrals re-referred within 24 months in Islington and Southend in the two years after MP onset



** p < 0.01, * p < 0.05, + p < 0.1
 Figures reflect Average Marginal Effects
 Sample size = 13807
 Secondary analysis

Figure 6: Time trends for the percentage of CIN referrals re-referred within 24 months



Probability of escalation to CPP or CLA within 12 months

Lastly, an analysis was performed to test for any impact on the probability that CIN referrals would escalate to CPP or CLA within 12 months. There are several important caveats to these results that require clarification.

First, although Southend was a suitable comparison borough for analysing CIN referrals, there was evidence that it was not a suitable comparison borough for escalations. Relative to 2012-13, there was a statistically significant difference in trends between Islington and Southend in 2014-15, the year *before* intervention onset ($p < 0.01$). This suggests that Islington and Southend may have experienced differing trends in escalations even if MP had not been introduced in Islington. This means that the analysis of this outcome is severely limited in its ability to establish that MP *caused* changes in escalations in Islington. Therefore, the effects here are interpreted as associations between MP and the observed changes in escalations. Further research is needed to attribute these changes specifically to MP or other factors.⁸

Second, the effect in 2014-15 is itself difficult to interpret. Given that this year is just prior to intervention onset, some CIN referrals opened in this year have continued into the next year, and may have experienced part of MP when it was introduced. Therefore, the outcomes in 2014-2015 may also partially reflect the impact of MP on these CIN referrals. It is ambiguous whether the effect in 2014-2015 reflects the partial impact of MP, or unrelated differences between Islington and Southend (see Appendix 4 for details). Interpretation of this analysis is therefore severely limited.

With these caveats in mind, the analysis showed that, when compared to Southend, there was no significant association between MP and the probability of CIN referrals escalating to CPP or CLA in the first or second post-intervention year in Islington. Relative to 2012-13, in 2015-16, there was an 8.8 pp increase in CIN referrals in Islington experiencing escalations, compared to a 9.2 pp increase in Southend ($p = 0.85$). In 2016-17, there was a 9 pp increase in CIN referrals experiencing escalations, compared to a 6.7 pp increase in Southend ($p = 0.15$).

However, in the third post-intervention year, MP was associated with a significant *increase* in the probability of CIN referrals in Islington experiencing escalations. In 2017-18, there was an 8.9 pp increase in CIN referrals experiencing escalations, compared to a 3.4 pp increase in Southend, a statistically significant difference ($p < 0.01$). Overall, when comparing all three post-intervention years to all three pre-intervention years in a DiD analysis, there was an increase in the probability of escalations in Islington after the intervention ($p < 0.01$). Outcomes for all three years and time trends for Islington and Southend are shown in Appendix 4.

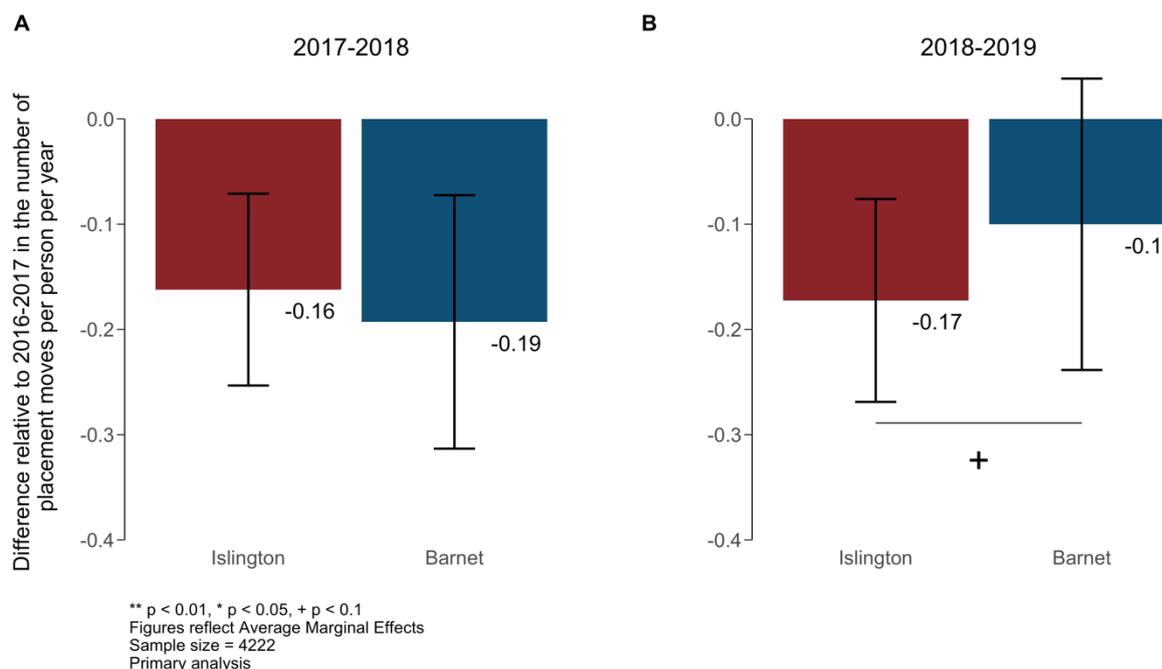
⁸ By this, it is meant that there is a statistical relationship between MP and changes in the outcome, but there is currently insufficient evidence to conclude that this relationship is causal.

Outcomes for CLA

Number of placement moves

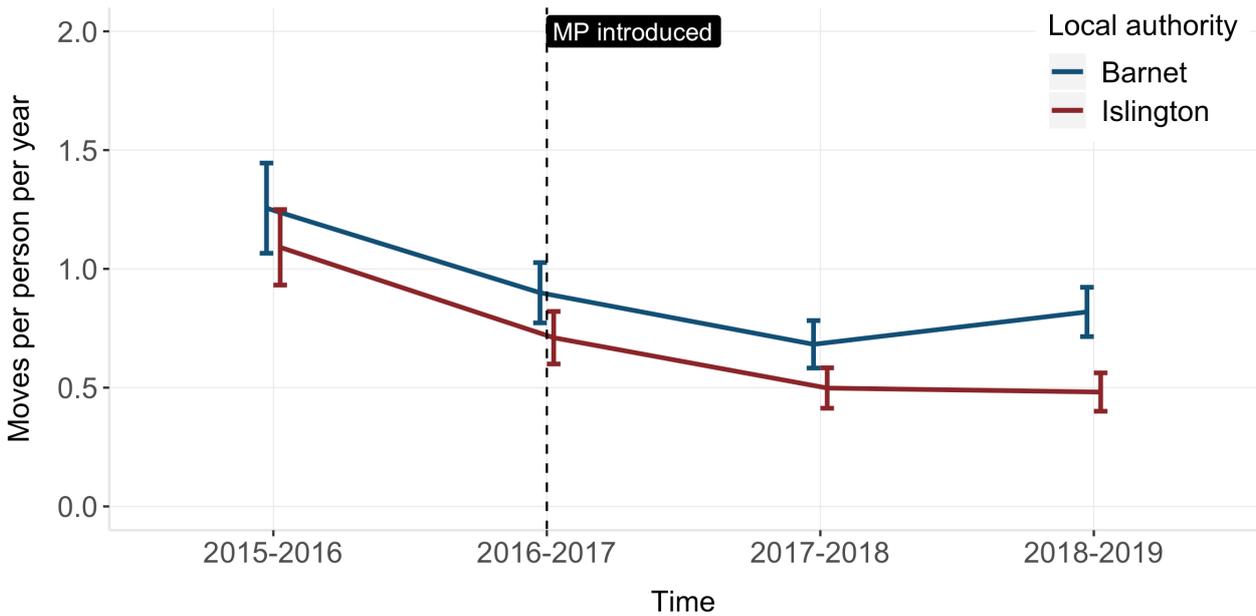
The evaluation did not detect any significant association between MP and the number of placement moves per CLA per year in the first year after intervention onset. Relative to 2016-17, in 2017-18, the number of moves per CLA per year in Islington decreased by 0.16 moves, whereas in Barnet, this figure decreased by 0.19 moves, a difference which is not statistically significant ($p = 0.66$). However, there was a marginal decrease in the number of moves that CLA in Islington experienced in the second year after intervention onset. In 2018-19, the number of moves per CLA per year in Islington decreased by 0.17 moves, compared to a decrease of 0.1 moves in Barnet, a difference above the conventional statistical threshold ($p = 0.099$). Figure 7 shows the changes in Islington and Barnet for both years (reported as average marginal effects).

Figure 7. Differences in the number of placement moves that CLA experienced in Islington and Barnet in the two years after MP onset



Importantly, the marginally significant effect in 2018-19 is partly driven by a slight increase in the number of moves in Barnet in this year, rather than a decrease in moves in Islington, as can be seen in Figure 8. The cause of this increase in Barnet is unclear.

Figure 8. Time trends for the number of placement moves that CLA experienced

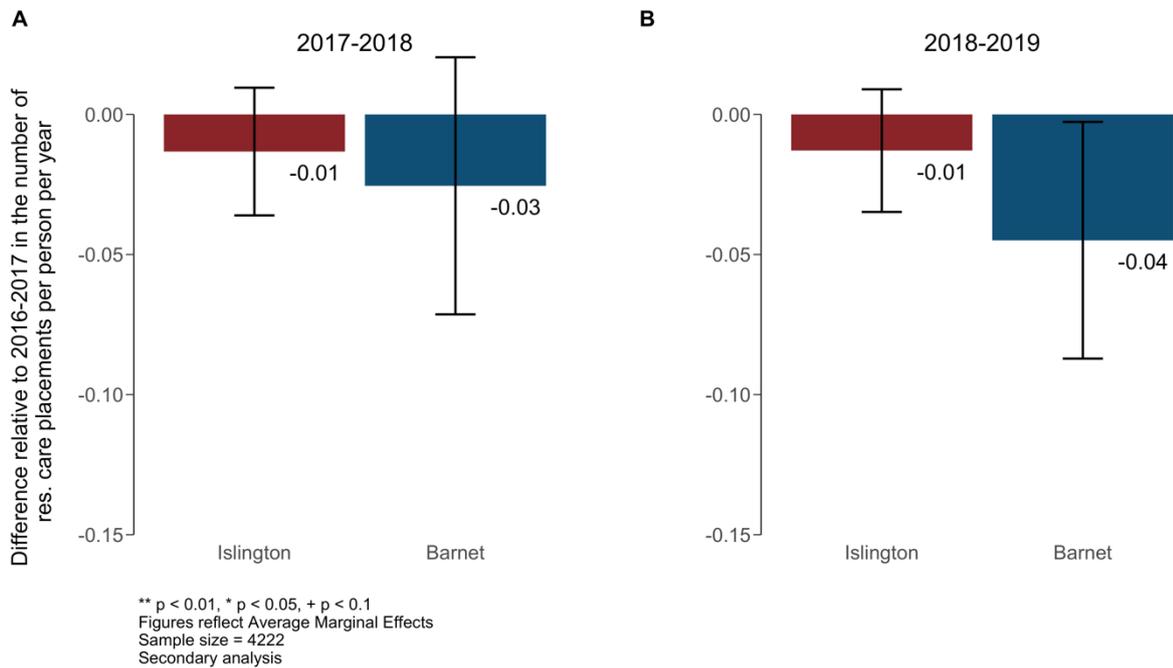


When analysing both years together in a DiD analysis, there was an effect just at the conventional statistical threshold ($p = 0.05$). Given the uncertainty around the comparability of trends in Islington and Barnet (see Section 2.4), and the statistical uncertainty around these results, these findings provide only limited evidence of an association between MP and the number of placement moves that CLA experienced in Islington.

Number of residential care placements

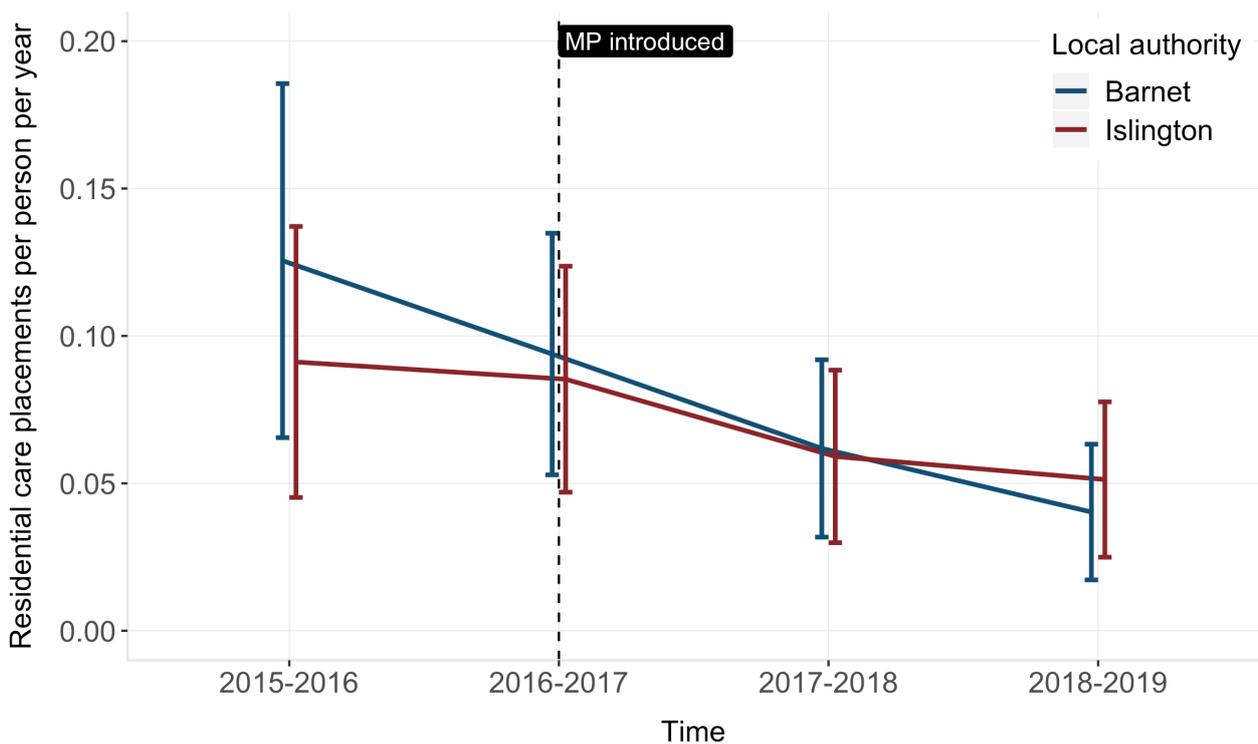
The evaluation did not detect a significant association between MP and the number of residential care placements that CLA experienced in either the first (2017-18) or second (2018-19) year after intervention onset, or when analysing both years together. Relative to 2016-17, in 2017-18, the average number of residential care placements per CLA per year decreased by 0.01 placements, compared to a decrease of 0.03 placements in Barnet, a difference which is not statistically significant ($p = 0.93$). In 2018-19, the average number of residential care placements per CLA per year decreased by 0.01 placements, compared to a decrease of 0.04 placements in Barnet, a difference which again is not statistically significant ($p = 0.33$). Finally, there was also no significant effect when analysing both years together ($p = 0.33$). These changes in Islington and Barnet for both years are shown in Figure 9.

Figure 9. Differences in the number of residential care placements that CLA experienced in Islington and Barnet in the two years after MP onset



Islington and Barnet show very similar trends in this outcome across all four years, as can be seen in Figure 10.

Figure 10. Time trends for the number of residential care placements that CLA experienced



3.3 Proximal indicators of impact for families

Key findings: Proximal indicators of stability for families

- Stability for families was reported when MP was delivered as intended. Individual differences in receptivity to the interventions and variations in embedding and SW support led to differences in stability outcomes for families which explains the lack of impact on primary outcomes. When present, stability was described as improvements in:
- **Relationships:** Stability was influenced through trusted and more empathetic relationships between MCs, FC's and SWs. Relationships were mediated by; improved confidence in parenting abilities and practitioner confidence to deliver MP; increased trust between families and practitioners and improved collaboration between families and SWs and between practitioners in their working relationships.
- **Wider support networks:** Having access to shared support and therapeutic systems promoted stability, but was not available to all families in-need.

The ToC for CLA proposed that the primary outcome of stability, as measured by stability of placements, reductions in residential care placements, permanence of care, stability of caring relationships and SW/FC/SSW retention, were influenced by changes in practice at the SSW, SW and FC level, as they took on an MP approach. These changes in practice were hypothesised to trigger changes leading to non-judgmental attitudes towards CYP behaviour, a more empathetic approach to CYPs and the creation of a safe environment for CYPs. This in turn led to more positive relationships between CLAs and adults, more trusting relationships and an improved understanding of the CYPs own needs.

These mechanisms were proposed to be underpinned by improved trust between FCs, SWs and SSWs and more positive working relationships between FCs and SWS and SSWs. For SWs the training was proposed to have led to more confidence in MP, a focus on skills not metrics and improved direct work between the SW and CYP. The role of the SSW was proposed to promote more self-reflexivity in SWs during supervision and promote a non-judgemental approach to their practice.

Whilst the impact analysis revealed limited evidence of improved stability on primary impact outcomes, the qualitative analysis revealed proximal indications of good MP practice and varying degrees of perceived family and emotional stability. Some, but not all mechanisms of change were observed: The MP programme intended to deliver strength-based practices of MSW (CIN), and DDP and TIP (CLA) through an intensive skills-based training programme. However, varying levels of consistency of training provision, embedding and practice across the MP programme were evidenced. This impacted family stability outcomes: when MP was delivered as intended, strength-based

practice and associated skills improved. This in turn led to better relationships between families and practitioners, improved confidence, collaboration, trust and increased stability for families. However, these benefits were not reported by all families, due to variations in provision of MP and examples of unstable environments for families. Thus there was evidence of some interim good practice, but it was not ubiquitous, subsequently elements of good practice did not translate into overall positive impacts on primary outcomes as reported in the quantitative analysis.

Relationships

Proximal indicators of good MP practice included improved relationships between families and SWs which, consistent with the CLA ToC, suggests that more stable placements are driven by better support by Islington CSC.

MP training allowed SSWs to have improved relationships with FCs, who in turn improved their empathy and relatability to CLA. Consistent with the ToC, adopting the new MP approach, which involved skills linked to empathy, acceptance and curiosity, improved SSWs/SWs relationships with families, and FCs relationships with CLAs. According to SSWs, FCs demonstrated better awareness of CYPs behaviour and responded more appropriately to challenging behaviour such as trying to be understanding and accepting of the roots of behavioural difficulties. For CLA, DDP was described by SWs as a communication guide for having therapeutic conversations with MCs, with the aim of helping them to understand the emotions and behaviours of YPs. For CIN, SWs reported the MSW emphasis on relational working, encouraging and facilitating problem solving and drawing on an individual's motivation rather than dictating to them, built stronger relationships, which mediated proximal stability indicators for some CYPs. This was consistent with reports from CYPs, who described feeling better understood, demonstrating that DDP, MSW and TIP could be effective when successfully implemented.

“The latest one [SW], yes [...] Well, she's more understanding and she makes you feel a bit more good about yourself, I would say that apart from the others. Yes, she's just more understanding, that's it.” (CIN01)

Confidence

MCs experienced an increase in confidence in their parenting and ability to deal with problems that arose, due to improved relationships with their SW. Increased confidence in the MC was driven by increased empathy and a non-judgemental approach of the SW. SWs were described by MCs as gathering more well rounded information and comprehensive understanding of families and their experiences, indicating that SWs were using the MP approach. For example, in the CLA evaluation, a FC described their SW as having high expectations of the FC and the SW could be critical. Post MP intervention, the FC described the SW as less judgemental, more accepting, empathetic and understanding. This led them to seeing the SW as a source of support and help, resulting in increased stability for the FCs as they were more likely to stick with difficulties within a

placement and less likely to experience blocked care. This links directly to the proposed mechanisms of change in the CLA ToC.

Across both the CIN and CLA models SWs felt more confident working with families following attending the various MWM training components. Specifically, SWs experienced more confidence having conversations with families and finding new ways to overcome hurdles that have left their cases 'stuck' and not moving forward. SWs also reported how having non-judgemental supervisory support and feedback, and ongoing practice of these new skills, increased their confidence in their practice and mediated a stronger more empathetic understanding of the underpinnings of CYPs' behaviour.

Trust

Underlying improved relationships between families and their SW was an increase in trust. For MCs and FCs, this was driven by receiving consistent support from the same professional supporting their family. In the past, FCs reported experiencing less consistency in support, stating they would never have the same worker call them back. In one example, a CYP in the CIN intervention described how their SW would take the time to play games with them, ask about their day and give advice on how to cope with bullies at school. However, due to the level of historical distrust this CYP had experienced with Islington CSC, despite the effort the SW was investing in the relationships, gaining the young person's trust was described as a slow, step-by-step process.

"Sometimes I don't really feel comfortable talking about stuff, because it makes me sad and angry. When I feel okay telling him [the SW] about stuff, he's okay with it. If he says, 'How do you feel when this and that happens?' And then I say, 'I don't really want to talk about it. Can we pass on to the next question?'" **(CIN05)**

Equally, another MC in the CIN intervention, whose child had engaged very well with their SW, described them as feeling comfortable talking to their SW and described the relationship as stable, kind and caring.

"Because when we came back, after a short time she started school, so I was seeing [SW] [...] I was taking her with me for her to have a chance to talk because she really loves her and she wanted to meet her. Like you say, she was the first face that was smiling for us and saying; Everything is going to be okay; so we're attached to her."
(CIN & MC04)

This demonstrates that some families were beginning to respond to the new MP approach, and developing more trusted relationships with SWs, but response varied depending on individual receptivity to the SWs. This highlights how working with the MP model, and building those trusted relationships was a work in progress over time, requiring SWs to be consistently applying and embedding their newly learnt skills.

Collaboration

Another important element in building trusted relationships evidenced from the qualitative analysis was for the SW to work collaboratively with the CYP, the parent and carer and other professionals working with the family. Reflecting this, one parent described how pleased they were to be 'kept in the loop'. In the past, families often made changes that their SW instructed them to make, but when the case was closed were unable to sustain those changes because of a lack of motivation. Consistent with the ToC, SWs described that working collaboratively on change meant that families felt more empowered and were more likely to sustain improvements.

"It's basically about taking an approach that's empowering, that is collaborative.

Rather than maybe a more directive model or an approach where you're telling people what to do, it's more exploring with them what changes they want to happen and supporting them to identify their own goals and move towards them."

(CIN-SW-05)

Although not identified in the CLA ToC, collaboration between professionals was also an important proximal mechanism of change. Different professionals and teams worked collaboratively in their uptake of the approach which resulted in more consistency across different sources of support using the new model. For example, staff would work together, using informal training practices to develop their new skills. Additionally, the SW, FC and school staff had more of a shared understanding as to how they're expected to behave and communicate with CLAs.

These examples of building trust and collaborative working demonstrate that there is evidence of beginnings of good MP practice as reflected as mechanisms of change in the ToC. However, the degree to which this was experienced differed across families; some families had trusting and collaborative relationships with their SW, whilst others were still a work in progress. Equally, practitioners demonstrated different degrees of collaborative working, which supports the limited evidence of the primary impact findings.

Wider support systems

Alongside improvements in relationships, trust and collaboration, having access to wider support systems led to increased confidence in families and foster families, and subsequent proximal stability outcomes. In contrast to the ToC, this was not a proposed mechanism of change, although the impacts on wellbeing were considered as secondary outcomes. Having the opportunity to share experiences with others who had had similar experiences positively impacted families' mental and emotional wellbeing. The peer support groups that FCs attended as part of the CLA intervention, had been beneficial for them; they were perceived by SSWs to be able to be vulnerable with one another and open up more when talking about their experiences. This was supported by the FC survey findings where 57% (8/14) rated foster care social support groups as good or

excellent. Being able to turn to close support networks also had a positive impact on families' wellbeing.

Having access to therapeutic services also influenced emotional stability. A MC described that they had received more emotional support than before and that their CYP had accessed a school-based therapy programme. However, other families had therapeutic support services pending, which resulted in feelings of instability. For example, a MC explained that their family's SW had tried to help him gain access to a men's support group which he envisioned would be beneficial for him when it started. Importantly, this MC would have liked to have received mental health support during a challenging time.

Results from the FC survey (Table 3) are consistent with these findings and reflect a perceived need for increased support across a range of outcomes including financial, mental health and practitioner support.

Table 3. Support priorities for foster carers (N=14)

Support type	% (n)
Financial support	29 (4)
CAMHS supported	21 (3)
Respite foster care support	21 (3)
SSW or SW support	21 (3)
Training provision	7 (1)
Out of hours emergency support	0 (0)
Support groups for FCs	0 (0)

Barriers and limitations to impact

Whilst there is evidence of elements of good practice and proximal indicators of perceived stability for families, this was not experienced by all families, which explains why significant improvements were not seen on primary impact evaluation outcomes. There were clear examples of instability for families which were linked to factors outside of the control of the intervention, such as financial or housing issues. Equally, extreme circumstance made MP challenging to implement, where crisis management was understandably prioritised.

“When we came back, we were really homeless, hopeless, broken. We had no money, nothing, and we needed more financial support. I had to borrow some money from a

friend, and I still can't give it back because I'm still not having that much... We are on Universal Credit and her Child Benefit was refused until now." **(CIN04)**

For families in dire situations such as homelessness, basic needs such as food, clothing and shelter seriously compromised any efforts to improve relationships and increase family stability. This indicates that for families living in chaotic or unstable physical and environmental conditions, the priority was to provide practical support rather than employ the more incremental and relationship-based techniques emphasised within the MP programme. This indicates that degree of stability may be required for MP techniques to be as effective as they are in other contexts, however this requires further exploration.

A potential backfire effect of the programme not outlined on the CLA ToC was that improved relationships between families and their SWs led to greater levels of anxiety about the support ending, particularly when families felt that support was required. For some families, there were real concerns about their ability to cope without their SW.

"Yes, because I wouldn't know how to keep that line of communication between myself and the kids' father [without her SW]. If she helps us to work on it until then, I think we would be a much better place without needing a third party to help us with that, and until then, I want her to stay on, yes, so luckily, she is." **(MC01)**

From the SWs' point of view, the end of their involvement could be challenging because of the investment they had made in developing a relationship with the child and their family:

"Then there's the sense of responsibility as well, I have to say, you build relationships with people and it's really difficult to say goodbye to them and you do, as a social worker, they get to a certain age, you have to hand them over, or you get another job. That's really difficult because you tell these people, the children, you really mean something to me, you've impacted me all my life, and then you've got to cut them off, that's quite difficult." **(CLA-SW-02)**

The challenges in consistent embedding practices, variations in quality of supervision and training for SWs, contextual factors such as severe instability like homelessness or backfire effects when CSC support was withdrawn, provides insights explaining the limited evidence on primary outcomes of impact.

3.4 Cost evaluation

Due to the uncertainty around the impact of the MP project on either CIN or CLA stability outcomes, a cost benefit analysis was unfeasible. Instead, a unit cost analysis was conducted on fixed and variable costs for the two intervention time periods (2015-2017 and 2017-2019). Round 1 of the project received funding to the amount of £2,961,087 and Round 2 received funding to the amount of £1,919,033.

Costs included ongoing expenditure on staff hires and staff time on training, as well as setup costs including IT purchases. The full costs are listed in Table 4 below.

Table 4. Full lists of costs per funding round

Cost	Funding Round 1 (2015-2017)	Funding Round 2 (2017-2019)	Total
Staff-New Hire	£1,550,244	£1,245,404	£2,795,648
Staff-Project	£253,504	£317,039	£570,543
Staff-CAMHS/Health Workers	£371,183	£215,548	£586,731
Staff-Sessional Workers	£11,136	£5,949	£17,085
Staff-Management Time	£174,601	£50,000	£224,601
Training/recruitment	£32,042	£128,186	£160,228
Travel & Subsistence	£769	£996	£1,765
IT costs hardware/software	£33,044	£665	£33,709
Other costs	£31,713	£53,974	£85,147
Total	£2,458,234	£2,017,760	£4,475,994

The unit costs are presented based on the number of staff members who participated in the intervention by attending training and receiving ongoing support. Unit costs for CYP are based on how many CYP worked with staff during this time. Table 5 below outlines the numbers of CYP and staff and Table 6 outlines the unit costs. The unit costs were calculated by dividing the total cost by the total number of staff or CYP who received the intervention in each phase.

Table 5. Full numbers of CYP and Staff per funding round

	CYP	Staff
Funding Round 1 (2015-2017)	7,680	150
Funding Round 2 (2017-2019)	1,008	900
Total	8,688	1050

Table 6. Unit costs

	Unit Cost (£)
Overall CYP (2015-2019)	515
Overall Staff (2015-2019)	4,263
CIN (2015-2017)	320
CIN Staff (2015-2017)	16,388
CLA (2017-2019)	2,242
CLA Staff (2017-2019)	2,002

As demonstrated in Table 6, the intervention is considerably more expensive per unit for staff than for CYP. This is reasonable as there are considerably more CYP receiving the effects of the intervention once staff from both CIN and CLA teams have been trained. For other boroughs wishing to adopt this intervention, it is clear that the setup requires costs that aren't sustained for the rest of the intervention, meaning that once it is established, it is efficient to run and adapt to different teams.

3.5 Interpretation

The quantitative impact evaluation suggests that, on average, MP initially had a negative impact on CIN in Islington in that it led to an increase in the probability of CIN re-referral within 12 months, an effect that was clearest in the second year after intervention onset. In the third year, however, this changed to a positive impact, with a decrease in the probability of re-referral. In contrast, there was no impact on the probability of re-referral within 24 months. Lastly, there was some evidence that MP is associated with an increase in the probability of escalations to CPP or CLA in the third year, but interpretation of this analysis is severely limited by potentially differing trends in this outcome even prior to the intervention.

Overall, the evidence suggests that MP's positive impact on CIN emerges in the third year, and this is supported by IPE findings that highlighted the time required for SWs to feel comfortable with the new relationship building approach. It remains open to interpretation as to whether increased escalations to CPP or CLA is a positive or negative impact. The IPE provided examples of SWs using their new skills to build relationships with CYP, and in the process of investing this time, uncovered physical or emotional abuse they may otherwise have missed. It is possible that a trauma-focussed approach allows for a deeper exploration of family dynamics and CYP experiences, and as a result, may increase the likelihood of an escalation to CPP or CLA depending on what is uncovered.

IPE findings offer a potential explanation for why a negative impact was observed in the first two years. First, there was evidence that aspects of MP were burdensome for staff in Islington. This includes the way it was implemented and perceptions of an increased workload, as well as its focus on trauma and the associated emotional burden. Therefore, it is possible that it had taken time for staff to adapt to the change in caseload, and to build resilience to the trauma-focused approach. Second, there was evidence that the reach of the intervention increased over time as more staff moved through the quarterly training modules, but also that in between modules, staff were reached via informal training and shared peer knowledge. Together, these factors may have delayed the positive impact of MP on home stability for CIN, as new practices became more embedded over time.

The impact evaluation found limited evidence that MP is associated with a decrease in the number of moves that CLA in Islington experienced in the second year after intervention onset and particularly when considering both post-intervention years together. There was no significant association between MP and the number of residential care placements that CLA experienced. In contrast to the CIN evaluation, the CLA evaluation had a more limited window for analysis, with only two years available after the introduction of MP. Given the uncertainty around these results, it can only be concluded that MP might be a promising programme for the CLA population, and that a more robust evaluation with a longer time window is necessary.

IPE findings suggest possible reasons for why MP did not have a strong impact on the CLA population. First, there was evidence that caseloads for the CLA team were not able to be reduced enough to accommodate the additional training and practice that the intervention demanded, potentially leading to a lack of resources to practice and embed the training. The promising qualitative findings indicate that there have been positive changes to relationships and communications for CLA and FCs, indicators of improving home stability. MP was introduced to bring about systemic change at Islington CSC, a process which takes time to refine and embed and to this end, it may take more time before any positive effects on the CLA population are detectable in an impact evaluation.

4. Summary of key findings on 7 practice features and 7 outcomes

As reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (2017), evidence from the first round of the Innovation Programme led the DfE to identify 7 practice features and 7 outcomes to explore further in subsequent rounds (Sebba, McNeish & Rees, 2017). Below, we provide findings related to those features and outcomes that are relevant to MP.

Using a clear, strengths-based practice framework and skills directed work

The MP programme intended to deliver strength-based practices of MSW (CIN), and DDP and TIP (CLA) through an intensive skills-based training programme. We observed varying levels of consistency of training provision, embedding and practice across the MP programme. This impacted on perceived family outcomes: When MP was delivered as intended, strength-based practice and associated skills improved. This in turn led to increased confidence, agency and independence for the families.

Using systemic approaches to social work practice

A core element of the MP approach was to empower families to work collaboratively with professionals to achieve their goals. Our evaluation suggests that when trusted relationships were developed between practitioners and families this enabled collaborative working to improve family dynamics and subsequent engagement with different sources of support. This was evident at the family and wider network level, such as with SWs, mental health services and school-based support. However, practitioners also described challenges collaborating with such services as they lacked understanding of the MP approach, which acted as a barrier to supporting families at a wider network level.

High intensity and consistency of practitioner and a family focus

The MP approach intended to develop of strong, trusted relationships between families and practitioners built on consistency of care and focused on improving family dynamics. Our qualitative evaluation observed that whilst practitioners understood the value of developing these relationships, they also expressed tension between wanting to invest their time whilst managing existing caseloads. In practice, this led to variability in practitioners having the resources to deliver a high intensity, consistent and family-focused programme. The frequent use of agency staff and inconsistent training for permanent staff also meant that not all staff were using MP skills when working with families.

Outcomes

Reducing risk for children and young people

As described in the Logic Model, reduced risk for children should have resulted from improved relationships with the family and with their professional network. The indicators of interest were defined as whether the programme leads to reductions in residential care placements, stability of placement, permanence of care and stability of caring relationships. Whilst the qualitative evaluation demonstrated a shift towards these indicators through increased family stability in relation to some evidence of increased emotional stability for CYPs and stability at home, the quantitative impact evaluation paints a mixed picture. The probability of CIN re-referral within 12 months initially increased after intervention onset, and subsequently decreased in the third year. There was no accompanying impact on re-referrals within 24 months, suggesting limited impact in the longer term. Moreover, there was limited evidence suggesting that CLA experienced fewer placement moves and no evidence of fewer residential care placements.

Create greater stability for children and Increase in wellbeing and resilience

Our qualitative evaluation demonstrates interim findings of good practice and reports of increased family stability for some families. This in turn started to demonstrate improved CYP wellbeing, including independence, empowerment, improved mental health as well as improved stability at school. FCs reported increased confidence in caring ability and improved stability of placements. Accessing peer support groups built social networks and support systems. Taken together, these outcomes improved family resilience overall. However, as described above, these outcomes were variable between families, dependent upon consistency of embedding. Indeed, some families reported high levels of instability due to external factors out of the control of the intervention.

Generate better value for money

The project is more expensive to run relative to operating without MP. We are not confident enough in the impact analysis to determine whether the programme generates better value for money. It is clear from the cost unit analysis that a bulk of costs occur in the setup, and that the project is cheaper to run after the initial setup phase. What is not clear, is whether the training reduces high cost placement moves, re-referrals or escalations, as was not demonstrated in this evaluation.

5. Lessons and implications

We have identified lessons and implications for both project innovation and evaluation.

Project lessons and implications

1. **Combat innovation fatigue.** Staff attended training sessions without a clear idea of why they were giving up their time to learn new theories. To combat innovation fatigue, the purpose of new training needs to be clearly communicated to staff. This will allow staff to approach training with a more open mind, and to reflect on how new approaches can support them practicing in new ways. We recommend engaging staff early on by showing them how the new practice aligns with their work values, such as relationship building.
2. **Ensure consistent embedding.** Motivational interviewing, dyadic developmental practice and trauma informed practice require practice to be successfully embedded. Staff benefitted from formal support structures such as training, however these were implemented inconsistently. Specifically, there were issues with consistent 1:1 supervision, as well as ongoing coaching and mentoring. We recommend that managers be encouraged to commit to regular supervision to avoid the decrease in supervision described in the qualitative data, and that teams be briefed on the purpose of a practice champion, and the ways to go about accessing this service. This will allow for social workers to keep reflecting on their practice and provide a space to discuss how the theory is best implemented in the direct work they do with families.
3. **Leverage informal knowledge pathways.** Untrained staff and agency staff became familiar with core training concepts by informal training methods, such as peer to peer learning and conversations with trained staff. These informal knowledge pathways helped the staff team navigate any gaps in the training schedule and contributed to higher consistency in approach for social workers working with families. Depending on resourcing and schedules, perhaps Islington CSC could leverage informal support pathways in a more structured way, building on the coaching, supervision and practice championship models to include something similar for training delivery. This may introduce the basics to all staff in a more regular fashion than is currently being delivered under the formal training model.
4. **Address practical and emotional burdens.** Changes and improvements to practice were associated with an increase in burden. There were practical burdens for trained staff who had to upskill untrained staff, and we recommend that an online version of the training materials be made available to support new staff and agency staff in developing their practice. This could reduce the burden of staff who have attended training and, in relation to the previous recommendation, helps promote consistency in practice across the team. Staff also reported that an increased understanding of trauma and increased focus on trauma in practice could lead to greater emotional burden. This evaluation

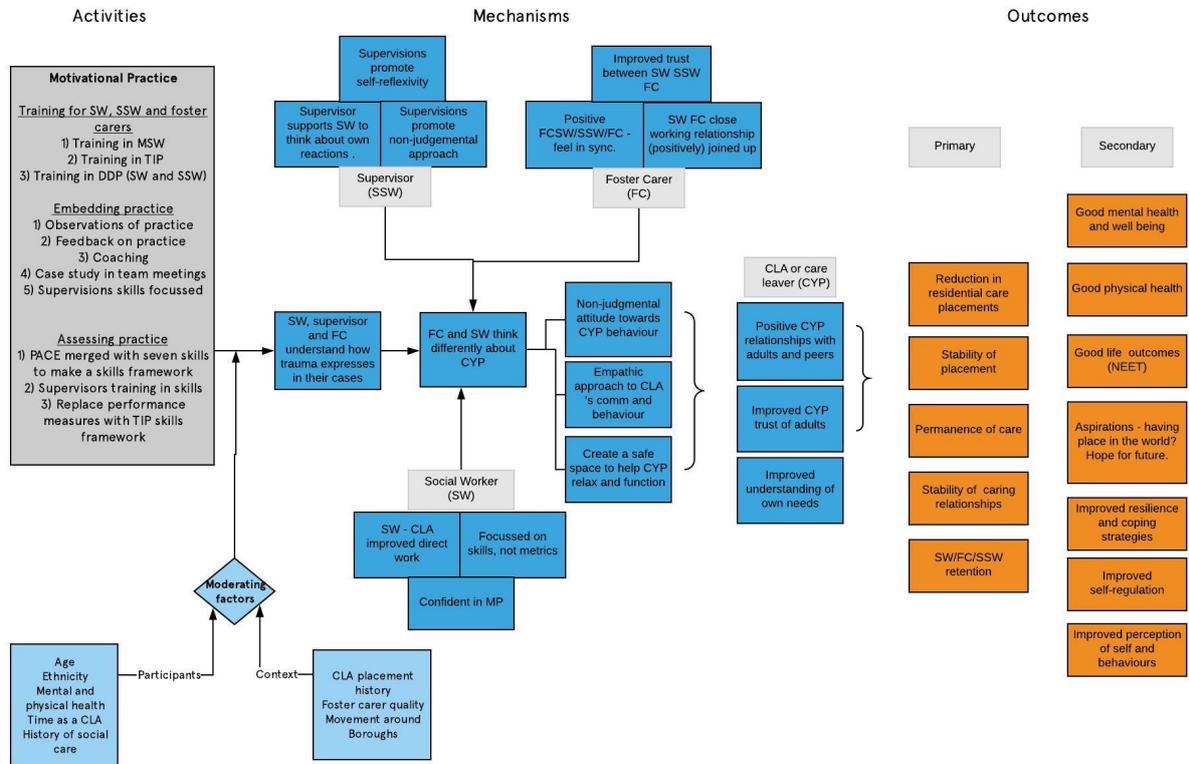
recommends that additional support services for debriefing, or additional training on coping with trauma stories may help staff in their new practice.

Evaluation lessons and implications:

- 1. Boroughs should have resources dedicated to supporting evaluations.** Boroughs have data necessary for evaluations that may be stored or migrated across different data management systems and may reflect different decision-making processes between boroughs. Preparing these data in a way which enables robust evaluations is time-consuming for boroughs and therefore requires sufficient resources to ensure that evaluations are supported.
- 2. During evaluation design, it should be easy to identify the nature and timing of any changes within boroughs that may impact evaluation-relevant outcomes.** Evaluating interventions often relies on comparing outcomes between evaluated and comparison boroughs. This comparability may be limited by changes within comparison boroughs that may impact evaluation-relevant outcomes. This is particularly important within Children's Social Care, with many boroughs simultaneously engaging in innovative programmes. The selection of appropriate comparison boroughs would therefore be enabled by having an easy way to identify the nature and timing of any changes across all boroughs.

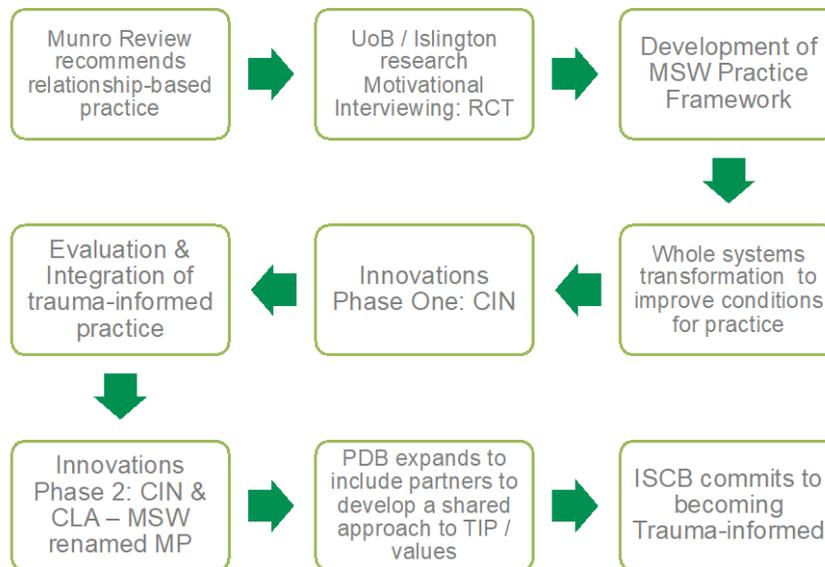
Appendix 1: Project theory of change

Figure 11. Project theory of change



Appendix 2: Islington's Practice Model

Overview: from Munro to Partnership Working Together



2011: Professor Eileen Munro Review for government. “Skills in forming relationships are fundamental to obtaining information that helps social workers understand what problems a family has and to engaging the child and family and working to promote change.”

2012: Partnership between Islington and University of Bedfordshire. Donald Forrester started with baseline observations of social work practice, which at that stage was seen as overly critical and directive and lacked child-focus.

2012 – 2015: UoB conducted a Randomised Control Trial (RCT) in Islington to examine the impact of a skills development package in MI on the quality of direct practice, level of parental engagement, and outcomes for families allocated a child and family social worker.

The Theory of Change is that relationship-based practice and a model to promote change would facilitate more effective social work practice.

Research, Review, Refine: Parents and practitioners liked the new practice but the RCT demonstrated tenuous links between skills and outcomes and concluded that if MI is to be integrated into SW practice, it required:

1. A Risk Framework and Risk Management

2. Adaptation to the safeguarding context and task

3. LA's should have a model of practice & be able to say what they strive to achieve

4. Organizations need to be designed to deliver the vision of practice they espouse

MI Skills: Empathy, collaboration, Evocation, Autonomy

Safeguarding: Child Focus, Purposefulness, Clarity of Concerns were added to the MI framework to become **Motivational Social Work**

Motivational Social Work: A Practice Model



Innovations Phase One (CIN)

- Practice model developed
- Practice framework
- Training across CIN teams
- Observation of practice, coding & coaching
- Supervision & leadership Model
- Integrated risk framework
- Clinician support
- Family feedback sought

2015 – 2017: Roll out of Motivational Social Work across CIN with training, observation & coaching, group supervision. Alongside this was “whole systems transformation”, aiming to improve conditions for practice: reducing bureaucracy; reduced caseloads; strategy for recruitment, retention & career progression to attract good practitioners; robust QA and reflection on data management linked to practice.

Research, Review, Refine: External Evaluation (Luckock et al, 2017) highlighted positive parent feedback and improved practitioner skill and confidence. The research was still inconclusive in establishing causality between improvements in practice / positive engagement with families and child outcomes. As relationships with families improved, more questions emerged, especially regarding SW's confidence & skill engaging meaningfully in children's lived experiences and traumatic histories.

2018 – 2019: Trauma-informed practice was integrated into the Motivational Practice model (renamed to include non-SW practitioners). Training, observation and coaching, group supervision was researched in CLA. The evolved model emphasized the balance of relationship-building skills and respectful authority. Research outcomes demonstrated that coaching significantly improved practice.

Research Conclusions (UoB): Motivational Practice has...

- made visible the '*invisible trade*' of social work (Pithouse, 1987)
- developed and used '*a clear, strengths-based practice framework*' alongside the mechanism of coaching
- which enabled '*staff to do skilled direct work*' (Trowler, 2018)

2019 – 2020: Islington's Safeguarding Children's Board is now committed to becoming Trauma Informed... to effect change and help make children in Islington safer by effective Working Together and developing a shared language / practice model

2020 – 2021: Scale & Spread. Islington is testing the application of the practice framework to other practice models e.g. Signs of Safety. The framework is essentially based on behaviours / practice skills that can be taught, observed, measured, coached, practiced and learned. ***PRACTICE, PRACTICE, PRACTICE!!!***

Appendix 3: Changes to evaluation methods

Changes to quantitative impact evaluation of CIN outcomes

- The evaluation plan defined the outcomes concerning CIN re-referrals and escalations in terms of *participants*, rather than *referrals*. However, participants can have multiple referrals per year. It was therefore decided to analyse the outcome at the referral level. Because 91% of participants had only one referral per year in any case, this decision has very limited impact on the analysis results.
- As a result of the above change, the following secondary outcome became redundant: “Rate (%) of re-referrals (referrals within 12 months of a previous referral) to Children’s Social Care, in one year, as a proportion of all referrals to CSC”.
- The evaluation plan initially defined escalations to CP and CLA as separate outcome indicators. However, CLA escalations were relatively rare in the dataset (4% of CIN referrals escalated to CLA within 12 months). These two indicators were therefore combined into a single outcome.

Changes to quantitative impact evaluation of CLA outcomes

- The range of data for analysis was extended from ending at March 2019 to ending at August 2019 (i.e., two years after intervention onset), in order to increase the number of cases for analysis.
- To maximise the sample size for analysis, the primary outcome indicator was changed to include all placement moves, rather than foster care placements only.
- The outcome indicators were adjusted to refer to the *first and second year after intervention onset*, with intervention onset being August 2017. The evaluation plan defined the outcome indicators with respect to “the 12 months following enrolment in the evaluation”. However, the meaning of participant “enrolment” in the evaluation is unclear, because the intervention consisted of training for social workers and foster carers, with participants continuously engaging with CSC services. One approach is to consider when participants first started receiving CSC services. However, this start date differs across individuals and therefore poses a problem for binning the placement data into fixed time windows before and after intervention onset, which is a necessary step for the DiD analysis, including the parallel trends test. For example, the differing start dates mean that some CLA cases would have placements both before and after the intervention onset. Instead, the updated definition enabled binning the placement data into fixed time-bins corresponding to one and two years before and after intervention onset, with some CLA cases appearing in multiple bins.
- To preserve the amount of information in the data, it was decided to analyse the *number* of residential care placements that CLA experienced, rather than

whether a CLA experienced a residential placement or not, as originally defined in the evaluation plan.

- Due to unavailable or incomplete data, analysing the following secondary outcome indicators from the evaluation plan was not possible:
 - Rate (%) of care leavers who are in education, employment or training
 - Rate (%) of CLA classed as persistent absentees
 - Rate (%) of CLA experiencing 1 or more fixed-term exclusions in the 12 months following enrolment in the evaluation
 - Rate (%) of CLA experiencing 1 or more permanent exclusions in the 12 months following enrolment in the evaluation

Changes to the qualitative evaluation

- Following interim reporting and discussions with Islington CSC, it was decided that a rescope of both qualitative projects would be an effective process for ensuring high quality data collection within reasonable timelines and budget.
- Overall, the number of participants was reduced, but ensured greater diversity in the sample was nevertheless ensured. It was also decided to move away from longitudinal designs to single time point data collection.
- The research questions for each evaluation were altered, structuring the objectives around the three main components of the evaluation:
 - Processes of implementation
 - Impact
 - Mechanisms of impact

Children In Need (CIN) Project

- Originally, it was proposed to conduct short (30-45min) interviews with 15 families and their social workers.
- It was decided that it would be more appropriate to focus on the depth of experience for families, whilst still maintaining range and diversity in the sample. The number of cases was reduced from 15 to 10; however, the length and depth of interviews with families was increased to 45 mins-1 hour.
 - Reducing the number of cases by 5 allowed the development of more detailed topic guides and to focus efforts on capturing the range and diversity of the sample through more involved recruitment and in partnership with Islington.
- The discussion also highlighted the need to capture more breadth of social worker experience for social workers working across multiple cases, which would mean unmatching the social workers from the participant families. As many social workers work across many families, it was felt that 10 social worker depth interviews would capture the necessary perspectives.
 - This helped with recruitment, as the original proposal involved consenting families to consent to their social worker being interviewed. Under the new

strategy, social workers consented themselves, and were purposively sampled based on their experience and other factors, which captured greater range.

- This also helped with minimising burden on social workers, who now only completed a single depth interview. Under the previous arrangement, the same social worker may have been interviewed multiple times depending on which families consented.
- It was proposed to conduct depth interviews with ten matched families (ten CIN and ten parents/guardians), as well as depth interviews with 10 unmatched social workers working with multiple families (n=30)

Children Looked After (CLA) Project

- Originally a case study approach was proposed, including conducting interviews with five looked after children (CLA), five foster carers (FC), five social workers, and five supervising social workers (n=20).
- Following discussions with Islington, it was decided to include Youth Personal Advisors (YPAs) in the sample, as they work closely with older CLA. The PAs were interviewed via a focus group (n=6-8) which helped compare and contrast varying perspectives of these key workers, as well contextualised the perspectives of families and their other supports.
- It was also decided to unmatched social workers and supervising social workers from CLA and foster carers in order to capture perspectives across multiple cases and families. Instead interviews were conducted with 8-10 families (CLA and FC), 10 social workers and 10 supervising social workers (n=36-40).
- A longitudinal design was originally proposed, capturing perspectives at two time points. Following discussions with Islington, it was deemed important for the participants to be able to reflect on the embedding of the intervention in a single interview, and the single time point also enabled interviewing families who have been engaged in the intervention for less time. The focus was on triangulation through the gathering of in-depth multiple contrasting perspectives, and recruitment efforts were focussed on capturing a range of family engagement models and experiences.
- The original evaluation plan proposed a cross sectional survey at two points to generalise themes from the case studies. Surveys were initially proposed for both social workers and foster carers, however due to the low numbers of social workers involved in the intervention, it was proposed to work with social workers to help foster carers complete exit surveys. This was done to maximise response rates for foster carers, and enabled capturing very important perspectives from the foster carers regarding their experience of the service.

Appendix 3: Limitations of the evaluation

- **Uncertainty around the comparability of outcome time trends between Islington and Barnet:** Although parallel (i.e., comparable) time trends in CLA outcomes in Islington and Barnet before the intervention were confirmed, it was discovered that Barnet had introduced its own innovation programme in January 2017 (REACH). This may have impacted the outcomes of their CLA population, and thereby introduces uncertainty around the comparability of Islington and Barnet after intervention onset. The impact evaluation is therefore unable to conclude whether MP *caused* any changes in the outcome measures. Instead, it can conclude that MP is *associated* with changes in the outcome measures.
- **Uncertainty around the comparability of time trends in CIN escalations between Islington and Southend:** In the analysis of CIN escalations to CPP or CLA, there was evidence that Islington and Southend may have experienced differing trends in the probability of escalation even before MP was introduced in Islington (i.e., evidence that Islington and Southend may not be comparable for this outcome). Therefore, the evaluation cannot conclude that MP *caused* any changes in the probability of escalation in Islington in the post-intervention years.
- **Analytical ambiguity due to CIN referrals overlapping pre- and post-intervention years:** Outcomes for the CIN evaluation are all defined using a prospective time window (e.g., whether a referral has led to a re-referral or an escalation within 12 months of opening). This means that referrals that open in one year can extend into another year. This is potentially problematic for referrals opened in the year just before intervention onset, because these referrals may partly experience MP in the post-intervention year, whereas their outcome (e.g., a re-referral) will be assigned to the pre-intervention year. Therefore, if there is a significant effect in this pre-intervention year, it is unclear whether it reflects the impact of the intervention or unrelated differences between Islington and Southend. The same limitation arises when analysing re-referrals within 24 months, although it concerns the two years before intervention onset. Any significant effects in these pre-intervention years are difficult to interpret and will limit the ability to infer causality from the analysis as is.
- **Unsuitability of comparison borough data management systems:** there was difficulty finding a suitable comparator borough for the CIN evaluation. Due to the dates of the original innovation (2015-2017), historic data from 2012-2014 was required in order to perform the DiD parallel trends analysis to determine suitability. Over the past 7 years, several boroughs had changed their data management systems, making it difficult to track individual cases in the pre-innovation period.

Fortunately, the data team at Southend-on-Sea were able to migrate earlier data into a compatible format to perform the analysis.

- **Potential differences in decision-making and/or data recording practices across years and local authorities:** There may be subtle differences between years and local authorities in how decisions about placements and referrals are made and/or how this information is recorded. For example, there is known variation across local authorities in the numbers of referrals resulting in No Further Action (Department for Education, 2019). The DiD analysis is robust to differences between local authorities, if these differences do not vary in time. However, the DiD cannot account for differences that vary across local authorities and time (for example, changes across time in how one specific borough conducts decision-making or data recording concerning referrals).
- **Sample size limitations (number of cases and timeframe):** A robust DiD analysis requires a substantial amount of data in terms of the number of observations per time period and the number of time periods before and after intervention onset. This is important for determining that the parallel trends assumption has not been violated. Additionally, given that the intervention consisted of training, supervision, and embedding of practices in Islington, it is possible that the impact of MP might take longer to emerge. This might therefore require a longer post-intervention observation period for analysis than what was currently possible. This may be particularly true for the CLA evaluation for which only two post-intervention years were available for analysis.
- **Limitations of the qualitative sample:** the difficulty meeting sample quotas in the CIN parent/child cases has limited confidence in capturing the range and diversity of family experience in the programme.
- **Survey response totals:** there was a good response rate from foster carers (44%), however due to the low numbers of eligible foster carers at Islington CSC, there were low overall numbers which made analysis of the findings difficult beyond basic descriptive statistics.

Appendix 4: Quantitative evaluation details

Impact evaluation of CIN outcomes

Table 7. CIN quantitative impact evaluation outcome indicators

Outcome	Indicator
Reduce CIN re-referrals	4. Probability of CIN re-referral within 12 months of referral opening, in each of the three years after intervention onset (March 2015-2018) <i>(Primary outcome indicator)</i>
	5. Probability of CIN re-referral within 24 months of referral opening, in each of the two years after intervention onset (March 2015-2017) <i>(Secondary outcome indicator)</i>
Reduce CIN escalations to CPP or CLA	6. Probability of CIN escalations to CPP or CLA within 12 months of referral opening, in each of the three years after intervention onset (March 2015-2018) <i>(Secondary outcome indicator)</i>

Definition of a CIN referral. A CIN referral is any referral that has not resulted in a No Further Action outcome at the initial referral stage and that has not been closed with Closure Code RC8 (Department for Education, 2019a). In dataset used for this evaluation, CIN referrals were indicated with CIN start dates, which point to the referral start date. These referrals may lead to a CIN Plan (or equivalent, depending on year and borough), a Child Protection Plan (CPP), and/or a Child Looked After (CLA) status.

Definition of a re-referral. Re-referrals were defined as CIN referrals that occur within 12 months (or 24 months) of the previous referral start date. This is consistent with the approach used by the Department for Education (DfE), although in the current evaluation only CIN referrals and re-referrals are analysed, whereas the DfE includes all referrals (Department for Education, 2019a).

Definition of an escalation. Escalations were defined as any CP or CLA start dates that occurred within 12 months of the initial referral start date. This included CP or CLA start dates that occurred in the middle of a referral and those that occurred at the start of a subsequent referral, as long as they occurred within 12 months. The only exception is CP or CLA start dates that coincided with the initial referral start date (i.e., the beginning of the 12-month window), which were not counted as escalations.

Evaluation design

Difference-in-difference (DiD) analysis: Due to complexities with the intervention and Islington's commitments for training delivery, the evaluation was limited to a quasi-

experimental difference-in-difference (DiD) analysis. This method estimates the impact of the MP intervention by comparing the change in outcomes among CIN in Islington before and after the intervention with the equivalent change in outcomes among CIN in a comparison borough over the same time period. The DiD analysis is a level 3 on the Maryland scientific scale.

DiD analysis relies on a central assumption that the time trends in the outcome measures in Islington and the comparison borough are parallel before the intervention and that they would have remained parallel if MP was not introduced in Islington. This should be the case even if the boroughs may differ in the outcome measures at any one time point. This “parallel trends assumption” enables the evaluation to infer that any change in the outcome measures after the intervention is caused by the intervention itself, and not any other factors which differently affect Islington and the comparison borough. This idea guided the choice of comparison borough.

Identifying a comparison borough: In order to identify the most suitable comparison borough for Islington, we used the following criteria.

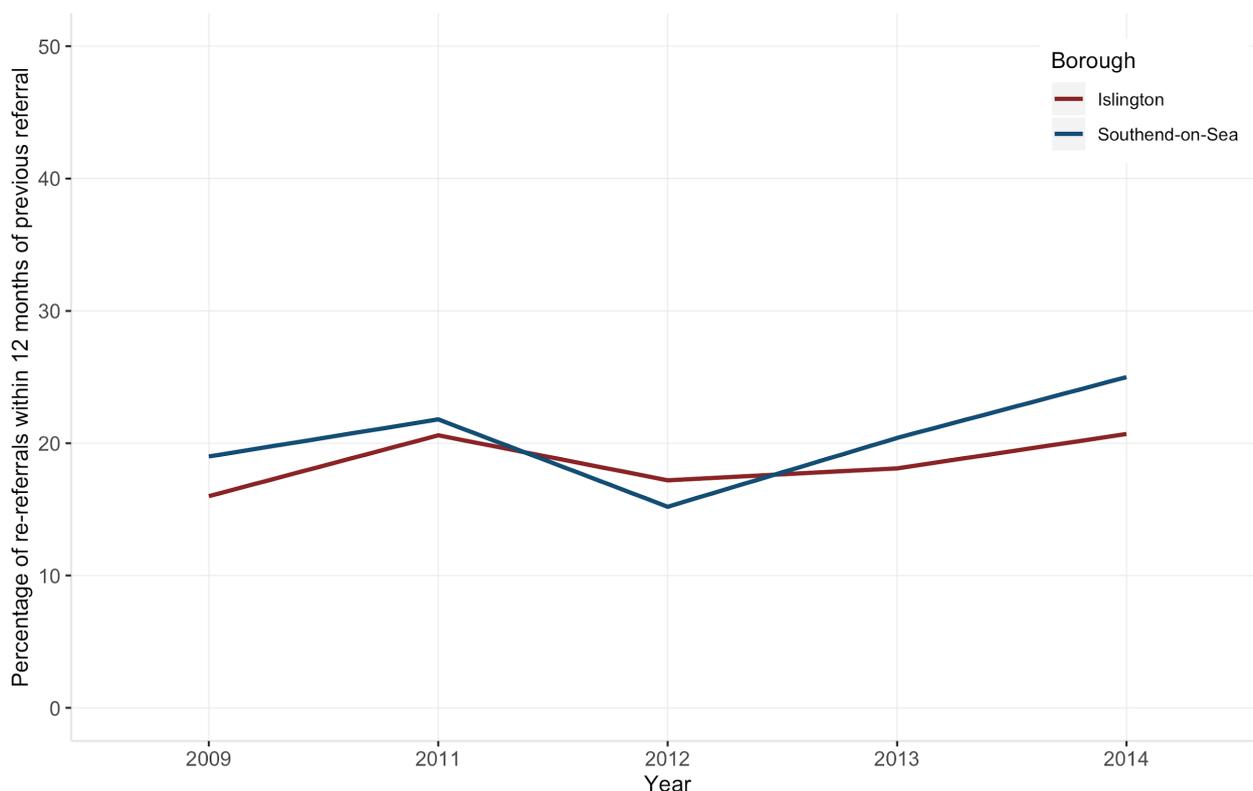
First, the comparison borough had to exhibit time trends that are parallel to Islington, up to intervention onset (March 2015), in outcome measures most similar to the outcomes of interest for the evaluation. To identify such an area, data from the Local Authority Interactive Tool (LAIT) from 2009-2014 were used (Department for Education, 2014). Each borough was informally compared to Islington on the proportion of CIN re-referrals within 12 months of a previous referral, a measure that was most similar to the primary outcome and that was available for all years in 2009-2014 for most boroughs. Additionally, it was ensured that any suitable borough was comparable to Islington on other, less directly relevant measures: (1) the absolute difference in the number of re-referrals relative to Islington; and (2) Ofsted ratings (“Children who need help and protection” and overall rating).

Second, the aim was to find a comparison borough that has not introduced or had plans to introduce any training interventions of their own for the CIN population during March 2015 (i.e., when Islington introduced the MP intervention).

Lastly, there was a preference for boroughs within Greater London and those who were willing to collaborate on the project. Based on all of these factors, Southend-on-Sea (Southend) was identified as a suitable match⁹ (see Figure 12).

⁹ Southwark was initially chosen but they were unable to provide suitable data for all required years due to migration of their data management systems.

Figure 12. Time trends in the percentage of re-referrals within 12 months of a previous referral (2009-2014)



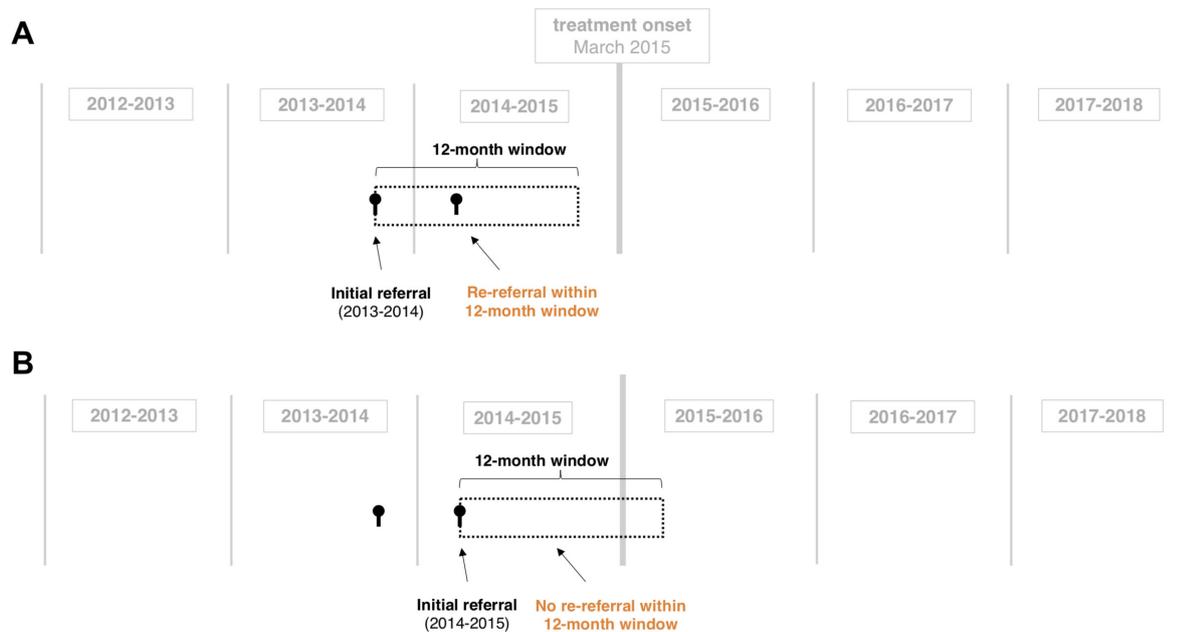
Notes: Data obtained from the Local Authority Interactive Tool (LAIT)

Description of data

The intervention onset occurred in Islington in 2015-03-01. Administrative data were obtained from Islington and Southend on referrals that opened between 2012 and 2019.

To compare time trends in outcomes, referrals were binned by their start dates into yearly time-bins before and after the intervention, from 2012-03-01 until 2018-03-01 (see Figure 2). This enabled the analysis of outcomes for referrals starting in each year before and after intervention onset. Outcomes were defined according to a prospective time window, starting from the referral start date (e.g., whether a re-referral occurred within 12 months from the referral start date; see Figure 2).

Figure 13. Illustration of how data were binned and how outcomes were defined.



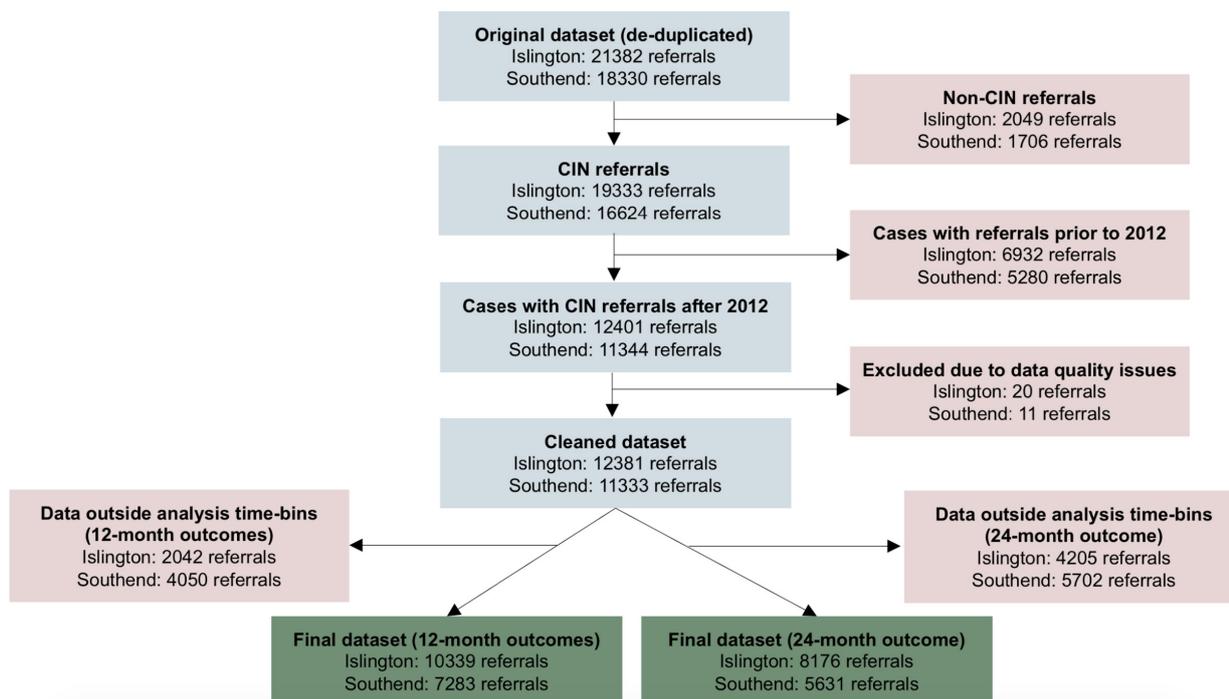
Notes: Black pins indicate the referral start dates. Data were binned into yearly time-bins according to the referral start dates. Dashed box indicates the 12-month (or 24-month) window from the referral start date in which re-referrals or escalations were considered. Each referral can be counted as a “re-referral” outcome (Panel A, orange label) and as an “initial” referral, for which an outcome was defined (Panel B, black label). All outcomes were binary (e.g., 1 = a re-referral occurred within 12 months; 0 = no re-referral occurred within 12 months). For example, a single re-referral or multiple re-referrals within the 12-month time window were labelled as equivalent outcomes. The same applied to the escalation outcome. Note that because data were analysed at the referral level, each unique CIN case could appear in multiple observations across time-bins.

Inclusions and exclusions

Given that outcomes were defined according to a prospective time window, it was necessary to be able to observe each referral for at least 12 months (or 24 months) from the referral start date. However, the data from Islington went up to March 2019. Therefore, for the primary and secondary outcomes requiring a 12-month window, it was only possible to analyse referrals up to March 2018. For the secondary outcome requiring a 24-month window, it was only possible to analyse referrals up to March 2017 (i.e., referrals in the last time-bin, 2017-2018, were excluded).

Additionally, only referrals from CYP who have had their very first referral on or after 2012-03-01 (the start of the first time-bin) were included. This enabled the inclusion of a covariate for the age at first CIN referral (see Primary Analysis below), which is a useful predictor of subsequent re-referrals (Troncoso, 2017). See Figure 14 for the consort diagram.

Figure 14. Consort diagram of data inclusions and exclusions.



Notes: Data quality issues included missing dates of birth and primary need codes. Islington had less cases excluded at the final stage because this dataset went up to March 2019, compared to December 2019 for Southend.

Descriptive summary

Table 2 summarises the referral and escalation data. First, note that these figures are not comparable with published DfE statistics for the following reasons:

- Yearly time-bins are defined here from March to February to align with intervention onset, rather than April to March
- Referrals from cases who have had any referrals prior to 2012-03-01 and all non-CIN referrals are excluded
- Figures in each time-bin only include referrals that have *started* in a given year, rather than any referrals that are *open* in a given year

With these caveats in mind, in Islington, the percentage of CIN referrals that led to a re-referral within 12 months ranges from 14% to 20% across the six years summarised here. In Southend, this figure ranges from 18% to 26%. For both local authorities and all years, extending the prospective time window to 24 months considerably increases the percentage of referrals that led to a re-referral (e.g., from 18% to 31% in Islington in 2016-2017). In Islington, the percentage of CIN referrals that escalated to CPP or CLA within 12 months ranges from 7% to 13% across the six years. In Southend, this figure ranges from 7% to 17%.

Table 8. Summary of CIN cases, re-referrals, and escalations by time-bin and borough.

Borough	Year	Total cases	Total referrals	Percent re-referred within 12 months	Percent re-referred within 24 months	Percent escalated to CPP/CLA within 12 months
Islington	2012-2013	1164	1229	14.3% (176)	26.0% (319)	6.6% (81)
Islington	2013-2014	1451	1588	18.3% (290)	29.2% (464)	7.8% (124)
Islington	2014-2015	1504	1608	13.6% (218)	23.6% (379)	10.1% (162)
Islington	2015-2016	1540	1664	19.9% (331)	31.4% (522)	12.7% (212)
Islington	2016-2017	1881	2087	18.4% (385)	30.7% (641)	12.4% (258)
Islington	2017-2018	2025	2163	13.7% (297)	-	11.5% (249)
Southend	2012-2013	885	978	18.2% (178)	26.2% (256)	7.5% (73)
Southend	2013-2014	990	1127	20.1% (227)	28.2% (318)	10.2% (115)
Southend	2014-2015	829	928	18.8% (174)	26.9% (250)	16.9% (157)
Southend	2015-2016	944	1042	20.1% (209)	32.3% (337)	14.0% (146)
Southend	2016-2017	1449	1567	17.9% (280)	30.4% (477)	9.9% (155)
Southend	2017-2018	1454	1652	26.4% (436)	-	6.5% (108)

Notes: Parentheses indicate sample sizes. Individual CIN cases can appear in more than one time-bin. Post-intervention years are highlighted in green.

Primary analysis

Main specification. The outcome measure is binary (1 = a referral led to a re-referral within 12 months; 0 = it didn't). There is a non-extreme baseline proportion of re-referrals in the dataset, ranging from 14-26% across time-bins and boroughs. Therefore, the data should be fit reasonably well using a linear model.¹⁰ A model of the following form was fit:

$$(1) Y_i = \beta_0 + \beta_1 Time_{it}^{2013-2014} + \beta_2 Time_{it}^{2014-2015} + \beta_3 Time_{it}^{2015-2016} + \beta_4 Time_{it}^{2016-2017} + \beta_5 Time_{it}^{2017-2018} + \beta_6 LA_i + \beta_7 Time_{it}^{2013-2014} \times LA_i + \beta_8 Time_{it}^{2014-2015} \times LA_i + \beta_9 Time_{it}^{2015-2016} \times LA_i + \beta_{10} Time_{it}^{2016-2017} \times LA_i + \beta_{11} Time_{it}^{2017-2018} \times LA_i + \beta_{12} NeedCode_i + \beta_{13} Covariates_p + \epsilon_p$$

¹⁰ We also use logistic regression as a robustness check (see below).

where:

- Y_i is whether a referral i led to a re-referral within 12 months
- $Time_{it}^{2013-2014}$, $Time_{it}^{2014-2015}$, ... etc. are binary variables indicating the year t for referral i (the reference year for the analysis was 2012-2013).
- LA_i is a binary treatment variable indicating whether the local authority (borough) for referral i is Islington (or Southend)
- *Need Code* indicates the primary need code for referral i (11 different codes).
- $Covariates_p$ is a set of covariates for person p :
 - Age at first CIN referral and its 2nd and 3rd order polynomials (continuous). The latter are used to capture non-linearity in the relationship between age and the likelihood of a re-referral (e.g., floor and ceiling effects at 0 and 18 years, respectively; Troncoso, 2017).
 - Age at intervention start (continuous)
- ϵ_p are robust standard errors clustered at the person level p to account for multiple referrals from the same person across time-bins

β_7 and β_8 test for possible violations of the parallel trends assumption. They are interactions between LA and pre-treatment year 2013-2014 or 2014-2015 (with pre-treatment year 2012-2013 as a reference). If both interactions were non-significant, this was interpreted as the absence of evidence that the parallel trends assumption has been violated.

β_9 , β_{10} , and β_{11} are the coefficients of interest which test for the impact of MP on the proportion of referrals which led to re-referrals within 12 months, in the three years after intervention onset. These are interactions between LA and post-treatment year 2015-2016, 2016-2017, or 2017-2018 (with pre-treatment year 2012-2013 as a reference). A significant interaction was interpreted as evidence that MP impacted the number of re-referrals that CIN in that year experienced.

Bar graphs of the intervention effect. The results are presented by comparing the change in outcomes in Islington and in Southend in each year after MP was introduced, relative to 2012-13 (the reference year). Each change is reported as the average marginal effect (AME) of each post-intervention year for each borough (derived from the DiD analysis using the *margins* package in R; Leeper, 2018). This is the change in outcomes in a given year relative to a reference year for a given borough, averaged across the unit of analysis (i.e., CIN referrals) and controlling for all covariates. A difference between the AME in each borough corresponds directly to the DiD interaction effect (i.e., β_9 , β_{10} , and β_{11}). Error bars around the AMEs indicate 95% confidence intervals, adjusted for clustering as in the main regression specification.

Outcome time trend graphs. To visualise the time trends for the outcome, the percentage of CIN referrals that led to re-referrals within 12 months of opening (unadjusted for covariates), for each year and borough, was computed. Error bars indicate 95% confidence intervals.

Robustness checks. To confirm that the pattern of findings is not driven by the use of a linear model, a logistic regression model was additionally fit for each binary outcome and results reported alongside the linear regression in the tables below.

Secondary analysis

Probability of CIN re-referral within 24 months of referral opening. Analysis of this outcome was identical to the primary analysis except that data from the last time-bin (2017-2018) were not included, given that it was not possible to observe outcomes for these referrals for the full 24 months. Baseline percentages of re-referrals within 24 months ranged from 21-41% across time-bins and local authorities, suggesting that a linear model is also appropriate for this outcome.

Probability of CIN referral escalations to CPP or CLA within 12 months of referral opening. Analysis of this outcome was identical to the primary analysis. Baseline percentages of escalations within 12 months ranged from 7-17% across time-bins and local authorities, suggesting that a linear model is also appropriate for this outcome.

Exploratory analysis

Additionally, for each outcome, the overall effect was tested across the three (or two) post-treatment years, as compared to the three pre-intervention years. To do this, a model identical to model (1) was run, albeit with a binary time indicator (1 = after intervention, 0 = before intervention).

Additional quantitative results

Probability of CIN re-referral within 12 months

There was no evidence that the parallel trends assumption has been violated in either 2013-2014 or 2014-2015 (see Table 9, rows highlighted in red), therefore the results are interpreted as causal. When comparing all three post-intervention years to all pre-intervention years, there was no statistically significant effect ($\beta_{[Islington \times \text{Post Intervention}]} = -0.012$, SE = 0.013, p = 0.376).

Table 9. Regression results: Probability of CIN re-referral within 12 months.

	Probability of CIN re-referral within 12 months			
	Linear regression		Logistic regression	
	Estimate [standard error]	P-value	Estimate [standard error]	P-value
$LA_{Islington} \times Time_{2013-2014}$	0.016 [0.023]	0.477	0.133 [0.157]	0.399

LA _{Islington} × Time ₂₀₁₄₋₂₀₁₅	-0.007 [0.023]	0.753	-0.062 [0.170]	0.714
LA _{Islington} × Time ₂₀₁₅₋₂₀₁₆	0.043 [0.024]	0.075 +	0.314 [0.164]	0.055 +
LA _{Islington} × Time ₂₀₁₆₋₂₀₁₇	0.046 [0.023]	0.044 *	0.327 [0.161]	0.042 *
LA _{Islington} × Time ₂₀₁₇₋₂₀₁₈	-0.082 [0.022]	0.000 **	-0.495 [0.153]	0.001 **
LA _{Islington}	-0.048 [0.017]	0.005 **	-0.357 [0.127]	0.005 **
Time ₂₀₁₃₋₂₀₁₄	0.035 [0.017]	0.042 *	0.226 [0.113]	0.046 *
Time ₂₀₁₄₋₂₀₁₅	0.033 [0.020]	0.091 +	0.205 [0.130]	0.114
Time ₂₀₁₅₋₂₀₁₆	0.062 [0.021]	0.003 **	0.384 [0.132]	0.004 **
Time ₂₀₁₆₋₂₀₁₇	0.053 [0.021]	0.013 *	0.319 [0.137]	0.019 *
Time ₂₀₁₇₋₂₀₁₈	0.154 [0.022]	0.000 **	0.912 [0.131]	0.000 **
Need Code _{N1}	-0.012 [0.012]	0.303	-0.070 [0.072]	0.327
Need Code _{N2}	-0.047 [0.018]	0.009 **	-0.342 [0.142]	0.016 *
Need Code _{N3}	-0.046 [0.029]	0.107	-0.342 [0.239]	0.152
Need Code _{N4}	0.028 [0.017]	0.101	0.211 [0.108]	0.049 *
Need Code _{N5}	0.042 [0.017]	0.013 *	0.294 [0.103]	0.004 **
Need Code _{N6}	0.069 [0.024]	0.004 **	0.474 [0.140]	0.001 **
Need Code _{N7}	-0.108 [0.036]	0.003 **	-1.007 [0.509]	0.048 *
Need Code _{N8A}	-0.054 [0.029]	0.057 +	-0.442 [0.287]	0.124
Need Code _{N8U}	-0.118 [0.017]	0.000 **	-2.132 [0.586]	0.000 **
Need Code _{N9}	0.057 [0.031]	0.069 +	0.355 [0.172]	0.039 *
Age at CIN start	-0.025 [0.004]	0.000 **	-0.193 [0.031]	0.000 **
Age at CIN start ²	0.001 [0.000]	0.019 *	0.013 [0.004]	0.001 **
Age at CIN start ³	-0.000 [0.000]	0.010	-0.001 [0.000]	0.001 **
Age at intervention start	0.018 [0.003]	0.000 **	0.108 [0.018]	0.000 **
(Constant)	0.161 [0.020]	0.000 **	-1.617 [0.127]	0.000 **

Notes:

Standard errors are clustered at individual CIN case level

Observations = 17622

+ p < 0.1, * p < 0.05, ** p < 0.01

Probability of CIN re-referral within 24 months

There was no evidence that the parallel trends assumption has been violated in either 2013-2014 or 2014-2015 (see Table 10, rows highlighted in red), therefore these results are interpreted as causal. When comparing the two post-intervention years to all pre-intervention years, there was no statistically significant effect ($\beta_{\text{Islington} \times \text{Post Intervention}} = 0.009$, SE = 0.018, p = 0.61).

Table 10. Regression results: Probability of CIN re-referral within 24 months.

	Probability of CIN re-referral within 24 months			
	Linear regression		Logistic regression	
	Estimate [standard error]	P-value	Estimate [standard error]	P-value
$LA_{\text{Islington}} \times \text{Time}_{2013-2014}$	0.003 [0.026]	0.910	0.009 [0.132]	0.946
$LA_{\text{Islington}} \times \text{Time}_{2014-2015}$	-0.023 [0.027]	0.401	-0.128 [0.142]	0.368
$LA_{\text{Islington}} \times \text{Time}_{2015-2016}$	0.001 [0.027]	0.984	0.009 [0.136]	0.945
$LA_{\text{Islington}} \times \text{Time}_{2016-2017}$	0.003 [0.026]	0.895	0.012 [0.134]	0.928
$LA_{\text{Islington}}$	-0.007 [0.020]	0.708	-0.037 [0.105]	0.726
$\text{Time}_{2013-2014}$	0.058 [0.020]	0.003 **	0.275 [0.099]	0.006 **
$\text{Time}_{2014-2015}$	0.072 [0.022]	0.001 **	0.322 [0.113]	0.004 **
$\text{Time}_{2015-2016}$	0.160 [0.024]	0.000 **	0.734 [0.116]	0.000 **
$\text{Time}_{2016-2017}$	0.171 [0.026]	0.000 **	0.777 [0.123]	0.000 **
Need Code _{N1}	-0.027 [0.015]	0.062 +	-0.127 [0.071]	0.073 +
Need Code _{N2}	-0.092 [0.024]	0.000 **	-0.470 [0.136]	0.001 **
Need Code _{N3}	-0.066 [0.037]	0.079 +	-0.331 [0.201]	0.100
Need Code _{N4}	0.012 [0.022]	0.593	0.069 [0.106]	0.517
Need Code _{N5}	0.046 [0.020]	0.023 *	0.226 [0.097]	0.019 *
Need Code _{N6}	0.126 [0.031]	0.000 **	0.602 [0.139]	0.000 **
Need Code _{N7}	-0.197 [0.046]	0.000 **	-1.345 [0.504]	0.008 **
Need Code _{N8A}	-0.102 [0.035]	0.004 **	-0.612 [0.262]	0.020 *
Need Code _{N8U}	-0.202 [0.021]	0.000 **	-2.869 [0.712]	0.000 **
Need Code _{N9}	0.014 [0.036]	0.691	0.081 [0.167]	0.627
Age at CIN start	-0.056 [0.007]	0.000 **	-0.309 [0.031]	0.000 **

Age at CIN start ²	0.002 [0.001]	0.037 *	0.020 [0.004]	0.000 **
Age at CIN start ³	-0.000 [0.000]	0.032 *	-0.001 [0.000]	0.000 **
Age at intervention start	0.040 [0.005]	0.000 **	0.180 [0.021]	0.000 **
(Constant)	0.216 [0.024]	0.000 **	-1.210 [0.116]	0.000 **

Notes:

Standard errors are clustered at individual CIN case level

Observations = 13807

+ p < 0.1, * p < 0.05, ** p < 0.01

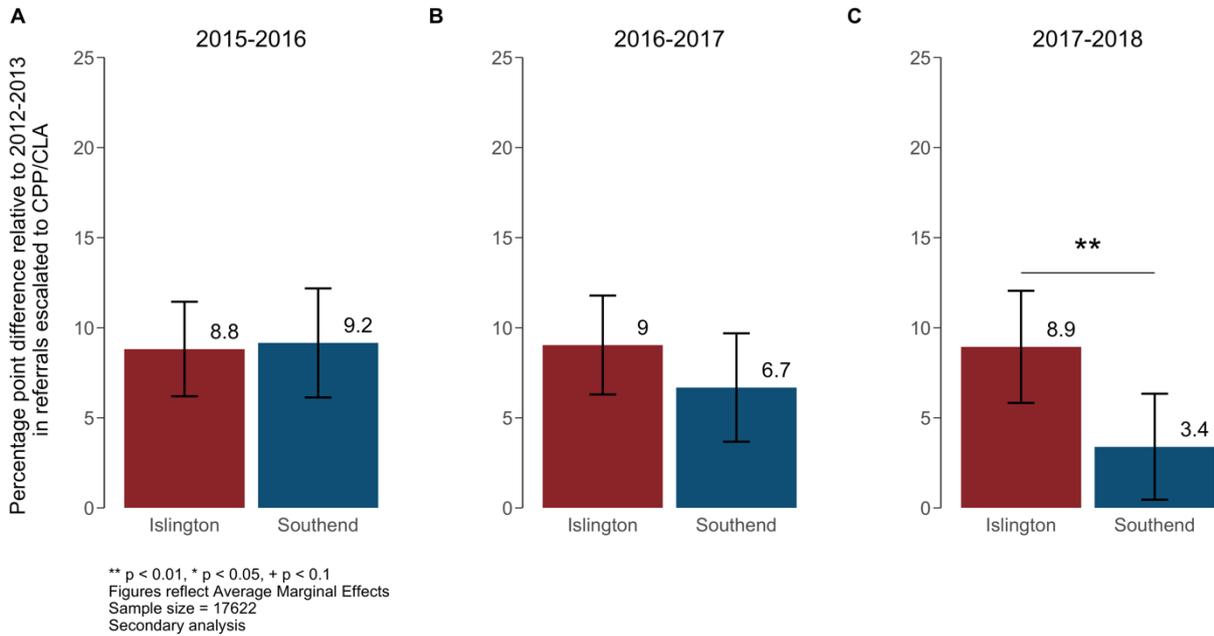
Probability of escalation to CPP or CLA within 12 months

There was evidence that the parallel trends assumption has been violated in 2014-2015 (see Table 11, rows highlighted in red). This indicates that it is not possible to infer causality from these estimates; instead these results are interpreted as associations. As discussed in the main text, interpretation of the effect in 2014-2015 is ambiguous, because it might also reflect a partial intervention effect. Some CIN referrals in this year may have continued into 2015-2016, when MP was introduced and their outcomes may reflect this partial exposure to MP. Note that if data from 2013-2014 (two years prior to MP onset) is analysed, no significant difference in trends is observed (see Table 11, rows highlighted in red). This would suggest that the effect in 2014-2015 may indeed be caused by partial exposure to MP. However, it should then be expected to observe a significant difference in 2015-2016 (when all referrals have been exposed to MP). No such an effect is observed (see Table 11, rows highlighted in green). Therefore, the interpretation around the effect in 2014-2015 remains ambiguous.

An alternative approach is to exclude any referrals in 2014-15 that extend into the following year. However, 52% of referrals in this time window match this criterion. It was therefore decided that interpreting results with such a significantly lower sample size (if these 52% of referrals were excluded) would not help clarify this issue.

Figure 15 shows the outcomes for all three post-intervention years.

Figure 15. Percentage point differences in CIN escalations to CPP or CLA within 12 months in Islington and Southend in each of the three years after MP onset.



The significant effect in 2017-2018 is partly driven by a decrease in the probability of escalations in Southend, as can be seen in Figure 16. The cause of this decrease is unclear. As outlined in Section 3.2, the assumption that Southend is a suitable comparator to Islington for this outcome is questionable and therefore, it is not possible to draw any strong conclusions about the impact of MP on the probability of escalation to CPP and/or CLA.

When comparing all three post-intervention years compared to all pre-intervention years, there was a statistically significant effect, with more escalations in the post-intervention years compared to the pre-intervention years ($\beta_{[Islington \times Post\ Intervention]} = 0.054$, SE = 0.01, $p < 0.001$).

Figure 16. Time trend for CIN escalations within 12 months

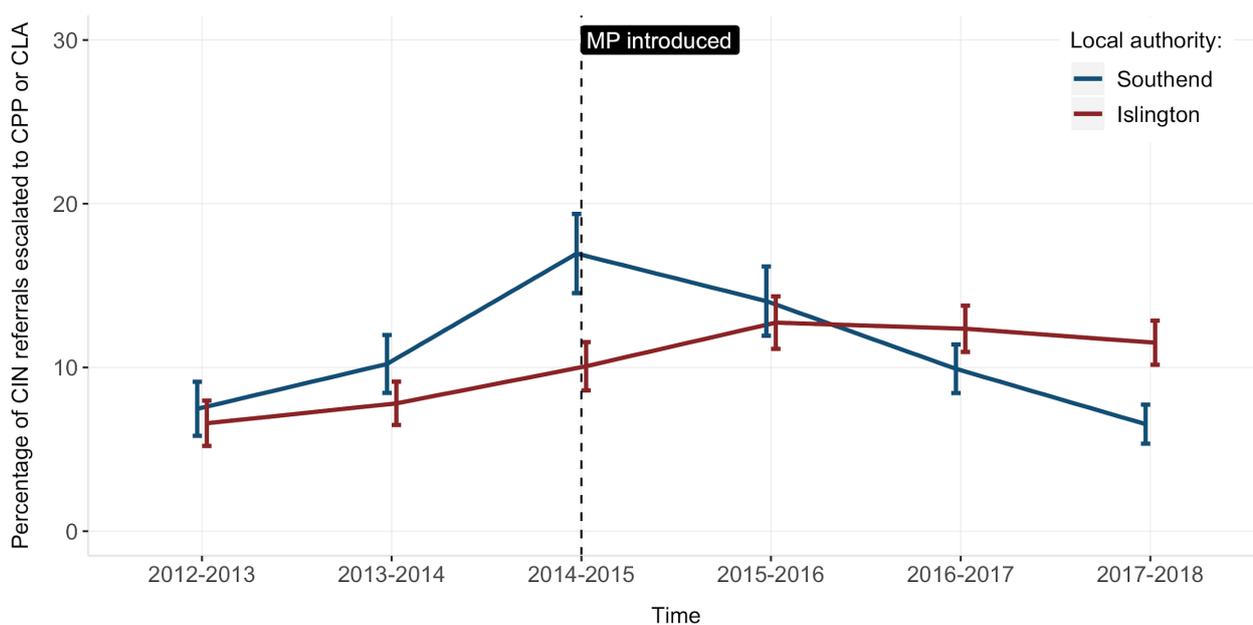


Table 11. Regression results: probability of escalation to CPP or CLA within 12 months.

	Probability of CIN escalation to CPP or CLA within 12 months			
	Linear regression		Logistic regression	
	Estimate [standard error]	P-value	Estimate [standard error]	P-value
LA _{Islington} × Time ₂₀₁₃₋₂₀₁₄	-0.012 [0.016]	0.442	-0.144 [0.219]	0.511
LA _{Islington} × Time ₂₀₁₄₋₂₀₁₅	-0.061 [0.018]	0.001 **	-0.502 [0.215]	0.020 *
LA _{Islington} × Time ₂₀₁₅₋₂₀₁₆	-0.003 [0.018]	0.848	0.035 [0.215]	0.871
LA _{Islington} × Time ₂₀₁₆₋₂₀₁₇	0.024 [0.016]	0.149	0.288 [0.217]	0.185
LA _{Islington} × Time ₂₀₁₇₋₂₀₁₈	0.055 [0.015]	0.000 **	0.763 [0.218]	0.000 **
LA _{Islington}	-0.005 [0.012]	0.692	-0.091 [0.177]	0.607
Time ₂₀₁₃₋₂₀₁₄	0.033 [0.012]	0.007 **	0.422 [0.159]	0.008 **
Time ₂₀₁₄₋₂₀₁₅	0.112 [0.015]	0.000 **	1.136 [0.158]	0.000 **
Time ₂₀₁₅₋₂₀₁₆	0.092 [0.015]	0.000 **	0.983 [0.169]	0.000 **
Time ₂₀₁₆₋₂₀₁₇	0.067 [0.015]	0.000 **	0.758 [0.181]	0.000 **
Time ₂₀₁₇₋₂₀₁₈	0.034 [0.015]	0.024 *	0.271 [0.185]	0.143
Need Code _{N1}	0.013 [0.008]	0.113	0.147 [0.093]	0.113

Need Code _{N2}	-0.065 [0.011]	0.000 **	-1.339 [0.290]	0.000 **
Need Code _{N3}	0.049 [0.027]	0.069 +	0.429 [0.217]	0.048 *
Need Code _{N4}	-0.010 [0.012]	0.413	-0.122 [0.152]	0.423
Need Code _{N5}	-0.002 [0.012]	0.851	-0.033 [0.138]	0.813
Need Code _{N6}	-0.019 [0.016]	0.248	-0.216 [0.225]	0.337
Need Code _{N7}	-0.057 [0.028]	0.039 *	-0.935 [0.730]	0.200
Need Code _{N8A}	0.123 [0.035]	0.000 **	1.139 [0.229]	0.000 **
Need Code _{N8U}	0.136 [0.033]	0.000 **	1.177 [0.214]	0.000 **
Need Code _{N9}	-0.073 [0.014]	0.000 **	-1.508 [0.465]	0.001 **
Age at CIN start	-0.052 [0.004]	0.000 **	-0.599 [0.040]	0.000 **
Age at CIN start ²	0.004 [0.001]	0.000 **	0.056 [0.005]	0.000 **
Age at CIN start ³	-0.000 [0.000]	0.000 **	-0.002 [0.000]	0.000 **
Age at intervention start	0.009 [0.003]	0.000 **	0.095 [0.024]	0.000 **
(Constant)	0.120 [0.015]	0.000 **	-2.202 [0.170]	0.000 **
<p>Notes:</p> <p>Standard errors are clustered at individual CIN case level Observations = 17622 + p < 0.1, * p < 0.05, ** p < 0.01</p>				

Impact evaluation of CLA outcomes

Table 12. CLA quantitative impact evaluation outcome indicators

Outcome	Indicator
Increase stability of CLA placements	Number of placement moves CLA experienced in each of the two years after intervention onset (August 2017-2019) <i>(Primary outcome indicator)</i>
Reduce residential care placements	Number of residential care placements CLA experienced in each of the two years after intervention onset (August 2017-2019) <i>(Secondary outcome indicator)</i>

Definition of moves. Moves were defined as placements that occurred after the very first placement. Note that children or young people (CYP) can lose or gain CLA status multiple times. Therefore only the very first time they became CLA was considered as their “CLA Start Date”. Accordingly, any subsequent placements (even if accompanied by a new CLA status) were counted as moves, as all of these changes reflect placement instability, in line with the evaluation aims.

Definition of residential care placements. To define residential care placements, the approach used in the Stability Index 2019, published by the Children’s Commissioner, was adopted (Clarke, 2019). This definition was broad in order to capture all placements that include some deprivation of liberty, and included:

- K1 - secure children’s home
- R1 - residential care home
- R5 - young offender institution
- S1 - residential school
- R2 - NHS/Health Trust or other establishment providing medical or nursing care

Evaluation design

Difference-in-difference (DiD) analysis: Due to complexities with the intervention and Islington’s commitments for training delivery, the evaluation was limited to a quasi-experimental difference-in-difference (DiD) analysis. This method estimates the impact of the MP intervention by comparing the change in outcomes among CLA in Islington before and after the intervention with the equivalent change in outcomes among CLA in a comparison borough over the same time period. The DiD analysis is a level 3 on the Maryland scientific scale.

DiD analysis relies on a central assumption that the time trends in the outcome measures in Islington and the comparison borough are parallel before the intervention and that they would have remained parallel if MP was not introduced in Islington. This should be the case even if the boroughs may differ in the outcome measures at any one time point. This “parallel trends assumption” enables the evaluation to infer that any change in the outcome measures after the intervention is caused by the intervention itself, and not any other factors which differently affect Islington and the comparison borough. This idea guided the choice of comparison borough.

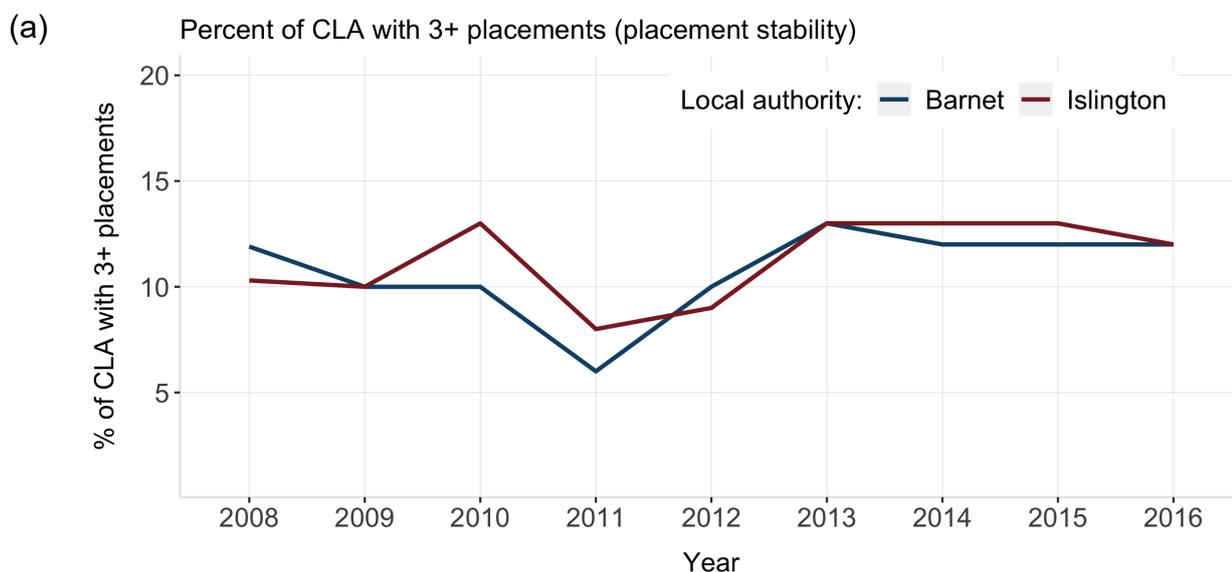
Identifying a comparison borough: The DiD analysis requires the identification of a comparison borough for Islington. In order to identify the most suitable comparison, the following criteria were used. First, the comparison borough had to exhibit time trends that are parallel to Islington, up to intervention onset (August 2017), in outcome measures most similar to the outcomes of interest for the evaluation. Data from the borough

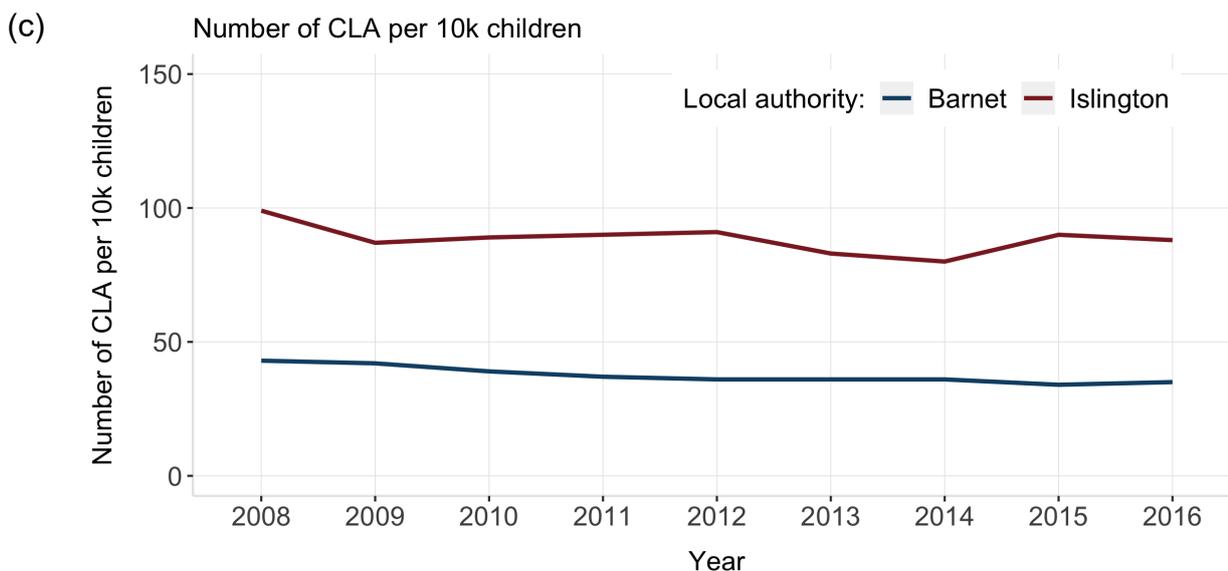
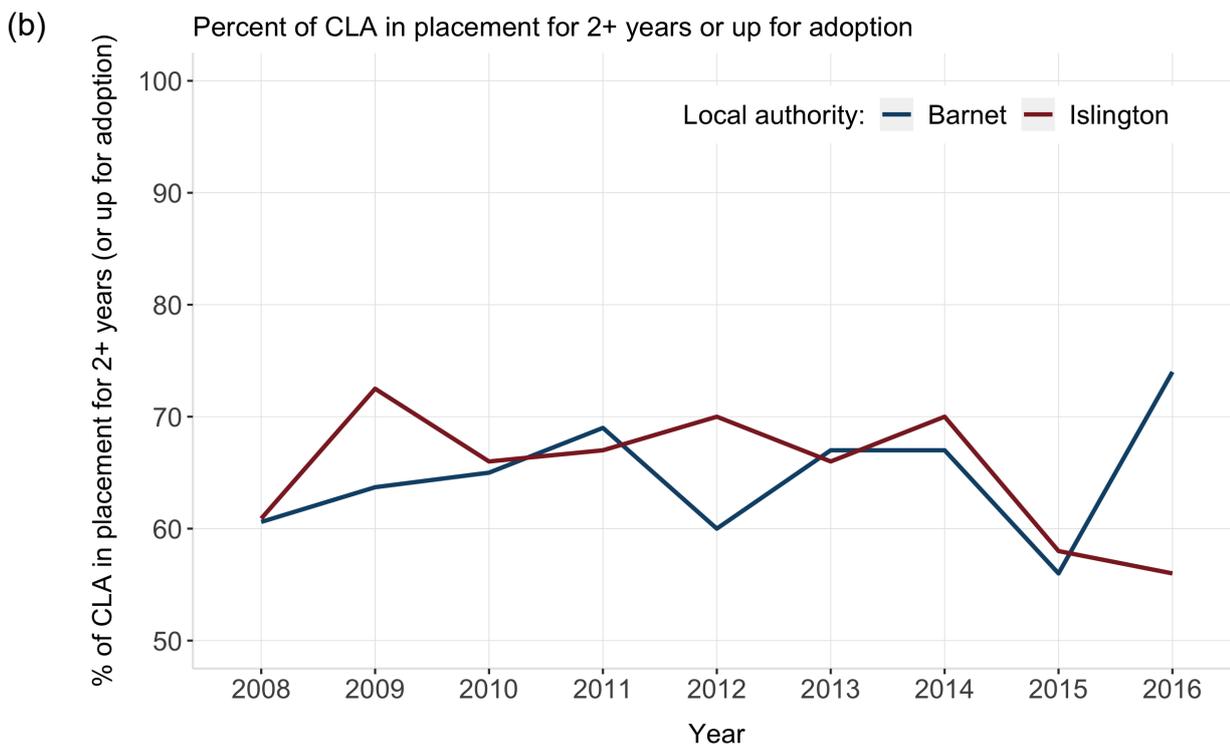
Interactive Tool (LAIT) from 2008-2016 were used; these summarise relevant CLA-related outcomes for each borough (Department for Education, 2014). Each borough was informally compared to Islington on the proportion of CLA cases that experienced three or more placements within 12 months, a measure that was most similar to the primary outcome and that was available for all years in 2008-2016 for most boroughs. In addition, it was ensured that any suitable borough was comparable to Islington on other, less directly relevant measures: (1) the proportion of CLA cases in a borough that were in the same placement for two or more years (or were put up for adoption); and (2) the number of CLA cases per 10,000 children in the borough population. Using these measures, boroughs were compared on time trends from 2008-2016 and 2014-2016, to identify both historic and more recent similarity.

Second, the aim was to find a comparison borough that did not introduce or have plans to introduce any training interventions of their own for the CLA and care leaver population during August 2017 (i.e., when Islington introduced the MP intervention).

Lastly, there was a preference for boroughs within Greater London and those who were willing to collaborate on the project. Based on these factors, Barnet was informally identified as the best match (see Figure 17).

Figure 17. Time trends in Islington and Barnet on the three outcome measures used to identify the comparison borough. (a) Percent of CLA with 3+ placements; this was the primary outcome. (b) Percent of CLA in a placement for 2+ years or up for adoption. (c) Number of CLA per 10k children in the borough.





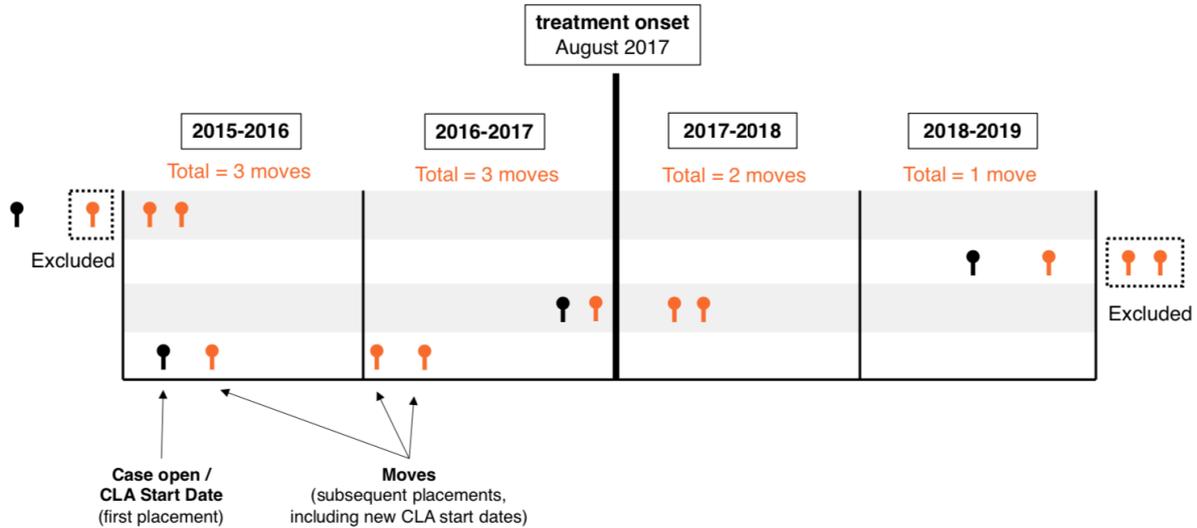
Description of data

The intervention onset occurred in Islington in August 2017. Administrative data were therefore obtained from Islington and Barnet on CLA cases open as of 2015-01-01 until 2019-12-31. These data include placements from CYP that became CLA prior to 2015 and from those that became CLA after 2015.

To compare time trends in outcomes, placements were binned by their start dates into yearly time-bins before and after the intervention, from 2015-08-01 until 2019-08-01 (see Figure 18). This enabled the analysis of placement moves and residential care placements starting in each year before and after intervention onset. See Figure 18 for an illustration of how this was done for placement moves. To analyse residential care

placements, the same procedure was used, except the first placement was included in the count of residential care placements.

Figure 18. Illustration of the data binning procedure.

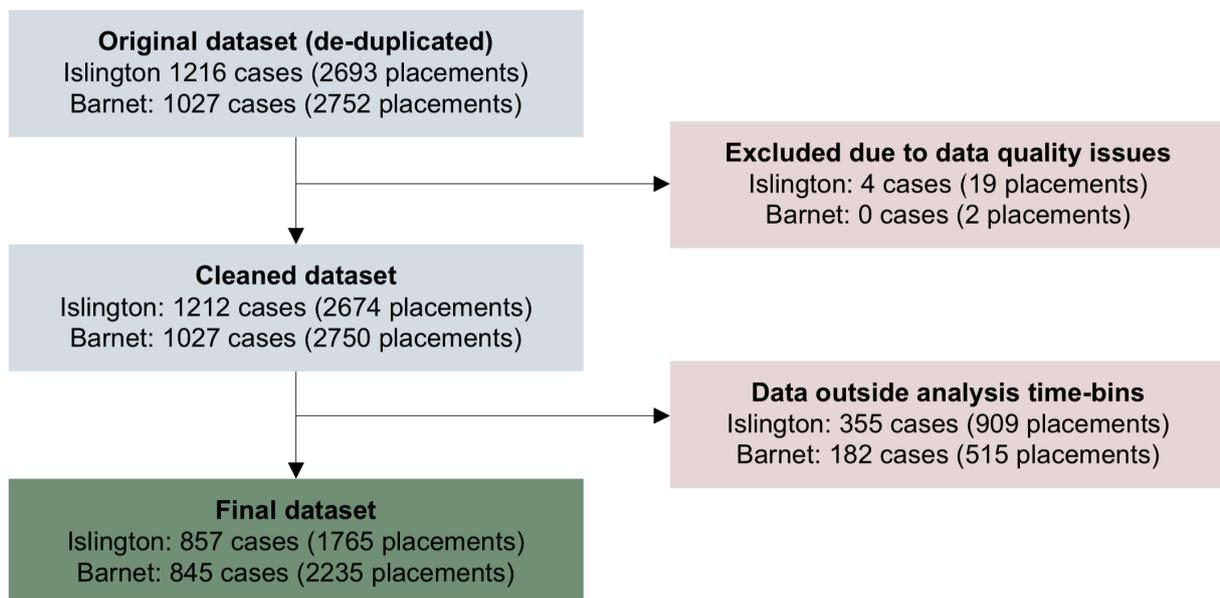


Notes: Each row represents a unique case (i.e., a CYP). Black pins represent when a CLA case first opens; orange pins represent subsequent moves. Cases in the dotted box are excluded from the analysis because they fall outside the analysis time windows.

Inclusions and exclusions

Placements were excluded if they were missing covariates or had other data quality issues and or if they fell outside the 12-month time-bins defined above (see Figure 19 for consort diagram).

Figure 19. Consort diagram of data inclusions and exclusions.



Notes: Data quality issues included missing dates of birth and primary need codes, placement start dates before CLA start dates, and CLA start dates after CYP turned 18.

Descriptive summary

See Table 13 for counts of CLA cases, placement moves, and residential care placements in each year and borough.

Table 13. Total number of CLA cases, placement moves, and residential care placements by time-bin and borough.

Borough	Year	Total CLA cases	Total number of moves	Total residential care placements
Islington	2015-2016	394	323	27
Islington	2016-2017	531	283	34
Islington	2017-2018	607	236	28
Islington	2018-2019	616	244	26
Barnet	2015-2016	325	300	30
Barnet	2016-2017	494	345	36
Barnet	2017-2018	591	320	29
Barnet	2018-2019	664	427	21

Notes: CLA cases can appear in more than one year and without necessarily experiencing any moves during a given time-bin.

Primary analysis

The outcome measure is a count (number of moves), which does not follow a normal distribution and which has a variance that is higher than the mean (i.e., it is over-dispersed). Therefore, this measure does not comply with the assumptions required for a linear model. For this reason, data were analysed by fitting a quasi-poisson model of the form:

$$(2) Y_{it} \sim \text{quasipoisson}(\lambda_{it}, \phi)$$

$$\log(\lambda_{it}) = \beta_0 + \beta_1 \text{Time}_{it}^{2015-2016} + \beta_2 \text{Time}_{it}^{2017-2018} + \beta_3 \text{Time}_{it}^{2018-2019} + \beta_4 LA_i + \beta_5 \text{Time}_{it}^{2015-2016} \times LA_i + \beta_6 \text{Time}_{it}^{2017-2018} \times LA_i + \beta_7 \text{Time}_{it}^{2018-2019} \times LA_i + \beta_8 \text{Covariates}_i + \text{Exposure}_{it}$$

(1)

where:

- Y_{it} is the number of moves for CLA case i at time t
- $Time_{it}^{2015-2016}$, $Time_{it}^{2017-2018}$, $Time_{it}^{2018-2019}$ are binary variables indicating the year t for CLA case i (the reference year for the analysis was 2016-2017).
- LA_i is a binary treatment variable indicating whether the local authority (borough) is Islington for CLA case i
- $Covariates_i$ is a set of covariates for CLA case i (see Table 2 below for details):
 - Age at CLA start date and its 2nd and 3rd order polynomials (continuous)
 - Age at treatment start (continuous)
 - Primary need code group (3 categories)
 - SEN group (6 categories)
 - Youth Justice legal status (binary)
 - PRU contact status (binary)
 - UASC status (binary)
 - Disabilities status (binary)
 - First placement residential care status (binary)
- $Exposure_{it}$ is an offset variable indicating the observation length for CLA case i at time t (see Figure 3 and details below, for how this was defined).
- Standard errors were clustered at the individual CLA case level to account for CLA cases having outcomes in multiple time-bins.¹¹

β_5 tests for a possible violation of the parallel trends assumption. It is an interaction between LA and pre-treatment year 2015-2016 (with pre-treatment year 2016-2017 as a reference). A non-significant interaction was interpreted as the absence of evidence that the parallel trends assumption has been violated.

β_6 and β_7 are the coefficients of interest that test for the impact of MP on the number of moves in the first and second year after intervention onset. They are interactions between

¹¹ Note that 76% of cases had outcomes defined for more than one year. However, the effect of the intervention is identified by variation in the outcome across CLA, rather than within CLA. Therefore fixed effects were not included for the CLA case identifier.

LA and post-treatment year 2017-2018 or 2018-2019 (with pre-treatment year 2016-2017 as a reference). A significant interaction was interpreted as evidence that MP impacted the number of moves that CLA cases experienced in that year.

Table 14. Covariates used in model (2).

Variable	Description
Age at CLA Start Date	Continuous variable indicating CLA's age at the CLA Start Date
Age at CLA Start Date (2nd order polynomial)	The quadratic and cubic terms of the above age variable, used to capture non-linearity in the relationship between age and the number of placements (e.g., floor and ceiling effects at 0 and 18 years, respectively; Troncoso, 2017).
Age at CLA Start Date (3rd order polynomial)	
Age at treatment start	Continuous variable indicating age at August 2017
Primary Need Code group	<p>Categorical variable indicating the relevant group of Primary Need Codes. Due to the rarity of some Need Codes in the data, the Need Codes present in the data were grouped into three groups, ranging from least to most associated with placement instability (Children's Commissioner's Office, 2018; Clarke, 2019):</p> <p>Group 1</p> <ul style="list-style-type: none"> ○ N2 - Child disability ○ N3 - Parent illness or disability ○ N8 - Absent Parenting or UASC ○ Not Recorded <p>Group 2</p> <ul style="list-style-type: none"> ○ N1 - Abuse or neglect ○ N4 - Family in acute stress ○ N5 - Family dysfunction <p>Group 3</p> <ul style="list-style-type: none"> ○ N6 - Socially unacceptable behaviour ○ N7 - Low income ○ Multiple primary need codes ○ No Recourse to Public Funds
SEN group	<p>Categorical variable indicating the relevant group of SEN statuses. Due to the rarity of some SEN statuses in the data, some of these present in the data were grouped into six groups (Children's Commissioner's Office, 2018; Clarke, 2019):</p> <ol style="list-style-type: none"> 1. Social, Emotional, and Mental Health (SEMH) needs

	<ol style="list-style-type: none"> 2. All learning difficulties 3. Physical disabilities including speech, language or communication difficulties; and vision and hearing impairment 4. Autistic spectrum disorders 5. Other, including No Specific Assessment 6. None
Youth Justice Legal Status	Binary variable indicating whether the CLA has a recorded youth justice legal status (codes J1, J2 or J3; Children’s Commissioner’s Office, 2018; Clarke, 2019).
PRU contact status	Binary variable indicating whether CLA had any contact with a Pupil Referral Unit
UASC status	Binary variable indicating whether CLA is an unaccompanied asylum-seeking child
Disabilities status	Binary variable indicating whether CLA is labelled as having disability needs
Residential care at first placement	Binary variable indicating whether the CLA’s first placement was in residential care

Notes: Covariates were included based on prior research showing that they were associated with placement outcomes for the CLA population (Children’s Commissioner’s Office, 2018; Clarke, 2019; Troncoso, 2017).

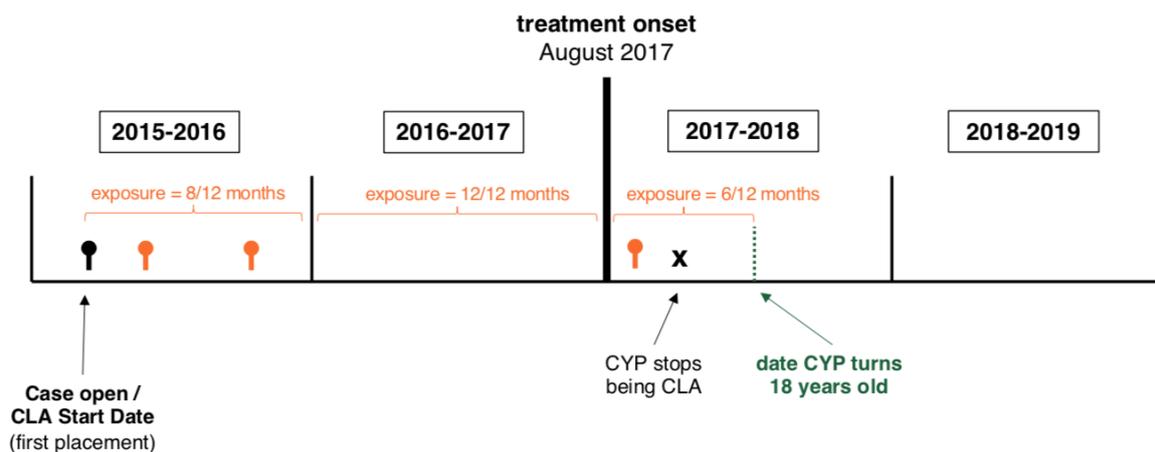
Exposure (offset variable). The offset variable controls for the differences in observation length between CLA cases within each year that arise because CLA cases are open for varying lengths of time. Put another way, the offset controls for the exposure that each CLA case has in each year to be observed. For example, a CLA case that is open for only 6 months of a year may have less moves than one that has been open for the entire 12 months, simply because there is less opportunity to observe moves in the former than the latter.

For each CLA, exposure was defined as the proportion of 12 months (the length of each time-bin) that potential moves could be observed. This was defined this for each CLA case in each year based on the CLA Start Date and the date the CYP would turn 18 years old. This was because the definition of moves included those that occurred after CLA cases had closed (i.e., following new CLA start dates and subsequent placements after the initial CLA Start Date). To remain consistent with this approach, the possibility that, even if a case had closed, it may re-open again in the future was allowed. Thus, a case’s exposure technically continues beyond the recorded CLA end date, at least until the CYP turns 18. See below (and Figure 3) for examples of exposure:

- If the CLA Start Date occurs at month 6 of the year and the CLA turns 18 after the end of the year, *Exposure = 6/12 months* for the year

- If the CLA Start Date occurs before the start of the year and the CLA turns 18 at month 6 of a year, *Exposure* = 6/12 months for the year
- If the CLA Start Date occurs at month 6 of the year and the CLA turns 18 at month 8 of the year, *Exposure* = 2/12 months for the year
- If the CLA Start Date occurs before the start of the year and the CLA turns 18 after the end of the year, *Exposure* = 12/12 months for the year

Figure 20. Illustration of how exposure was defined.



Notes: Each row represents a unique case (i.e., a CYP). Black pins represent when a CLA case opens; orange pins represent subsequent moves. 'X' indicates the latest CLA case closure available in the data for the CYP. Green dotted line indicates when the CYP turns 18 years old. Exposure was defined from the CLA start date until the time when CYP turns 18 years old.

Bar graphs of the intervention effect. The results are presented by comparing the change in outcomes in Islington and in Barnet in each year after MP was introduced, relative to 2016-17 (the reference year). Each change is reported as the average marginal effect (AME) of each post-intervention year for each borough (derived from the DiD analysis using the *margins* package in R; Leeper, 2018). This is the change in outcomes in a given year relative to a reference year for a given borough, averaged across the unit of analysis (i.e., CLA cases) and controlling for all covariates. A difference between the AME in each borough corresponds directly to the DiD interaction effect (i.e., β_6 and β_7). Error bars around the AMEs indicate 95% confidence intervals, adjusted for clustering as in the main regression specification.

Outcome time trend graphs. To visualise the time trends of the outcome measure in a manner consistent with the analysis, for each year and borough, the number of moves per person per year (i.e., an average, unadjusted for covariates), adjusted for the exposure that cases have in each time-bin, was computed:

$$\frac{totalMoves}{totalPersonYears}$$

Where:

- *totalMoves* is the sum of the number of moves in that year across all CLA cases in the borough.
- *totalPersonYears* is the sum of all the offsets (exposures) in that year across all CLA cases in the borough.

Similarly, 95% confidence intervals were computed for each year and borough:

$$1.96 \times \frac{\sqrt{\text{totalMoves} \times \delta}}{\text{totalPersonYears}}$$

Where:

- δ is the dispersion of the data (i.e., variance-to-mean ratio).

Secondary analysis

Analysis of the secondary outcome (the number of residential care placements) was identical to the primary analysis, except for two differences. First, the first placement was included in the count of residential care placements, as there was no longer specific interest in the number of moves. Second, the covariate “First placement residential care status” was excluded because it forms a part of the outcome of interest. All other details remained the same.

Exploratory analysis

Additionally, for each outcome, the overall effect was tested across the two post-treatment years, as compared to the two pre-intervention years. A model identical to model (2) was run, albeit with a binary time indicator (1 = after intervention, 0 = before intervention).

Additional quantitative results

Number of placement moves

There was no evidence that the parallel trends assumption has been violated in the pre-intervention period (see Table 15, row highlighted in red). When comparing both post-intervention years to both pre-intervention years, there was a marginally statistically significant effect ($\beta_{[\text{Islington} \times \text{Post Intervention}]} = -0.225$, SE = 0.117, p = 0.053).

Table 15. Regression output from the analysis of the number of placement moves.

	Number of placement moves	
	estimate [standard error]	P-value
$LA_{\text{Islington}} \times \text{Time}_{2015-2016}$	0.0963 [0.1390]	0.4885

LA _{Islington} × Time ₂₀₁₇₋₂₀₁₈	-0.0621 [0.1402]	0.6575
LA _{Islington} × Time ₂₀₁₈₋₂₀₁₉	-0.2461 [0.1491]	0.0987 +
LA _{Islington}	-0.3321 [0.1004]	0.0009 **
Time ₂₀₁₅₋₂₀₁₆	0.3562 [0.0932]	0.0001 **
Time ₂₀₁₇₋₂₀₁₈	-0.3006 [0.0967]	0.0019 **
Time ₂₀₁₈₋₂₀₁₉	-0.1448 [0.1035]	0.1619
Age at CLA start	-0.1471 [0.0529]	0.0054 **
Age at CLA start ²	0.0319 [0.0075]	0.0000 **
Age at CLA start ³	-0.0012 [0.0003]	0.0000 **
Age at intervention start	-0.0479 [0.0163]	0.0032 **
Need code group ₂	0.2085 [0.1156]	0.0713 +
Need code group ₃	0.1494 [0.2166]	0.4903
First Placement in Residential Care	0.0404 [0.1297]	0.7553
Pupil Referral Unit contact	0.5008 [0.0980]	0.0000 **
Unaccompanied asylum-seeking child	-0.2417 [0.1450]	0.0955 +
Disability	0.0848 [0.1270]	0.5044
Youth Justice Status	-0.3054 [0.1991]	0.1251
Special Education Needs _{ASD}	-0.0989 [0.2064]	0.6318
Special Education Needs _{LD}	0.1052 [0.1755]	0.5490
Special Education Needs _{other}	0.2951 [0.1664]	0.0761 +
Special Education Needs _{PD}	-0.6740 [0.2160]	0.0018 **
Special Education Needs _{SEMH}	0.3196 [0.0990]	0.0012 **
(Constant)	-1.2590 [0.1499]	0.0000 **

Notes:

Quasi-poisson regression; standard errors are clustered at CLA case level

Observations = 4222

+ p < 0.1, * p < 0.05, ** p < 0.01

ASD - Autistic Spectrum Disorder; LD - Learning Difficulties; PD - Physical Disabilities; SEMH - Social, Emotional, and Mental Health needs.

Number of residential care placements

No evidence was observed that the parallel trends assumption has been violated in the pre-intervention period (see Table 16, row highlighted in red). When comparing both post-intervention years to both pre-intervention years. There was no statistically significant effect ($\beta_{[Islington \times \text{Post Intervention}]} = 0.313$, $SE = 0.319$, $p = 0.327$).

Table 16. Regression output from the analysis of the number of residential care placements.

	Number of residential care placements	
	estimate [standard error]	p-value
$LA_{Islington} \times Time_{2015-2016}$	-0.2374 [0.3891]	0.5417
$LA_{Islington} \times Time_{2017-2018}$	0.0372 [0.4180]	0.9291
$LA_{Islington} \times Time_{2018-2019}$	0.4197 [0.4339]	0.3334
$LA_{Islington}$	-0.5554 [0.2830]	0.0497 *
$Time_{2015-2016}$	0.3298 [0.3018]	0.2745
$Time_{2017-2018}$	-0.3429 [0.3195]	0.2832
$Time_{2018-2019}$	-0.7165 [0.3425]	0.0364 *
Age at CLA start	-0.8609 [0.1792]	0.0000 **
Age at CLA start ²	0.1090 [0.0256]	0.0000 **
Age at CLA start ³	-0.0034 [0.0009]	0.0002 **
Age at intervention start	-0.0322 [0.0408]	0.4295
Need code group ₂	-0.4888 [0.3818]	0.2005
Need code group ₃	-0.0281 [0.4630]	0.9517
Pupil Referral Unit contact	0.7391 [0.2293]	0.0013 **
Unaccompanied asylum-seeking child	-2.0054 [1.0744]	0.0620 +
Disability	0.4534 [0.3094]	0.1428
Youth Justice Status	1.6479 [0.2812]	0.0000 **

Special Education Needs _{ASD}	0.3312 [0.5980]	0.5797
Special Education Needs _{LD}	0.1591 [0.3103]	0.6080
Special Education Needs _{other}	0.5622 [0.8023]	0.4835
Special Education Needs _{PD}	0.8609 [0.3813]	0.0240 *
Special Education Needs _{SEMH}	0.6967 [0.2990]	0.0198 *
(Constant)	-2.7633 [0.4574]	0.0000 **

Notes:

Quasi-poisson regression; standard errors are clustered at CLA case level

Observations = 4222

+ p < 0.1, * p < 0.05, ** p < 0.01

ASD - Autistic Spectrum Disorder; LD - Learning Difficulties; PD - Physical Disabilities; SEMH - Social, Emotional, and Mental Health needs.

Appendix 5: Qualitative evaluation details

Recruitment Details

The recruitment process began in July when sampling criteria were shared with Islington along with consent forms and information sheets for participants. At this stage weekly calls were also agreed with the Innovation team.

The recruitment process was as follows:

1. Innovation team reach out to social workers (via team managers) and share consent forms and information sheet;
2. Social workers agree to take part and to be contacted;
3. Innovation team pass on social worker details to BIT staff who then contact social workers directly to arrange a time.

This process was the same for supervisory social workers and personal assistants involved in the focus group. When recruiting for foster carers, parents and young people, the Innovation team contacted various team managers who then passed on information to families they deemed suitable. Consent to contact was required from the interviewees before it was possible to contact them directly.

Recruitment Barriers

Responses for CIN parent and young people interviews was very low; the feedback gathered from social workers outlined the following barriers:

-Lack of incentive; social workers felt awkward asking parents to take part when there was no compensation for the parent and young people involved. The Innovation Team later reintroduced a voucher reward for taking part. Again, social workers felt the amount was low and some social workers thought that parents would be able to get three times the amount for taking part in market research.

-No way to give written consent: Several parents had no way of signing a consent to contact form and sending back electronically due to lack of access to technology products. It was then agreed to obtain verbal consent to contact from the Innovation Team to bypass this.

Appendix 6: Survey findings

Below are the summary descriptive statistics of the responses to the most relevant questions in the FC survey

Table17. Survey demographics

Demographic characteristics	Most common: Number of respondents	Most Common: Category	Range of responses
Number of CYPs FC is currently looking after	64.3% (n=9)	1 CYP	Not currently looking after any CYPs, 1 or more CYPs
Age of CYPs	50% (n=6)*	16-20 years old	Birth-5 years old to 16-20 years old
Genders of CYPs	58.3% (n=7)*	All male	All males, all females, non-binary, different genders
Age of FC	69.2% (n=9)	51-60 years old	41-50 years of age – 51-60 years of age
Years of being a FC	41.7% (n=5)	0-5 years	1-5 years – 11-15 years
Number of CYPs looked after since first became a foster carer	57.1% (n=8)	1-4 CYPs	1-4 CYPs- 20+ CYPs
Types of CYPs foster carer looks after	42.9% (n=6)	CYPs with special needs (e.g., physical and learning disabilities, behavioral challenges)	CYPs with special needs, without special needs and both with and without special needs

*Two participants skipped this question; they are excluded from the total count of respondents for those specific questions

Table 18. Survey Training attendance

Type of training*	Percentage of respondents	Number of respondents
Introduction to PACE parenting for carers of children under 10 years old (2 day course)	21.4%	3
Introduction to PACE parenting for carers of children/young people over 10 years old (2 day course)	35.7%	5
Attachment-Based Fostering/Parenting course for carers of children under 10 years old (8 weeks - October to December 2018)	21.4%	3
Attachment-Based Fostering/Parenting course for carers of children/young people over 10 years old (8 weeks - January to March 2019)	14.3%	2

Nurturing Attachments course (18 weeks - January to December 2017)	7.1%	1
None of the training above	42.9%	6

*Participants can select more than one option

Table 19. Survey Variation in training attendance

Number of training courses attended	Percentage of respondents	Number of respondents	Notes
No training courses	42.9%	6	
One training course	21.4%	3	
Two training courses	21.4%	3	
Three training courses	7.1%	1	
Excluded	7.1%	1	Attended training courses outside of Islington CSC

Table 20. Survey Reasons for not attending training

Reason	Percentage of respondents	Number of respondents
Not suitable day of the week or time of day	33%	2
The training did not seem relevant to my role as a foster carer	17%	1
Other: Personal reasons	17%	1
Other: Conflict with work	33%	2

Table 21. Support for Foster Carers: Perceived importance and quality ratings

Type of Support	Rating type*	Respondents rated most common	Most Common response	Range of responses
Your supervising social worker	Importance	100% (n=14)	Very important	N/A
	Perceived quality	42.9% (n=6)	Excellent	Fair, good, very good, excellent
Your child(ren)'s social workers	Importance	92.9%(n=13)	Very important	Very important, not important
	Perceived quality	42.9% (n=6)	Good	Poor, good, very good, excellent
Out-of hours emergency support	Importance	71.4%(n=10)	Very important	Very important, moderately important
	Perceived quality	35.7% (n=5)	Good	Fair, good, very good, excellent, have not received this support

Support groups for foster carers	Importance	64.3%(n=9)	Very important	Very important, moderately important
	Perceived quality	42.9% (n=6)	Very good	Fair, good, very good, excellent
Foster care association	Importance	71.4%(n=10)	Very important	Very important, moderately important
	Perceived quality	42.9% (n=6)	Good	Poor, fair, good, very good, excellent
Respite foster carer	Importance	71.4%(n=10)	Very important	Very important, moderately important, not important, don't know what it is
	Perceived quality	64.3% (n=9)	Have not received this type of support	Poor, fair, good, very good, have not received this support
Financial support provided by Islington Children's Social Services	Importance	100.0%(n=14)	Very important	N/A
	Perceived quality	42.9% (n=6)	Good	Fair, good, very good, excellent, have not received this support
Training provided by Islington Children's Social Services	Importance	92.9%(n=13)	Very important	Very important, moderately important
	Perceived quality	42.9% (n=6)	Very good	Good, very good, excellent

Note:

Level of importance scale range: Not important, Moderately important, very important, I don't know what this is

Perceived quality of support scale range: Poor, fair, good, very good, excellent, I have not received this type of support

Table 22. Survey Training Logistics

Response Categories	Respondents that indicated most common option	Most common response	Range of responses
Training delivery date and time			
The training was	75% (n=9)	Yes	Yes, Somewhat

delivered at a convenient time of day			
The training was delivered during day(s) of the week that worked well with my schedule	50% (n=6)	Yes	Yes, somewhat, no, does not apply
It was difficult for me to make childcare arrangements to attend this training	50% (n=6)	Does not apply	Yes, somewhat, no, does not apply
I was difficult for me to take time off work to attend this training	83% (n=10)	Does not apply	Yes, somewhat, no, does not apply
Training location			
The training took place far away from my home, which made it inconvenient	58% (n=7)	No	No, does not apply
The building in which the training was held was easily accessible	92% (n=11)	Yes	Yes, does not apply
The room in which the training was held was easily accessible	92% (n=11)	Yes	Yes, does not apply
The room in which the training was held was crowded	58% (n=7)	No	Yes, somewhat, no, does not apply
The room in which the training was held negatively impacted by ability to learn	83% (n=10)	No	No, does not apply

Note: This table shows aggregated responses across all the training sessions. A participant was asked to rate the training logistics for each training they attended. Thus, the total number of responses is 12, which was completed by six respondents (i.e., 6 participants attended a total of 12 training sessions). One participant's responses for two training sessions were excluded because they indicated they attended those training sessions outside of Islington CSC.

Table 23 Survey Training delivery

Response Categories	Respondents that indicated most common option	Most common response	Range of responses
Training facilitators			
The facilitators were knowledgeable about the training content	81.8% (n=9)	Completely True	Mostly true, completely true
The facilitators delivered the training in an engaging way	60% (n=10)**	Completely True	Mostly true, completely true
Training length and content			
The training was too long	100% (n=11)	Not at all true	N/A
The training content was easy to understand	45.5% (n=5) 45.5%(n=5)	Mostly true Completely true	Somewhat true, mostly true, completely true
The purpose of the training was clearly explained	81.8% (n=9)	Completely True	Mostly true, completely true
The training content was relevant to my role as a Foster Carer	81.8% (n=9)	Completely True	Somewhat true, mostly true, completely true
The training provided sufficient opportunities to ask questions	81.8% (n=9)	Completely True	Mostly true, completely true
The training provided sufficient time to practice applying the knowledge and skills	54.5% (n=6)	Completely True	Somewhat true, mostly true, completely true
The training activities were useful	72.7% (n=8)	Completely True	Somewhat true, mostly true, completely true
The training provided sufficient opportunities to take a break	63.6% (n=7)	Completely True	Mostly true, completely true

Useful take-home resources were provided to the training participants	54.5% (n=6)	Completely True	Not at all true, mostly true, completely true
I left the training feeling prepared to use the knowledge and skills I learned in my role as a Foster Carer	63.6% (n=7)	Completely True	Mostly true, completely true

N=11, No response of those eligible n=1

*One participant did not respond to this subquestion

Note: Response scale range - Not at all true, slightly true, somewhat true, mostly true, completely true, I don't remember, Didn't respond

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