



Department  
for Education

# Compass Service

**Evaluation Report**

**July 2017**

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# Executive summary

## Summary of the project and evaluation

The aim of the Compass service was to build upon the success of a therapeutic education service in Norfolk (the Compass School) through a bespoke multidisciplinary package of care that supported young people who were Looked After Children (LAC) or are at risk of being taken into care, to ensure that they could remain with the family wherever possible and be reunified at the earliest opportunity. This comprised developing the Compass Outreach Service (COS), the Virtual Residential School (VRS), and the Family Development Unit. This allowed families to receive individualised care designed around their needs. At the time this report was written, the full Compass model had not been implemented (the Family Development Unit was estimated to become operational in January 2017) so the evaluation focused on COS and VRS. The overarching aim of the evaluation was to examine whether, and by what means, the Compass service (COS and/or VRS) was effective at improving young people's wellbeing.

## Methodology of the evaluation

A quantitative driven, multilevel mixed methods design was used, with a qualitative component to triangulate the quantitative data (Teddlie & Tashakkori, 2008). It comprised the following strands: COS service data ( $n=152$  cases, 53 (35%) of which were open and 99 (65%) had been discharged by July 2016); routinely collected outcome data completed when young people joined the Compass service (T1) and 4 to 6 months later (T2) including measures completed by young people, parents or carers, teachers, and clinicians; and qualitative data consisting of interviews with young people ( $n=22$ , 5 from COS and 17 from VRS) and parents or carers ( $n=17$ , 13 from COS, 1 from VRS and 3 with missing information), and focus groups with professionals ( $n=5$  with 24 Compass staff from COS and VRS).

The evaluation questions were:

- does the Compass service reduce the number of young people becoming engaged in statutory social care service?
- does the Compass service improve young people's emotional, behavioural and family functioning?
- does the Compass service improve young people's academic attainment?
- what might be the mechanisms by which the Compass service improves young people's outcomes?

- what is staff's experience of the Compass service?
- what is the young people's and parents or carers' experience of staff at the Compass service?
- what are the results of the cost-benefit analysis?

## Key findings

Evidence suggested that the COS was associated with a reduction in the use of statutory social care services: 9 cases who were admitted to COS with a legal status were discharged from COS without one, and only 3 children could not be prevented from becoming LAC from admission to discharge. Furthermore, COS data showed that out of the 16 young people who were living in foster care at referral, 5 were successfully returned to their homes. Data also showed that 11 out of 70 young people who were living at home at referral could not be prevented from going into foster care.

In the focus groups, staff described sustained long-term work with children, young people and families as helping to stabilise home environments, reducing out-of-county placements or children becoming looked after, and increasing reunifications. Some staff noted the potential cost-saving of the Compass service by reducing placement breakdowns, out-of-county placements, or children becoming looked after, or by increasing reunifications and educational engagement. Even though the dataset for COS cases is of high-quality and captures a range of data items, as the Compass approach aims to be holistic, it might be useful for a future evaluation to add items about the particular aspects of the Compass service that the young person is attending (for example, COS only, COS plus VRS, etc.).

According to most parents and young people, the Compass service provided a more holistic approach compared to other services, as it focused, not only on the child, but also on the family. Within this context, both parents and young people reported that Compass supported young people in their emotional wellbeing (especially their confidence and self-esteem) and their behavioural difficulties (especially with anger and aggressive behaviour). Parents and young people also reported that Compass supported the family by improving parental skills and by reunifying relationships between parents and their young people; between siblings, and with extended family. However, some young people reported uncertainties about any changes in themselves or their families since accessing the Compass service.

Overall, outcome measures completed by young people, parents and teachers showed no change in young people's internalising and externalising problems or in young people's self-esteem. Positive changes in young people's hyperactivity problems and total difficulties were reported by young people; and changes in young people's peer problems and total difficulties were reported by their parents. Furthermore, staff



reported that, as a group, young people had a better level of functioning 4 to 6 months after entering Compass. The results presented were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained. In addition, a longer follow-up of those who access the Compass service is necessary to examine the long-term effects of the service.

Parent reports of COS improving academic attainment were mixed, due to the varied involvement of COS in educational provision. Parents with experience of the VRS described their involvement through feedback to education staff during meetings. Parents with no experience of VRS described not needing such support as this domain was stable, or because parents felt that this work had not commenced. Two parents whose young people accessed the VRS described the negative aspects of these services as including the lack of information about the provision, and the upper age limit of 14. On the other hand, almost half of interviewed young people described improvements in their school work and abilities within their education provision. Further evaluation of the impact of Compass on academic attainment could be conducted using academic data from pupils in VRS.

The majority of staff described the key mechanism by which Compass was effective was through working with the whole family to empower children, young people and families to better manage emotional and behavioural difficulties in the home, which reduced the need to engage with services as well as preventing the escalation of difficulties to the point of crisis. Compass support of the whole family was also reported by young people as a key mechanism. Furthermore, the ability to work flexibly to meet the individual needs of children, young people and families was described by Compass staff as the lynchpin to this innovation. Young people independently reported the same – that is, the positive effect of the service's flexibility. Another mechanism reported by staff was the multidisciplinary team work which, according to them, provided the right mix of skills to meet the individual needs of children, young people and families; gave staff the opportunity to learn from, and support, colleagues; and to come together to share knowledge and experience about a case.

According to parents, a key means to improving outcomes was in increasing their confidence (both in themselves and as parents), and an increase in their parental abilities and knowledge. Providing parents with a different perspective during a crisis situation was another mechanism which was reported to improve outcomes for young people.

In the focus groups, all staff described high levels of job satisfaction from working with children, young people and families and witnessing positive changes in their lives. Other sources of staff's job satisfaction were MDT work, the ability to work flexibly and to sustain long-term work, and the feeling that their work was filling an important gap in the care of young people and parents or carers. However, when the focus groups were

conducted, the volume of work, in terms of engaging with multiple individuals across a large geographical area; and administrative or information sharing difficulties, were described as challenges which, according to the Compass team, have now been addressed. Building on the success of the cross-sector working and the multidisciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care.

Regarding parents' experiences of staff at Compass, they were overall positive. Staff members were described as genuine, non-judgemental, supportive, down-to-earth and approachable. When compared to other services, Compass staff were reported to respond immediately to issues. The home visitation service provided by COS was reported by parents to make it easier to talk about difficult situations. Young people described staff as "open", "friendly" and "lovely", and reported having a positive relationship with them.

Finally, it was estimated by the cost-benefit analysis conducted by our partner York Consulting that, through the implementation of COS, the local authority costs were reduced. This is evidenced by the fact that COS supported their target group - most of the cases (49, 33%) were Child in Need; followed by 39 (26%) who were in Child Protection; 33 (22%) who were LAC, and 21 (14%) who were in Voluntary Accommodation - and its Fiscal Return on Investment (FROI) was estimated to be 3.39. This demonstrates a positive cost benefit outcome equating to a saving of £3.39 for every £1 invested in the project. Data received from COS for the cost benefits analysis (CBA) was high-quality and, therefore, York Consulting was able to build a robust model. Although anything above a FROI of £1 is perceived to be a good result for this type of analysis (York Consulting), COS' FROI of £3.39 indicates that COS is achieving greater value for money for local and central government. However, the CBA analysis was based on COS closed cases, in order to avoid the risk of double counting savings, meaning that it excluded open cases that might have been in COS for a long time, which in turn might have skewed results in favour of COS. In order to avoid this possible bias, the COS team is currently collecting data which can be used to measure savings in real time on a month-by-month basis. This was reported by the COS team as one of the positive legacies of the evaluation.

## **What were the barriers and facilitators to implementing and sustaining the Compass service?**

Compass was described by parents as non-judgemental, which facilitated involvement within the service, as parents felt supported and able to be open and honest with staff. Furthermore, Compass was reported by parents and young people as being more

personalised and flexible than other services, as staff responded to the individual needs of the family; provided one-to-one support, and were able to offer a more bespoke package whilst maintaining a reliable and immediate response. In terms of barriers, some parents reported a slow referral process and a lack of communication between social workers and Compass about timeframes for the referral.

## **Implications and recommendations for policy and practice**

In Norfolk, there is a need for Compass to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, parents reported that the Compass service supported young people in a range of difficulties (for example, exclusion from education, preventing the young person from being criminalised, and maintaining a child with complex difficulties within a placement); young people noted how Compass staff were attuned to their needs and appeared to understand their problems; and staff in focus groups described Compass as accessing children, young people, and families who would not necessarily be able to be seen by other services and stated that the MDT met their needs effectively.

Within this context, wider dissemination of information about Compass would help the innovation to be embedded and to reach a greater number of young people and parents. It will be crucial to maintain the level of care with larger numbers of service users. Dissemination would also mean that more young people and families would access Compass, and hence more resources would be needed in order to cope with future staffing and demand. Parents noted this, and described a need for the service to expand, as the demand for the service is growing while the capacity has remained the same. Currently, VRS has secured funding for 5 years and COS is on recurrent budget basis.

In addition, it is of particular relevance to expand Compass to include all the components of the model (such as the Family Development Unit). In that way a complete evaluation of the model, and its aim of stepping up support to stepping down need could be conducted.

## Overview of the project

The first Compass School opened in 2009 as a response to the need for a therapeutic education provision for children who would otherwise have been placed in out-of-county placements, owing to their complex needs. This was recognised as an opportunity to invest in developing an innovative service to support these children within their families and communities. Through its success in preventing out of county placements, the Compass has grown to its current size. This innovation project had 3 components (please refer to Appendix A for a diagram of the full Compass model once fully implemented):

### 1. Virtual Residential School Model (VRS)

The project team wanted to build upon the success of their current therapeutic education service, The Compass Centre, by creating a Virtual Residential School aimed at children and young people who required therapeutic foster care and a specialist education provision. This new service is offering training, consultation and supervision to foster carers in placements formally attached to the school's education and therapy provision for children across Norfolk. The integrated approach seeks to encourage foster carers to feel part of a multi-disciplinary team, rather than becoming isolated and too often overlooked in the decision making about the children in their care.

The 'virtual' component of the VRS refers to the residential aspect of the school. The foster placements attached to the therapeutic education provision means that children have the benefits of a consistent approach across their home and school placements without the risk factors associated with institutionalisation. The additional training and supervision provided for carers also means that they are able to manage children with more complex needs who would otherwise end up in a traditional residential provision. This reassures foster and kinship carers that the child will not be repeatedly excluded.

The project team aims for the VRS to become a series of hubs from where they are able to deliver education for their pupils, their families and the staff working with them. They provide therapy and social care interventions from within a fully integrated service that acts as a single point of access for families who would otherwise fall through the gaps between services.

The Compass therapeutic model is based on the clinical application of attachment theory. It aims to provide a similar emotionally regulated and emotionally literate relational environment for pupils both at home and at school, which acts as a secure base for pupils to develop their attachment security.

The staff training and supervision provided by the clinical team creates a therapeutic milieu that provides the repeated exposure to predictable, boundaried, unconditional,

reflective and consistent relationships that are at the foundation of attachment security. VRS creates opportunities for pupils to feel safe; take appropriate risks; develop trust in others, and improve their emotional regulation, resilience and self-esteem. The Compass approach maintains a clear focus on 5 key areas: relationships, responsibilities, risk, reflective practice, and research.

Pupils attend the schools for their full 25 hours each week. In addition to their education, pupils access therapeutic interventions from the clinical teams in their respective school. These include individual therapy, group workshops, activity sessions, psychoeducation and restorative approaches. Families are also offered systemic (family therapy) appointments, individual psychotherapy for parents, parenting skills training, video interactive guidance and family activity days.

The VRS is the most intensive level of support offered by the Compass Service.

## 2. Family Development Unit

Where families have received support in the community that has not been effective in helping reduce safeguarding concerns, the Family Development Unit will aim to provide more intensive support as an alternative to entering care proceedings. The Family Development Team will be able to undertake community based assessments of parenting capacity and issues of risk. The Family Development Unit will also include the creation of a more intensive day service, in which family assessments can take place in a clinic setting. Using these interventions, the Family Development Unit will also be able to assess and support families working towards reunification.

## 3. Compass Outreach Service (COS)

As a result of the difficulties leading to the young people being placed in the Compass Centre, a number of the young people accessing the service are Looked After Children (LAC) or are at risk of being taken into care. Compass therefore developed an innovative provision to support these young people, building on the success of the current therapeutic education service. The aim of this new service, COS, is to step up levels of support for families, foster carers and social care professionals, as a means to step down the levels of need. The service includes staff from Norfolk County Council, Norfolk and Suffolk NHS Foundation Trust (NSFT) and The Benjamin Foundation. The Benjamin Foundation is a charity that aims to help people face the challenges they encounter through 4 main services:

- homelessness: accommodation centres for young adults that provide support and a safe place to live while they get their lives back on track
- families: support those who need help to strength family relationships

- children: work with schools to support children with issues including bullying and also provide childcare with a day nursery and pre- and post- school clubs
- furniture store: 3 stores raise money to support the rest of the Foundation work by selling donated furniture and electrical goods.

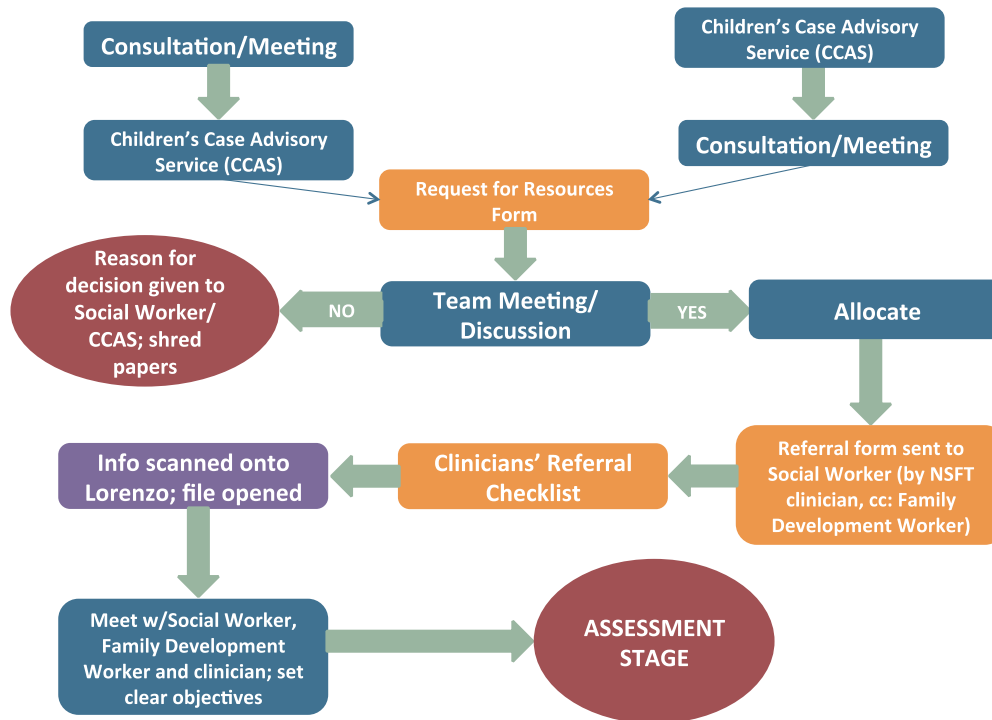
COS follows a similar therapeutic model to the one implemented within the schools. The clinical team works alongside colleagues from children's services to provide direct interventions for children, young people and families where there is a risk of a child coming into care; or of placement breakdown; or in order to step a child down from residential to foster care, return from an out of county placement or reunify with their family of origin.

Clinicians provide individually tailored interventions based on specific objectives and intervention goals identified by the local authority at the single point of access (see below for a description of the referral pathway). Interventions available through the Compass Outreach team include systemic family therapy, art psychotherapy, individual therapy for children and/or parents, practical family support and parent skills training. These services are delivered to families in the community rather than expecting them to access traditional mental health clinics. The success of the approach is based upon achieving second order change, when families, professionals and services develop new ways of relating to one another based on fundamental changes in their values, beliefs and assumptions.

## **Referral pathway**

Compass aims to step up support in order to step down need (please see Appendix B). Compass has an admissions process to discuss placement of referrals, which involves discussions between Children's Case Advisory Services, the Short Stay School for Norfolk, Clinical Commissioning Group and the clinical team at the Compass Centre. They do not accept referrals from any other source. However, pupils who have been permanently excluded from mainstream education, who have complex needs, are suitable for a referral to the Compass Centre.

**Figure 1: Compass referral pathway**



COS team has reported that it has been important for them to sit on the NCC Children’s Case Advisory Service (CCAS) to discuss referrals and to inform decision making about the most appropriate cases to be seen within the service. It also ensures that there are shared discussions about service availability and resource implications, rather than holding a waiting list.

The VRS referral route has changed during the course of the implementation year. At the start, education placements were agreed at the Special Educational Needs Placement Advisory Group (SENPAAG) in NCC who identified those children in need of specialist education placements. There was then an assessment undertaken of their mental health needs and applications made to the Health Complex Cases Panel which agreed additional health funding from the Clinical Commissioning Group (CCG) for the therapeutic provision.

During Compass recommissioning discussions they were able to agree a more streamlined process in which the Compass Schools (including the health provision) was jointly commissioned in a block contract of 50 places by NCC and the 5 Norfolk CCGs. Cases were still discussed at SENPAAG, but a representative from the CCGs sat on the Compass Schools admissions panel that met each half term. This provides oversight from the CCGs that the pupils offered places had the appropriate level of therapeutic

needs and that they had previously been offered universal services which were not able to realise lasting change.

## **What the project was intending to achieve**

The aims of the project were to reduce local authority costs of children entering or remaining in care, combined with an improvement in educational outcomes for looked after children.

By following this approach, and in producing the service, NSFT expected to:

- improve Norfolk's local offer for looked-after children
- reduce the need for expensive out-of-county placements
- improve the education, mental health and social outcomes for some of the county's most vulnerable children
- promote successful integration of education, health and social care services
- develop the ability of multi-agency staff to promote sustainable change for families
- share and manage risk more effectively so that services were both safe and inclusive
- develop and scale an innovation that could be replicated nationally

## **What the project was intending to do to achieve these outcomes**

The proposed innovation had 4 main elements:

1. the development of a VRS Model
2. developing COS
3. creating a Family Development Unit
4. scaling up the Compass approach

The relationship between the different elements of Compass can be seen in the Appendices.

## **Relevant existing research relating to this innovation**

Research has shown that young people who were brought up in care are:

- 10 times more likely to be excluded from school



- 12 times more likely to leave school without any qualifications
- 4 times more likely to suffer from mental health problems
- 4 times more likely to be unemployed
- 60 times more likely to be homeless
- 50 times more likely to go to prison
- 66 times more likely to require social care for their own children (Warren, 1999)

Children in long-term foster care do not tend to benefit from outpatient mental health services alone (Bellamy, Gopalan, & Traube, 2010). Research indicates that foster carer support (Bellamy, Gopalan, & Traube, 2010) and placement stability (Newton, Litrownik, & Landsverk, 2000) are crucial factors in determining mental health outcomes of LAC. Traditional Child and Adolescent Mental Health Services (CAMHS) struggle to meet the needs of LAC and those who have experienced neglect, developmental trauma or have social, emotional and behavioural difficulties. Children from these families frequently fall into the gaps between services, and problems in family relationships, school attendance, youth offending and mental health needs escalate.

When local placements break down, children end up being placed in increasingly expensive and distant provisions. Statutory guidance provided by the DfE (2010) states that children should live in their local community, where it is safe to do so, to ensure that they are able to access local services and maintain links with friends and family. Despite this guidance, in 2013 one in 10 looked after children were living more than 20 miles outside their local community (DfE, 2013).

Placement stability for children, either in care or with their families, often depends on the resilience of their education provision (Jackson and Thomas, 2000). Placement breakdown frequently occurs when children are permanently excluded from school and kinship or foster carers are reluctant to accept children who are not in full time education.

Placing these children in residential homes, or out of county provisions, leads to further attachment disruption, poor social and educational outcomes, institutionalisation and excessive financial demands on local authorities. It is also a significant concern that once children have been taken into care, only about 50% of reunifications to birth families are successful (Luke, Sinclair, Woolgar and Sebba 2014). This is often due to the lack of adequate preparation or sustained support being made available following the child's return home.

## Changes to the project's intended outcomes

Even though implementation of VRS proved more difficult than expected, due to the difficulties encountered in finding enough foster parents to engage in the programme, there were no significant changes to the project's intended outcomes. Specifically, COS has been fully operational since April 2015 and the VRS model has been fully operational in Compass Schools in Norfolk (48 pupils), Great Yarmouth (24 pupils), Norwich (12 pupils) and King's Lynn (12 pupils).

Nonetheless, the full Compass model was not fully operational as the Family Development Unit was not due to begin work until January 2017. In addition, fewer service users than expected were involved in the development and implementation of Compass services, which is an area the Compass team aims to address in 2017 by involving service users in the design and delivery of the service.

## Context within which this innovation has been taking place

Norfolk County Council (NCC) is composed of 7 local government districts: Norwich City, Breckland District, Broadland District, Great Yarmouth Borough, North Norfolk District, King's Lynn and West Norfolk Borough, and South Norfolk. Its estimated mid-2015 population was 884,978 people, of whom 21.27% (188,231) were estimated to be under 19 years of age (ONS, 2016). Regarding gender of people under 19, 48.9% were female.

NCC was ranked 88<sup>th</sup> most deprived LA out of 152 LAs in England in 2015 (1st being most deprived), with 14.8% of pupils in primary school and 11.9% of pupils in secondary school eligible for free school meals, compared to 15.6% and 13.9% in England, respectively, (GOV.UK, 2016). Of the young people aged 16-18 years, NCC had 4.2% not in education, employment or training in 2015, the same percentage as in England.

In 2016, NCC had 118,384 pupils in 456 schools, 124 academies and 53 Sure Start Children Centres; 10% primary pupils and 6.7% secondary pupils first language was other than English (compared to 20.1% and 15.7% in England, respectively).

NCC does not have an in-patient mental health facility for children and young people, but as it is under NSFT, it has access to [Lothian Tier 4 Adolescent Inpatient Unit](#), which is located in Suffolk County Council. This entails that all children and young people's mental health Tier 4 admissions are made outside the LA's borders. In Norfolk, there is one adolescent inpatient unit, that is not run by the NHS but by Huntercombe.

The rate of LAC per 10,000 children aged under 18 in 2015 was 64 (and in England was 60), whilst the rate of children in need per 10,000 in 2015 was 491.6 and in

England was 337.3 (GOV.UK, 2016). The Children's Services LAC Benchmarking Club data indicates that Norfolk has a disproportionate number of LAC per head of the population when compared to its statistical neighbours. Of these children Norfolk has a significantly higher proportion in residential care (11.8%) compared to the national average (5.3%). Indeed Norfolk's figure is higher than any other Local Authority nationally.

This contributes to the fact that Norfolk has a higher gross weekly spend on an average placement (£976) than the national figure of £832. These figures not only represent a significant demand on financial resources, but also mean that there is a cohort of children in Norfolk that are likely to be suitable for foster care placements, who are, unfortunately, in residential provision.

The financial gap for LAC placements in Norfolk is also widened by the fact that local health commissioners are currently investing less in providing for the health element of funding for this cohort (£109 per week) than the national average of £148 per week for each child. It is essential that health commissioners are made more aware of the mental health, attachment and developmental needs of looked after children, and that targeted investment when these children are young is the best way of reducing the burden they place on health and criminal justice services in future.

In relation to Norfolk's fostering provision, a disproportionate number (22%) of children are in expensive (£450 - £500 p.w) placements compared to only 4.6% of the national cohort. This is likely to be a consequence of the lack of availability of foster placements locally and the extra resources that the local authority has to commit to attract carers. However, carers are also motivated and maintained by being offered the appropriate levels of support they required to meet the complex needs of these children.

The Local Authority predicts that, if changes do not occur, the number of looked-after children will have risen to 1,360 by 2017. This would inevitably incur additional costs to the authority, as each looked after child costs an average of £46,300 a year (Grimmer, 2013). If this number can be reduced, it is estimated that the authority could save up to £34 million by 2017.

# Overview of the evaluation

## Evaluation questions

The overarching aim of the evaluation was to examine whether and by what means the Compass service<sup>1</sup> was effective at improving young people's wellbeing. The secondary outcomes were:

- to examine whether the Compass service was effective at improving young people's emotional, behavioural and family functioning
- to examine whether the Compass service was effective at improving young people's academic attainment
- to understand the mechanisms by which the Compass service was effective at improving young people's outcomes
- to explore the robustness of data collection for economic analysis

These outcomes were operationalised in the following research questions:

- does the Compass service reduce the number of young people becoming engaged in statutory social care service?
- does the Compass service improve young people's emotional, behavioural and family functioning?
- does the Compass service improve young people's academic attainment?
- what might be the mechanisms by which the Compass service improves young people's outcomes?
- what is staff's experience of the Compass service?
- what is the experience of young people, parents and carers of staff at the Compass service?
- what are the barriers and facilitators to implementing and sustaining the Compass service?
- what are the results of the cost-benefit analysis?

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<sup>1</sup> In this report "Compass service" will be used to refer to COS and/or VRS.

## Methodology used to address these questions

An explanatory case study design was employed to explore and describe the Compass service and also to develop theories of causal mechanisms of the impact of Compass on young people's outcomes (Yin, 2009). A quantitative, multilevel mixed methods design was used, with a qualitative component to triangulate the quantitative data (Teddle & Tashakkori, 2008). Quantitative data was used to examine changes in young people's outcome at admission and during Compass interventions. An embedded researcher, supervised by the evaluation team, played a key part in the evaluation.

The evaluation was designed to maximise the use of existing data and data collection procedures to minimise burden on young people, parents, carers and staff. The evaluation comprised the following strands:

- COS service data was analysed to describe the service provided to parents and young people and to explore trajectories of young people seen by COS (n= 152 cases, 53 (35%) of which were open and 99 (65%) had been discharged by July 2016)
- outcome data was collected and analysed to explore how appropriately young people and families' mental health needs were met by the Compass service. Measures were completed when young people joined the Compass service (T1) and 4 to 6 months later (T2). Some measures were not appropriate for some cases and, therefore, the measure was not used; reasons for not using measures were recorded but are not presented to preserve anonymity. Measures used were:
  - Achenbach System of Empirically Based Assessment (ASEBA; Achenbach, 1991a, Achenbach, 1991b) that assesses adaptive and maladaptive functioning, and was completed by parents or carers, young people, and teachers (n=23 young people, 48 parents and 64 teachers regarding the functioning of 87 young people completed at T1; n=3 young people, 7 parents and 10 teachers completed at T2). Internalising, externalising and total difficulties scales were used in this evaluation
  - Strengths and Difficulties Questionnaire (SDQ; Goodman 1997): that is a brief behavioural screening questionnaire, was completed by parents or carers, young people, and teachers (n=27 young people, 58 parents and 75 teachers at T1; n=8 young people, 7 parents and 19 teachers at T2). It is composed of 4 difficulties scales (Emotional Problems, Conduct Problems, Hyperactivity Problems and Peer Problems), and one strengths scale (Pro-social Behaviour). It also has an Impact scale, which provides a measure of the child's distress and the impact of the child's difficulties on home life, friendships, classroom learning, and leisure activities
  - Children Global Assessment Scale (CGAS; Schaffer et al., 1983) that provides a global measure of children's and adolescent's functioning and was completed by Compass staff (n=81 at T1 and n=39 at T2)

- Client Engagement in Child Protective Services Questionnaires (CECPS; Yatchmenoff, 2005) that is a multidimensional measure of client engagement in child welfare services and was completed by parents or carers and social workers (n=58 CECPS completed by parents and 70 by social workers at T1, and n=8 CECPS completed by parents and 7 by social workers at T2)
- Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) that assesses the young person's self-esteem, and was completed by young people (n=39 young people at T1 and 8 young people at T2)
- qualitative data consisting of interviews with young people (n=22) and parents or carers (n=17) involved in the Compass service, and focus groups (n=5) with professionals (n=24) involved in both COS and VRS before and/or after the Compass service. As the evaluation was of an integrated model of service delivery, it sought to involve representatives from COS and VRS in order to explore their views and experiences of the provision. By including service users and staff from each of the provisions, the evaluation provides the best possible coverage of the service. Data was analysed to understand how experience compares to other services that young people, parents and carers might have used in the past, and how service users' and providers' needs were met
- York Consulting led the cost-benefit analysis (CBA)

Under the supervision of the evaluation team, the embedded researcher prepared the documents for the ethics application, conducted interviews with young people and parents (and then transcribed and analysed them), arranged the focus groups with Compass staff and arranged collection of outcome measures at T1 and T2.

## **Focus groups with staff and interviews with parents or carers and young people**

All Compass staff were invited to participate in focus groups. Before conducting the focus groups, researchers explained the aims of the focus groups, provided information sheets to participants, and answered their questions. Staff consented for focus groups to be recorded and transcribed.

Twenty-four staff took part in 5 focus groups. Focus groups were conducted with a mixture of staff from COS and VRS and included 9 managers, 5 assistant psychologists, 4 clinical psychologists, 3 family development workers, one social worker, one family and systemic psychotherapist, and one art psychotherapist. All focus groups were conducted during January 2016. Nine participants were male and the rest were female. The mean age of participants was 34 years (ranging from 23 to 54 years). In terms of ethnicity, all participants were white except for one who was mixed race, and one who preferred not to answer. Only one participant worked part-time. The average

years of experience in working with a similar population were 10 years (ranging from 4 months to 35 years).

Parents and young people were invited to participate in interviews by the embedded research assistant, who also provided them with an information sheet explaining the study. If parents of young people were interested in participating, they completed the “Expression of interest” form and agreed on a specific date and place for the interviews. A full explanation of the research was provided to parents and young people before the beginning of the interviews. Interviewees gave their informed consent to be interviewed, and for the researcher to record and transcribe the interview.

A total of 17 parents or carers were interviewed. Demographic information was recorded for 14 of them. Out of those 14 parents, 13 were from COS service and one from VRS. All parents were white; 13 were female and 1 was male. The average age of parents was 42 (SD=11.44), with a range between 29 and 64 years. In terms of marital status, 4 were married, 3 were divorced, 2 had never been married or in civil partnership, 3 were separated but still legally married or in civil partnership, and 2 were widowed. Regarding occupation, 2 were foster carers, 6 were homemakers, 2 worked in the service sector, 2 in the health sector, and one was unemployed.

Twenty-two young people were interviewed, 17 from VRS and 5 from COS. Ages ranged between 8 and 16 (average age=11, SD=2.81); 4 of them were female and 18 were male. All 22 young people were white.

## **Changes to evaluation methodology from the original design**

There were no substantive changes to the evaluation methodology from the original design. However, a few minor modifications were:

- due to the extension of the implementation of COS and VRS, and the deadline for this report, data collection was extended until beginning of October 2016
- contextual data for Norfolk (the number of young people entering care in Norfolk) was not made available to the research team due to capacity issues in the council team
- the original economic evaluation partner did not have the capacity to carry out this aspect of the evaluation due to unexpected lack of staffing. Therefore, York Consulting conducted the economic evaluation. We were only expecting to be able to examine the feasibility of collecting data for the CBA but, as there was more data available, we were able to conduct a CBA, results of which are presented below

## Key findings

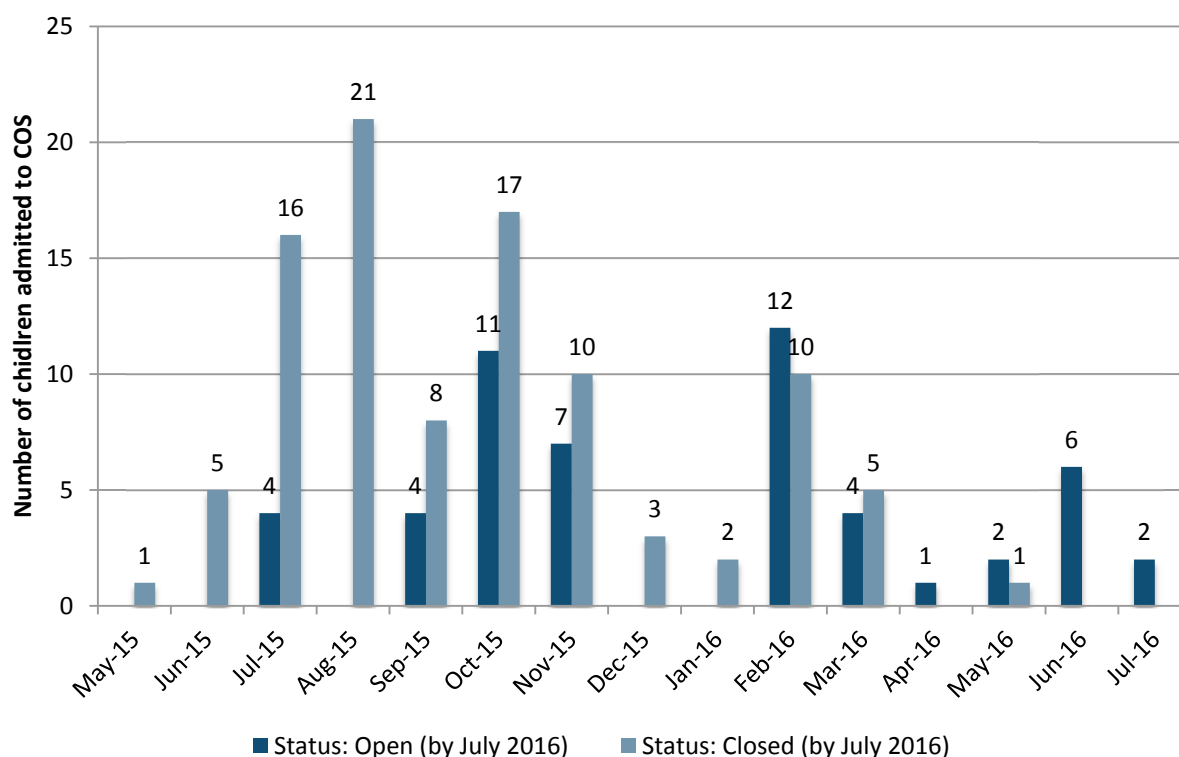
This section presents a summary of the results obtained. For complementary results please refer to the Appendices, except for the qualitative analysis of the parents and young people's interviews and of the focus groups which are available on request.

## Characteristics of the service provided by COS

### COS service data

A total of 152 cases were seen by COS between May 2015 and July 2016, 53 (35%) of which were open, and 99 (65%) of which had been discharged by July 2016. Figure 2 below shows the number of people admitted to COS per month and their status by July 2016. Closed cases were on average 8.8 months in the service (SD=2.8, n=92), with a range of 3.1 and 14.1 months, and a mode of 9-10 months.

**Figure 2: Number of cases admitted to COS by month and their status by July 2016**



Source: COS service data

Out of the 152 cases, 87 (57%) were referred for family stabilisation, 35 (23%) for care placement stabilisation, and 28 (18%) for reunification.



## Does the Compass service reduce the number of young people becoming engaged in statutory social care service?

### COS service data

Evidence suggested that COS was associated with a reduction in the use of statutory social care services. Data regarding legal status at referral was available for 148 cases out of the 152. Most of the cases (49, 33%) were Child in Need, followed by 39 (26%) who were in Child Protection, 33 (22%) who were Looked After Children, 21 (14%) who were in Voluntary Accommodation, 2 (1%) were in Family Support Process, 1 was in the process of adoption, and 3 (2%) had no legal status.

Regarding the legal status of discharged cases (n=99), 9 cases who were admitted to COS with a legal status were discharged from COS without one, and only 3 children could not be prevented from becoming “Looked After Children” from admission to discharge (see Table 1).

**Table 1: Legal status at referral and discharge for discharged cases (n=99)**

Legal status at referral	Legal status at discharge								Total at referral
	No legal status	Family Support Process	Child in Need	Child Protection Plan	Voluntary Accommodation	Looked After Children	Adoption	Special Guardianship Order	
No legal status	3								3
Family Support Process		2							2
Child in Need	4	5	16		2			4	31
Child Protection Plan	8		8	6	2	1		2	27
Voluntary Accommodation	1		3	1	9	2			16
Looked After Children		1				18			19
Adoption							1		1
Total at discharge	16	8	27	7	13	21	1	6	99

Data regarding accommodation status at referral was available for 148 cases out of the 152 in COS dataset. Most of the cases (102, 69%) were living at home, followed by 30 (20%) who were in foster care.

As Table 2 shows, data for closed cases (n=99) shows that, out of the 16 young people who were living in foster care at referral, 10 were still living in foster care at discharge and 5 were living in their homes again. Data also indicated that 11 out of 70 young people who were living at home at referral could not be prevented from going into foster care.

**Table 2: Accommodation status at referral and discharge for discharged cases (n=99)**

Accommodation Status at Referral	Accommodation Status At Discharge						Total at referral
	Foster Care	Home	Kinship	Residential	Secure	Independent / Sheltered Living	
Foster Care	10	5		1			16
Home	11	55	3	1			70
Kinship			7				7
Residential		1		2		1	4
Secure					1		1
Tier 4				1			1
Total at discharge	21	61	10	5	1	1	99

## Focus Groups<sup>2</sup>

The sustained long-term work with children, young people and families was described as helping to stabilise home environments, reducing out of county placements or children becoming looked after and increasing reunifications. Some staff noted the potential cost saving of the Compass service through reduced placement breakdowns, out of county placements, or children becoming looked after, or by increasing reunifications and educational engagement. Moreover, the ability to sustain work with children, young people and families over the long-term was described as leading to enhanced outcomes for children, young people and families, as staff reported being able to develop robust relationships with children, young people and families and work with them to tackle entrenched problems, thereby helping children, young people and families to manage emotional and behavioural difficulties in the future, before they reached crisis.

In addition to providing care that would not necessarily be available from other services, focus group staff described Compass as accessing children, young people and families who would not necessarily be able to be seen by other services. Some staff noted how this gap had been explicitly identified by service users, the Care Quality Commission (CQC) and the Office for Standards in Education, Children's Services and Skills (Ofsted). Multidisciplinary team (MDT) working was described as essential to achieving this.

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<sup>2</sup> In some parts, results do not differentiate between the Compass services. This is partly due to how data was collected (for example, focus groups were conducted with staff from COS and VRS, or outcome data did not specify whether young people were from COS or VRS). This is also a reflection of the Compass approach itself, as they aim to provide an integrated service and, for example, some young people are seen by both VRS and COS teams. Furthermore, it is difficult to differentiate effects of individual components in multicomponent, complex interventions such as Compass.

# Does the Compass service improve young people's emotional, behavioural and family functioning?

## Parents

More than half of the parents (9 out of 17) reported that COS supported the emotional wellbeing of their children. This improvement was described to be related to the confidence and self-esteem of young people, and in the ability of COS to develop positive relationships:

"I think because of the work [clinician] and everybody is doing with her, she'd begun to realise that actually she's a worthwhile person. She's getting more self-esteem, she's getting some confidence"<sup>3</sup> (Parent)

Parents recognised the importance COS placed on improving functioning, describing it as one of the main goals of COS in addition to supporting the young person with various difficulties including exclusion from education; preventing the young person from being criminalised, and maintaining a child with complex difficulties within a placement. Support in situations such as this was reported to have a positive impact on the emotional functioning of young people involved with COS:

"It's about actually seeing that child smile, and actually be happy and not as anxious" (Parent)

In addition to improvements in emotional functioning, most of the parents (14 out of 17) reported vast improvements in the children's behaviours. This improvement was particularly evident where the young person had problems with anger and aggressive behaviour. Parents reported their children and young people to be calmer and more settled, with a reduction in violent behaviour:

"Over about 3 months she just went from being this hyperactive rocket to a calm little girl" (Parent)

Changes related to the happiness of young people were reported as one of the unexpected changes by parents. Other unexpected changes included increases in self-confidence within the parents themselves:

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<sup>3</sup> A random sample of transcripts of parent and young people's interviews were made available to Anna Freud National Centre for Children and Families in order to supervise qualitative analysis conducted by embedded researcher. Hence, quotes are presented without a randomly generated number for parents and young people's interviews.

“I think if I like rewind about 4 years ago, I don’t think I would think that we’d be in the position we are now... [person] is just a dream to have around you know...and I’ve always said to Compass that like, I’ll be forever grateful for what they’ve done and how they’ve helped us” (Parent)

Family functioning was another area found to improve as a result of the services provided by COS in 10 of the participating families. This improvement was related to reunifying relationships between parents and their young people, between siblings and with extended family:

“With their help, just got my family back hopefully, just gelled us as a family” (Parent)

Skills such as improved parenting practice, developed through involvement with COS, was reported to be another factor in improving family functioning:

“They’re focused on how I was parented and how that impacts on how I parent my children...it’s about us getting the help we need to change what we do to then help [young person]” (Parent)

“keeping it consistent and having the same consequences and things like that really helped” (Parent)

Parents reported improvements in family functioning to the point where they had a reduced need for service involvement, thus enabling the family to manage without COS:

“Hopefully when it’s just me and [young person], and we can manage on our own you know” (Parent)

The service provided by COS was reported as being more holistic than other services, as other services were described as only focusing on the child and not the family:

“They’re supposed to help me as well but they were not very good at all” (Parent)

Parents were therefore more satisfied with COS, as they offered support for any problems experienced by parents or other family members.

## **Young people**

Most of the young people (14 out of 21) described a reduction in their anger and aggressive behaviours, with fewer incidences of violence and aggressive behaviour than in the past. They described being able to manage their emotions better since accessing the service, by removing themselves from a situation or through discussing how they felt with others: “I haven’t been getting angry as much. I haven’t been throwing chairs and tables... yeah it’s just really helped me with my anger as well”.

Young people also reported noticing improvements in their emotional wellbeing while working with the Compass service (8 out of 21). The young people described improvements in their ability to discuss their problems with staff and other people. They reported feeling happier overall, with references to increased confidence, self-esteem, positive attitude and motivation to engage with others since accessing the Compass service:

“Being more happy. Just being happy, yeah” (Young person)

“I think that is just being more confident in myself and being more confident in other situations as well, and that, just change the way you think about things, yeah” (Young person)

In addition, improvements in family relationships since working with the Compass service were reported by young people (8 out of 22). The young people described feeling as though the Compass service had supported the whole family, and how this had strengthened the young person’s relationships with their parents or carers. In addition, 3 of the young people reported that, since using the Compass service, their family was arguing less, and had improved their ability to talk nicely to one another:

“She just makes me feel more wanted at home really because ages ago I didn’t. I hated being here, like I hated it. So it’s just made me like realise a lot more, open my eyes a little bit. I feel more mine and mum’s relationship is doing better, yeah definitely so” (Young person)

However, 9 out of 21 young people reported uncertainties about any changes in themselves or their families since accessing the Compass service.

## **Outcome measures**

Routinely collected data was used in order to make the evaluation sustainable beyond its end. Unlike in a randomised controlled trial (RCT), where random allocation of participants ensures homogeneity of groups at baseline, the methodology of this evaluation entails challenges when identifying a comparator group that is actually comparable (as in 2 groups without systematic differences at baseline). Hence, even where significant changes are reported the lack of a comparison group entails that they cannot be directly attributed to COS. Despite this limitation, routinely collected data was collected and analysed in order to explore how young people were (or were not) changing after accessing COS.

- **ASEBA**

A total of 23 young people, 48 parents and 64 teachers completed the ASEBA for 87 young people at T1. Due to small sample size of paired data (n=3 for young people,

n=7 for parent and n=10 for teacher completed ASEBA at T2), non-parametric analyses were conducted. There were no significant differences in Internalising, Externalising or Total problems scales for all informants (young people, parents and teachers).

- RSE
  - Regarding self-esteem, 39 young people completed the RSE at T1 and 8 at T2. As there were only 8 young people with paired RSE scores, non-parametric tests were used to explore the difference between T1 and T2. Even though at T2 the mean self-esteem score was lower (representing a better self-esteem), this was not statistically significant ( $T=3.5$ ,  $z=0$ ,  $p>.05$ ).
- CGAS
  - Compass staff completed the CGAS for 81 young people at T1 and 39 young people at T2. As shown in Table 3 below, most of the young people at T1 (29, 36%) were in the “Some noticeable problems” category, whilst most of the young people at T2 (10, 26%) were one category up (which was “Some problems”). Importantly, only one young person (1.2%) was categorised in the “Doing well” range at T1, whilst 6 (15%) were at T2.

**Table 3: Frequency and percentage of CGAS scores at T1 and T2**

CGAS category	T1		T2	
	N	%	N	%
11-20: Very severely impaired	1	1.2%	0	0.0%
21-30: Severe problems	1	1.2%	0	0.0%
31-40: Serious problems	9	11.1%	2	5.1%
41-50: Obvious problems	23	28.4%	9	23.1%
51-60: Some noticeable problems	29	35.8%	9	23.1%
61-70: Some problems	12	14.8%	10	25.6%
71-80: Doing all right	5	6.2%	3	7.7%
81-90: Doing well	1	1.2%	6	15.4%
Total	81	100.0%	39	100.0%

The mean difference between CGAS scores T1 ( $M=51.95$ ;  $SD=13.03$ ) and T2 ( $M=61.23$ ;  $SD=13.76$ ) was statistically different, showing an increase of scores from T1 to T2 ( $t(38)=3.6$ ,  $p=.001$ ,  $r=.30$ ). This showed that, as a group, young people improved, according to Compass staff, as higher scores in CGAS mean a better level of functioning.

- CECPS
  - Regarding parents’ engagement in their care, at T1 37 (64%) had a strong positive engagement, 9 (16%) had marginal engagement or fluctuations, and 12 (21%) parents

lacked positive engagement. When only looking at the cases that had paired data (n=7), all parents had a strong engagement at both T1 and T2.

On the other hand, social workers reported that at T1 2 (3%) parents had a strong positive engagement, 42 (60%) parents had marginal engagement or fluctuations, and 26 (37%) parents lacked positive engagement. When only the cases that had paired data (n=7) were taken into account, most of the families stayed in the same category of engagement in T1 and T2 (3 families in the “lacking positive engagement” and 2 in the “Marginal engagement or fluctuations”). One family, though, improved its level of engagement, from the “Lacking positive engagement” group to “Marginal engagement or fluctuations”.

- SDQ

Regarding the Strengths and Difficulties Questionnaire (SDQ), 27 young people completed it at T1 and 8 at T2; 58 parents completed the SDQ at T1 and 7 at T2; and 75 teachers completed the SDQ at T1 and 19 at T2.

Paired SDQ numbers were lower, with 8 completed by young people, 7 completed by parents, and 18 completed by teachers for the Total Difficulties scale. Non-parametric statistics were used, due of the low number of paired SDQs in all informants. For young people, hyperactivity and total difficulties levels were significantly higher at T1 than at T2 ( $Z=2.003$ ;  $p<.05$ ;  $Z=2.04$ ;  $p<.05$ , respectively), and for SDQs completed by parents about their young person, peer problems and total difficulties levels were significantly higher at T1 than on T2 ( $Z=2.12$ ;  $p<.05$ ; and  $Z=2.21$ ,  $p<.05$ ). None of the SDQ scales presented a significant difference between T1 and T2 according to teachers.

The SDQ also has clinical cut-off points that divide young people in a clinical or non-clinical range for each sub-scale and the Total Difficulties Scale (Goodman et al. 2001). Clinical change (CC) refers to the young person crossing the clinical threshold. However, a young person might have a big fluctuation in scores without crossing the clinical threshold, or might have a small change that crosses the clinical threshold. Reliable clinical change (RCC) is a measure of the minimum change in scores that a young person needs to have in order for that change not to be considered as not due to random fluctuations or measurement errors.

As can be seen in Table 4, in the Total Difficulties scale, 14 out of 27 (52%) young people were in the clinical range at T1 and 4 out of 8 (50%) at T2 according to the young people report, 35 out of 58 (60%) young people were in the clinical range at T1 and 4 out of 7 (57%) at T2 according to parent reports, and 32 out of 75 (43%) were in the clinical range at T1 and 7 out of 19 (37%) at T2.

**Table 4: Frequency of young people who were in the clinical and non-clinical group according to young people, parents and teachers in Total Difficulties SDQ Scale**

		Young People		Parent		Teacher	
		Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical	Clinical
Total difficulties	T1	13	14	23	35	43	32
	T2	4	4	3	4	12	7

As shown in Table 5, out of the 8 young people who had paired Total Difficulties Scores completed by themselves, 1 recovered (moved from the clinical to the non-clinical group) and reliably improved (change in score was not due to random fluctuations or measurement error), 2 reliably improved whilst starting and finishing in the non-clinical group, and 5 neither recovered, nor had a reliable change in scores.

Out of the 7 young people who had a paired Total Difficulties Score completed by parents, 2 recovered but the change was not reliable, 1 reliably improved but stayed in the clinical group from T1 to T2, and 4 neither recovered, nor had a reliable change in scores.

Out of the 18 young people who had a paired Total Difficulties Score completed by teachers, 1 recovered and reliably improved, 14 neither recovered, nor had a reliable change in scores, 2 reliably deteriorated of which one started and ended in the clinical group, whilst the other remained in the non-clinical group, and one reliably deteriorated (moved from the non-clinical to the clinical group).

**Table 5: Clinical change (CC) and Reliable clinical change (RCC) in young people reported by young people, parents and teachers in Total Difficulties SDQ Scale**

	Young people			Parent			Teacher		
	RCC Reliably Improved	RCC No change	RCC Reliably deteriorated	RCC Reliably Improved	RCC No change	RCC Reliably deteriorated	RCC Reliably Improved	RCC No change	RCC Reliably deteriorated
CC-Recovered	1	0	0	0	2	0	1	0	0
CC-No change	2	5	0	1	4	0	0	14	2
CC-Deteriorated	0	0	0	0	0	0	0	0	1



## Does the Compass service improve young people's academic attainment?

### Parents

Reports of COS improving academic attainment were mixed due to the varied involvement of COS in educational provision. Parents with experience of the VRS described their involvement in terms of feedback to education staff during meetings. Parents with no experience of VRS described not needing such support as this domain was stable, or because parents felt that this work had not commenced:

“School is sort of quite separate at the moment. He's coping there and that's working, and they've been very good and very supportive of him. So that's not been an involvement” (Parent)

Two parents whose young people accessed VRS described the negative aspects of these services to include the lack of information about the provision, and the upper age limit of 14. These may have an effect on VRS improving young people's academic attainment:

“I think it's just the way that they have to just leave, when they get to that age...they made him into this better person, and then I felt you've just abandoned us now” (Parent)

### Young people

Almost half of the young people described improvements in their school work and abilities within their education provision (10 out of 21). In particular, 6 young people reported feeling supported in their academic work, and improving in their ability to complete work at school. Two of the young people accessing COS reported how COS staff would communicate with their mainstream education provision, to provide the school with advice on how to handle different situations with the young person. In addition, one of the young people attending the VRS noted how other children had been able to successfully return to mainstream education as a result of accessing the Compass service:

“Yeah I mean there's a lot of examples that they've proved it, so... as in they've helped a lot of people in their future, like the people who've left only because their behaviour has become enough to be in a mainstream school” (Young person)

However, 6 out of 21 young people reported being uncertain as to whether there had been any changes in their academic work or abilities within their education provision, stating that they were not sure, or did not know.

## What might be the mechanisms by which the Compass service improves young people's outcomes?

### Focus Groups

The majority of staff described the key mechanism by which Compass was effective as working with the whole family to empower children, young people and families to better manage emotional and behavioural difficulties in the home, thus reducing both the need to engage with services and the escalation of difficulties to the point of crisis. Bespoke and sustained long-term work with children, young people and families was described as key to establishing the relationships with children, young people and families necessary to promote such changes.

The ability to work flexibly to meet the individual needs of children, young people and families was described as the lynchpin to this innovation. However, it was also acknowledged that developing a new, innovative service was time-consuming and challenging as new processes and systems had to be developed.

Another central mechanism by which the Compass service was effective was MDT work that provided – as reported by staff in the focus groups – the right mix of skills to meet the individual needs of children, young people and families; learn from and support colleagues, and come together to share knowledge and experience about a case. Some staff suggested there was scope to build on this further with cross-team supervision.

### Parents

The most common change which parents reported to improve outcomes was an increase in their confidence, both in themselves and in their confidence as parents: “I feel definitely more confident”. Parents described an increase in their parenting abilities and their knowledge of young people's difficulties and needs; for example, learning about psychological models and techniques. This included increased confidence in managing behaviour due to the additional support and information available from COS:

“Yeah it's given us like a help, with like information that we need for any like problems that we have. If there's someone that we need to go and see or speak to, we can always go and see them” (Parent)

and through feeling less stressed due to relaxation techniques developed from working with COS:

“I suppose with the kinds of tools that [clinician] gave me...because like that helps me with my stress and stuff, if I’m less stressed obviously I find it easier to deal with like the situation that have come up” (Parent)

Providing parents with a different perspective during a crisis situation was another mechanism which was found to improve outcomes for young people:

“It’s changed a great deal because I just see things differently, I don’t know, it’s like a lot better”; “I often ring [clinician]...that gives me time to calm down and it gives [young person] time to calm down” (Parent)

Parents noted feeling as though someone was there for them if they needed them:

“Just to be able to phone someone up and go ‘ahhh’, and to know, well, that they’re there” (Parent)

This mechanism was found to improve emotional wellbeing, as it produced positive changes in parents:

“I’m a lot more positive than I used to be, and I suppose I’ve just got an outlet for me” (Parent)

Additionally, parents felt confident that the support they were receiving was making positive changes in their families and situations:

“Being able to talk to someone and basically if there’s a problem I know there’s someone who’s going to listen and we’re going to work through the problem” (Parent)

In addition to managing their children’s behaviour, parents felt better able to manage and understand their children’s emotional needs:

“...we can do it without someone else telling us...we can manage the outbursts” (Parent)

This enabled parents to spend more time with their children:

“I think sometimes it’s just awareness. Of my needs or his needs or what is happening in a situation. And I couldn’t have done that without the input from staff” (Parent)

Increases in parental knowledge such as this are a mechanism by which COS improves outcomes as, following COS involvement, parents were found to then spend more time investing in developmentally appropriate activities with their children. This was possible as parents reported feeling more confident in their own ability to cope, without the need for additional support of services:

“Being a mum. Being on my own. I never thought I could be on my own” (Parent)

## Young people

One feature reported by young people (9 out of 22) was that Compass offers support for the whole family. This aspect was described by both young people accessing COS and those in the VRS.

Some young people (4 young people who were both from COS and VRS) described how Compass offered a flexible tailored approach, and how they felt as though they were not pressured to do anything that they did not want to do. The young people noted different areas that the Compass service had supported them in, including mental health and therapeutic support, and also more general areas such as support with education and employment:

“It’s more generalised. That’s more like, overall how I’m feeling if I’ve got any specific worries on my mind, if I need to talk about anything” (Young person)

The young people attending the VRS reported that their family members would often attend the schools for activity days and Christmas fairs, and one young person also described how VRS offered individual therapy for parents. A further 2 young people from the VRS described how Compass would visit the home to support their parents: “Someone’s organising for the whole family to go bowling and stuff”.

Eleven of the young people accessing VRS described positive aspects of the environment within the schools and the activities offered by the provision. The young people described how some of the resources within VRS, such as the “target room”<sup>4</sup> contributed towards their positive experience of the service. Two young people noted how the schedule allowed the pupils to have free time during the week, which they found more accessible than other education provisions that they had attended. In addition, 4 of the young people attending VRS reported the small class sizes to be a helpful aspect of the provision.

A further feature of COS which was reported to improve young people’s outcomes was the service’s consistency and reliability (2 young people). One of the young people noted how appointments were never cancelled, and if the clinician arranged to meet then they would always be there. In addition, 4 young people noted how working with

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<sup>4</sup> A “target room” is a room with a large target painted on the wall that pupils can access by meeting their targets set for that day. Targets are tailored to each pupil’s individual needs and current levels of functioning. The target rooms have a pool table and computer console and are set up as an informal space more akin to a youth club environment. This acts as a reward for positive engagement and as an area in which pupils can develop their peer relationship skills with minimal support from staff. Staff also sometimes use the activities available in the target room as a foundation for keywork sessions in which they spend dedicated time with individual pupils providing kinaesthetic opportunities for self reflection, emotional regulation and social skills development.

Compass enabled them to access additional support that they need from alternative services:

“They’ve been working along with my CAMHS team, difficulties that I have, like mental health problems” (Young person)

Flexibility of the service was also described by some young people (5 out of 22) as having a positive impact. Young people valued being able to go out with the clinicians and do activities that they enjoyed. In addition, young people reported that they valued the flexibility of the approach: for example, in that they were able to go out to different places and do different activities with the clinicians during their sessions, and in that appointments were home-based rather than located in a clinic setting:

“I enjoy it to be honest. It’s nice to get out and do things and just speak about things really, yeah” (Young person)

“Not like in a room... it’s like getting out and doing things” (Young person)

## **What is staff’s experience of the Compass service?**

### **Focus Groups**

All participants described high levels of job satisfaction from working with children, young people and families and witnessing positive changes in their lives (for example, helping to stabilise home environments, reducing out of county placements or children becoming looked after, preventing crisis, among others).

Furthermore, the Compass service staff described that high levels of supervision (including clinical, group and ad hoc phone support) were very effective for providing enhanced, safe care and reducing staff stress.

Other sources of staff’s job satisfaction can be found in other sections of the report; for example MDT work, the ability to work flexibly and to sustain work over a long-term, or the feeling that their work was filling an important gap in the care of young people and parents or carers.

However, when the focus groups were conducted, work volume in terms of engaging with multiple individuals across a large geographical area, and administrative or information sharing difficulties, were described as challenges. Based on feedback from the evaluation from staff focus groups, the Compass team reported that they addressed administrative and information sharing difficulties. This iterative approach to developing the innovation based on the evaluation was described by both the implementation and the evaluation teams as a strength of the project.

## What is the experience of young people and parents or carers of staff at the Compass service?

### Parents

Parents frequently described their experience of staff at COS compared to their experiences of other services. Comparatively, COS staff were reported to respond immediately to issues, and their action and care happened quicker:

“With Compass it just seemed that there was that immediate, once you’ve got the worker...there’s quite an immediate response” (Parent)

“If you get somebody that could come out to the homes and could get to befriend them through relationships, which is the approach [clinician] takes” (Parent)

COS staff were described as being assigned to a family at the beginning of the process, which was found to be more acceptable than in other services, such as CAMHS, where parents reported experiences of multiple staff members.

The home visitation service provided by COS was reported by parents to make it easier to talk about difficult situations:

“It feels much easier, it being here and doing it, because I’m on my own turf...and I can let go about how I feel” (Parent)

Home visitation also enabled staff to spend time with the young people and get to know them: as one parent described, this was facilitated by COS having a range of staff available to be matched to certain children, which in turn supported the development of relationships. It was also reported staff wouldn’t leave until the family was ready for them to do so; parents appreciated this level of dedication: “they’re willing to put their time in”.

Staff were described as genuine, non-judgemental, supportive, down-to-earth, approachable. They were regarded as knowledgeable and specialised in their management of children with behavioural problems:

“It is that knowledge and experience of the staff and knowing how to support his needs. The one-to-one as well I suppose, and the same classroom sizes” (Parent)

Parents described feeling listened to by staff, and also being able to talk to staff about emotional or difficult subjects because they trusted members of staff:

“We’ve felt listened to, as I say we ring up someone answers, or gets back to you which is fine” (Parent)

Overall, parents' experiences of staff at COS were positive. However, this also presents an issue regarding the end of service as it evokes a sense of worry about when the service ends:

"I think the difficulty is going to be when those relationships end...one of the young people we've got at the moment is quite, not dependent, but looks forward to it and he's one of the most important figures in his life at the moment" (Parent)

The end of service resulted in escalating negative behaviours in young people:

"...his behaviour's gone downhill again a little bit now we've finished"

However, staff were found to prepare parents for this outcome:

"...but [clinician] did say to expect that, she said it's quite a normal thing to happen" (Parent)

## Young people

In terms of communication, young people (11 out of 17) reported feeling as though Compass staff listened to them in both provisions:

"Yeah they do listen to me. When I'm upset and angry, and when I've had a bad day at home" (Young person)

A further 6 young people described how Compass staff had explained the service and the roles of the staff to them at the beginning of the intervention:

"Yeah clinician explained all that when I first met her, like her main work" (Young person)

Young people (8 out of 21) reported having positive relationships with their Compass clinician; described how their clinician felt more like a friend than a professional, and described the staff as "open", "friendly" and "lovely".

Some young people (6 out of 22) described the Compass service as providing support and someone for them to talk to. They felt able to talk to Compass staff, as they were seen as welcoming, friendly, attuned to their needs and appeared to understand their problems. Two of the young people also described how the Compass service was consistent and reliable:

"Just making sure that young people have got someone to speak to, and like, just like safety, all sorts of different safety" (Young person)

“Focus on you. Yeah and like help you and stuff. Help all, kind of like, they work on you and what you’ve got rather than like just focusing on... one area. They kind of work with you, for you” (Young person)

However, 2 out of 17 young people were uncertain whether the staff within the Compass service listened to them. In particular, one young person described situations where new members of staff had started working within Compass, and therefore needed to learn about the children.

## **What are the barriers and facilitators to implementing and sustaining the Compass service?**

### **Facilitators**

#### **Parents**

In terms of facilitators, parents felt confident in the support they were accessing, and having access to this support. COS was described as non-judgemental which facilitated involvement within the service as parents felt supported and able to be open and honest with staff:

“It is a lot different because it seemed, before you have to go to them and they sit and judge, they sit in their ivory tower and judge, that’s how it feels anyway” (Parent)

Factors such as this resulted in parents feeling more satisfied with COS than with services they received in the past: “...they’re good, but they’re not like Compass”.

COS was reported as being more personalised than other services experienced by parents as they responded to the individual needs of the family and provided one-to-one support:

“It’s probably a bit more like, personalised in the sense that because they’re like, I mean a lot of the times I see [clinician] she comes to like the house...so it’s been a bit more casual” (Parent)

Through providing a more flexible service, parents were able to offer a more bespoke package whilst maintaining a reliable and immediate response from staff:

“Things are happening very quickly, which is quite good, and very unusual” (Parent)

“It seems to be more flexible. Seems to be more personal” (Parent)

“Just the perseverance and having the right amount of time, being reliable, being consistent” (Parent)



These positive facilitators are important as they address the negative aspects of other services reported by parents (such as formal, inflexible, unreliable, no personal level), therefore providing a more useful service.

## Young people

A facilitator described by 7 out of 22 young people from both provisions was that Compass offered support for the whole family. For example, 2 young people from VRS described how Compass would visit the home to support their parents:

“He does home visits. He sometimes comes round mine. He just talks to me and talks to my family, yeah to tell them what to do if stuff’s kicking off... because normally what happens if when stuff goes on at home I carry it to school and I start kicking off” (Young person)

In addition, young people (6 out of 22) reported that the Compass service was a more informal, flexible and tailored service, valuing that they were able to go out to different places and do different activities with the clinicians during their sessions, as opposed to being based in a clinic. Young people also noted how Compass staff were attuned to their needs and appeared to understand their problems. In addition, young people felt as though the work was flexible, and tailored to the support that the young people feel that they need. One young person described “keyworker time” to be the best aspect of Compass, as it provided them with additional support and someone to share any difficulties with.

Seven out of 22 young people accessing VRS described how the setting and structure of the schools was positive and helpful. Specifically, 2 young people noted how the schedule allowed the pupils to have free time during the week, which they found more accessible than other education provisions that they had attended, and 4 young people reported that the small class sizes and generally fewer children attending the schools was helpful because they struggled to manage in busy places.

## Barriers

### Focus Groups

The majority of participants described a need for greater clarity over the role of the service in assisting communication within Compass, and also with external colleagues; for example, when referring into the service.

When focus groups were conducted, a lack of information sharing was mentioned by the majority of staff as a key barrier to MDT working and implementing the Compass approach. In addition, infrastructure was mentioned as central to this, as information systems were not in place to facilitate sharing across sectors, as was not having a

physical base for the outreach service, meaning that staff had limited face-to-face interaction. Interaction across the school and outreach services was also described as minimal. At that time some staff described information sharing as better in the school service, which has been running for a longer time. The Compass team has reported that these issues have been mostly addressed since then, as focus groups results were reported back to the team in the interim report sent to DfE in March 2016 and by the embedded researcher; providing the Compass team with an opportunity to improve service delivery.

In addition, setting up a new infrastructure that crossed both health and social care was described as a barrier that took some time to overcome. However, the Compass team has reported since then that getting the process and governance arrangements in place was central to the project outcomes and shared ownership across the partnership.

Finally, challenges in recruiting foster carers (which was prevalent across social care services generally) were described as a barrier to the future direction of the Compass service.

## Parents

In terms of barriers, 5 out of 17 parents reported a slow referral process and a lack of communication between social workers and COS about timeframes for the referral:

“That seems to take a long time, and it’s not necessarily your side of things, but we never really know where we’re at with things” (Parent)

It is important to acknowledge factors such as this for service improvement: it shows that there is a need to emphasise a transparent referral route, and an open method of accessing information during referral.

This barrier was also expressed by parents who accessed the VRS. They described a lack of specialist provision within Norfolk, which meant that the traditional route into accessing specialist services was difficult to access. In addition, parents accessing VRS expressed frustration at the lack of explanation:

“That’s why I got frustrated with the school because I was trying to find out more about the school and the environment and what they have to offer, there was literally, there wasn’t much” (Parent)

Two parents suggested further improvements in relation to VRS through adding a welcome pack to provide information about the school, staff and structure of the provision:

“I think this is important about the need for a welcome pack. All mainstream schools do” (Parent)

The Compass team reported that they were addressing this issue through a new website, and they have prepared information packs for new referrals.

## **Young people**

A first barrier reported by some young people (6 out of 21) was that the other children's behaviour within VRS was a negative, distracting and unhelpful aspect of the provision:

"Well it's not the teachers, it's the kids. Sometimes all the kids are quite annoying, and sometimes bully me... that's what I don't like about Compass sometimes, because they let them do what, because some days they just go and let people pick up the chairs all the time and they don't say down. That's what I don't like about Compass" (Young person)

Two of the young people attending VRS also emphasised the need for the schools to continue to provide a service for young people above the age of 14 years old. At present the young people have to leave VRS at the end of year 9, when they are 14:

"I want them to get a year 10 and 11 so I can stay longer. So I don't have to leave at the end of year 9" (Young person)

In addition to the above, 3 of the young people suggested that there needed to be more trips offered to the young people attending VRS. In particular, one young person described how all trips had to be risk assessed, and that this was an obstacle in organising more frequent trips:

"I'd probably, because we don't really go out that much now, because we always used to be able to go over to the park without having to do a risk assessment or we could go to the shops without getting a risk assessment. Now we have to get it all risk assessed." (Young person)

## **How can Compass be sustained in the long-term?**

### **Focus groups**

Participants mentioned concerns from Compass staff, referrers and children, young people and families over the future of the service, in terms of whether or not it would be funded in the future given the transient nature of health and social care services and, if it was, whether service funding would be squeezed to the extent that staff could not sustain long-term work with children, young people and families, which was described as being so crucial to the effectiveness of the service and as preventing staff burnout. Since then, funding for VRS has been secured for 5 years and COS is on a recurrent basis.

One focus group suggested using a hub model for the outreach service, dovetailing with the VRS approach, as a means of fostering sustainability in the future. Moreover, the importance of joint commissioning between health and social care was described as necessary for the future viability of the service.

## **Parents**

Three parents described a need for the service to expand, as the demand for the service was growing but the capacity had remained the same. Therefore parents noted a need for more staff to be employed, and further funding to be granted to ensure that the provision continued and expanded:

“I think the reality is that it needs to expand, you need more people... actually there’s just not enough [clinicians], that’s the reality... you’re going to need more people”  
(Parent)

A detailed consideration of funding would have to be undertaken before any conclusions could be drawn on the sustainability of COS in the long term.

One parent noted the cost-effectiveness of the service to be positive as the service focused on returning young people, who had been placed in expensive out of country placements, to the county: “...what money it’s actually saving, it’s probably huge”. However, other parents did express worry about the sustainability of the service. These worries related to what would happen to the care of their children and families if COS did not receive funding, or if their situation no longer fitted with the service criteria.

## **What are the results of COS’ cost-benefit analysis?**

A cost-benefits analysis (CBA) for COS was conducted by an independent party (York Consulting). The following is the report prepared by John Rodger, Tim Allan, and Matthew Cutmore.

### **Assumptions and Limitations**

- we have designed a bespoke CBA model for Compass Outreach that allows for cashable benefits of children already in care to be calculated (other Innovation Fund CBA models often focus on the benefits of young people not entering care as a result of the intervention)
- unless stated otherwise, it is assumed that the cashable benefits used in the CBA can be attributed to Compass Outreach for 12 months
- given the available data, the cashable benefits covered by the CBA relate to reductions in placement costs and reduced reliance on statutory services

- for robustness, benefits have only been calculated on closed cases. Therefore, some of the more complex cases (requiring longer durations of support) are not factored into this preliminary CBA

## Compass Outreach Support

- as at early July 2016, Compass Outreach had supported 149 young people as shown in Table 6:

**Table 6: Number and frequency of young people in each reason for referral**

Reason for referral	Freq.	%
1 - Reunification	27	18.12%
2 - Return or Out of County Placement	1	0.67%
3 - Care Placement Stabilisation	35	23.49%
4 - Family Stabilisation	85	57.05%
5 - Step Down from Residential to Foster Care	1	0.67%
Total	149	100.00%

- of the 149 supported, 99 had been discharged on completion of their period of support
- based on the rate of discharges, we estimate that under a steady-state model (where the service has been operating long enough to have a constant flow of referrals and discharges), the service would be able to support and close 168 cases per year (99 cases discharged over 7 months equals an average of 14 per month. 14 multiplied by 12 months equals 168)

## Costs

- a review of the Compass Outreach accounts shows the expected running cost of the service to be £889,121. This is the steady-state cost as it does not include setup costs and assumes full operating capacity
- the cost per young person supported is £5,292 (£889,121 divided by 168 young people)
- ideally we would have sought to establish the resource cost per case but the data to do this was not available
- it has also not been possible to analyse costs by type of referral

## The Benefits: Removal of Adverse Outcomes

- benefits/cost avoidance is calculated for the 12 months immediately after the young person exits support. Outcomes data for discharged cases was provided by the Compass Outreach team. This was then translated into financial benefits by applying proxy values associated with these outcomes
- we cannot accurately predict what will happen to these young people in the future – there are too many variables. While we acknowledge that the work of Compass Outreach (and other support services) may benefit young people well in to their adult lives, to keep the model robust we only capture benefits that are immediate and can be tracked
- when monetising outcomes, we have used robust financial proxies. Benefits have been weighted to reflect the following post-Compass Outreach statuses:
  - remained open to social care: cashable benefits are reduced by 50% to reflect additional support costs and the likelihood of positive outcomes not being sustained over the longer-term
  - stepped down to universal support: cashable benefits are reduced by 25% to reflect ongoing support needs
  - closed to support: cashable benefits are not reduced as safeguarding concerns have been addressed

## Estimating Outcomes

- we were provided with data by the Compass Outreach team for each young person supported. Key variables in the data included:
  - case status (open to support, discharged or successfully closed)
  - type of referral
  - referral objective met
  - accommodation status on entry and exit from support
  - legal status on entry and exit from support
- the analysis of benefits has focused on cases that are closed to support; and where the referral objective had been reached
- data has been collected since the start of the service (May 2015). However, cases have only begun to close in the last 7 months. It has therefore been necessary to annualise outcomes based on the rate of closures observed during this period
- we have accounted for different levels of attribution for outcomes based on the reason for referral. For example, where the reason for referral was family stabilisation and the outcome was the young person remaining at the family home, we have

assumed LAC status has been avoided for 3 months (rather than the national average looked after period of 12 months), recognising that the situation at home may have been resolved by other means, such as other support or a change in family circumstances

## Monetised Outcomes: LAC

- in order to estimate the annual benefits of the service, we first calculated the benefits to date based on our sample of closed cases
- of the 72 cases where the referral objective was met, there were 67 outcomes recorded in relation to LAC. The total benefit (weighted to take account of ongoing support needs) is estimated at £1,681,906. The table below details the frequency of different LAC outcomes observed in our sample, the proxy measure applied and the total and weighted benefits

**Table 7: Monetised outcomes: LAC**

Outcome	Proxy	Benefit	Freq	Total benefit	Weighted benefit
Prevented LAC by stabilising situation at home	Average cost of foster placement for 12 months	£34,656	44	£1,524,864	£987,696
Reunified (from foster care)	Average cost of foster placement for 12 months	£34,656	8	£277,248	£199,272
Prevented LAC by stabilising kinship care	Average cost of foster placement for 12 months	£34,656	7	£242,592	£225,264
Facilitated kinship care	Average cost of foster placement for 12 months	£34,656	2	£69,312	£34,656
Stabilised foster placement	Average cost of residential placement for 3 months	£37,068	2	£74,136	£37,068
Reunified (following respite care)	Average cost of foster care for 3 months	£8,664	1	£8,664	£6,498
Reunified (from residential care)	Average cost of residential placement for 12 months	£148,272	1	£148,272	£74,136

Outcome	Proxy	Benefit	Freq	Total benefit	Weighted benefit
Stabilised residential placement	Average cost of high-need residential care for 3 months	£86,360	1	£86,360	£43,180
Stepped down from residential to independent living	Average cost of residential placement for 12 months	£148,272	1	£148,272	£74,136
Total			67	£2,579,720	£1,681,906

Proxies sourced from New Economy Manchester Unit Cost Database v1.4

## Monetised Outcomes: Support Services

- in relation to reduced reliance on statutory support services, there was a total weighted benefit of £94,098. The total benefits attributable to Compass Outreach for the 72 cases successfully closed to date is therefore £1,776,004 (see table below)

**Table 8: Monetised outcomes attributable to Compass Outreach Service**

Outcome	Benefit
LAC	£1,681,906
Support services	£94,098
Total	£1,776,004

## Annualising Monetised Outcomes

- based on our sample, the average benefit per young person discharged to date is £17,939 (total benefits of £1,776,004, divided by 99 discharges)
- the estimated annual case closures, when the service is operating at a steady state, is 168. This equates to an estimated total annual benefit of £3,013,752 (average benefit of £17,939 multiplied by 168)
- this is perhaps a conservative estimate as data regarding additional outcomes (such as school attendance, behaviour and offending) that are sometimes linked to young people in the looked after system have not been recorded. In addition:



- the costs of placement proceedings (which can be in the region of £90,000 per family) have not been included at this stage. This would require additional background and follow-up data for the young people supported by Compass Outreach
- for now, the analysis does not include any cases that involved returning from an out of county placement, because support for these cases is ongoing. Once closed, the benefits for these cases, if successful, will be significant

## **Fiscal Return on Investment**

- the Fiscal Return on Investment (FROI) shows the benefit:cost ratio for the Compass Outreach service
- total benefits (adverse outcomes avoided) were calculated to be £3,013,752 per year based on a steady-state model
- total annual steady-state costs are projected to be £889,121
- based on the above, the Fiscal Return on Investment is 3.39
- this demonstrates a positive cost benefit outcome equating to a saving of £3.39 for every £1 invested in the project
- we are confident in the robustness of the model due to the quality of data received from the Compass Outreach team (particularly in regard to different placement settings) and the data enabling us to factor for sustainability of outcomes on a case-by-case basis

## **Recommendations**

To enable a more detailed CBA, the Compass Outreach team should consider:

- calculating the staff time associated with different types of referrals and fine tuning the costs
- recording additional outcomes, such as school attendance, offending behaviour and care proceedings
- tracking young people 12 months after support to check the longer-term sustainability of outcomes

It is our understanding that the Compass Outreach team are keen to implement these changes into their management information to allow for live CBA reporting

Although anything above a FROI of £1 is perceived to be a good result for this type of analysis (York Consulting), COS' FROI of £3.39 indicates that COS is achieving greater value for money for local and central government. However, the CBA analysis was

based on COS closed cases in order to avoid the risk of double counting savings, meaning that it excluded open cases that might have been in COS for a long time, which in turn might have skewed results in favour of COS. In order to avoid this possible bias, the COS team is currently collecting data which can be used to measure savings in real time on a month-by-month basis. This was reported by the COS team as one of the positive legacies of the evaluation.

## Limitations of the evaluation and plans for the future

### Limitations of the evaluation

- data at local authority level was not obtained. However, if obtained in the future it is important to highlight that causality should not be inferred. This is not only because Compass is currently reaching a small percentage of children and young people who could benefit from such a programme, but also because factors other than Compass are likely to be influencing changes and/or fluctuations in numbers in contextual data
- sample size of outcome data: for example, even though 27 young people, 58 parents and 75 teachers completed the SDQ at T1, paired SDQs were significantly lower, with 8 paired SDQs completed by young people, 7 completed by parents and 18 by teachers. Hence, results presented were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained. Furthermore, a longer follow-up of those who access the Compass service is necessary to examine the long-term effects of the service
- even though, as presented in the next section, the embedded researcher was a facilitator for the evaluation, and made the evaluation more sustainable, they also made it potentially less independent
- as data was routinely collected, rather than collected under controlled conditions, there may be variations in how data was collected and recorded
- CBA was conducted with closed COS cases, which are mostly cases with a quick turnaround. In order to include the costs of open cases (which might have been in COS for a longer time), the team is now collecting data that can measure savings in real time on a month-by-month basis. This was reported by the COS team as one of the positive legacies of the evaluation
- the evaluation of Compass' impact on young people's academic attainment was only explored with qualitative data. However, further evaluation could be conducted using academic data from pupils in VRS
- focus groups were conducted in January 2016; some of the results reported here have changed since then
- most of the interviewed parents were recruited from COS and most of the interviewed young people were recruited from VRS. Therefore, parents' views of VRS and young people's views of COS might be under-represented
- in some parts of the report the results do not differentiate between the Compass services. This is partly due to how data was collected (for example, focus groups were conducted with staff from COS and VRS, or outcome data did not specify whether young people were from COS or VRS). This is also a reflection of the Compass

approach itself, as they aim to provide an integrated service and, for example, some young people are seen by both VRS and COS teams. Furthermore, it is difficult to differentiate effects of individual components in multicomponent, complex interventions such as Compass

- routinely collected data lacked a comparison group, which entails that results cannot be directly attributed to COS. In future evaluations, a synthetic control group could be used, using propensity score matching on routine clinical data from other similar services, or the wider local authority to try and make groups similar and more comparable

## **Appropriateness of the evaluative approach**

Bearing in mind the above limitations, the strengths of the evaluation were that:

- it addressed the central questions from different perspectives (those of staff, young people, and parents) using a number of data sources. This allowed a triangulation of data, which results in more reliable findings. For example:
  - the Compass service provided a more holistic approach compared to other services (see “Does the Compass service improve young people’s emotional, behavioural and family functioning?” section)
  - the positive effect of staff’s ability to work flexibly to meet the families’ needs (see “What might be the mechanisms by which the Compass service improves young people’s outcomes?” section)
  - the positive experience reported by both parents and young people with Compass staff and the overall approach (see “What is the experience of young people and parents or carers of staff at the Compass service?” section)
  - the evaluation drawing on quantitative data can be sustained by Compass after the end of our evaluation. It would be useful to continue to capture qualitative data from service users. However, this would be more sustainable if open-ended responses to questionnaires (such as the Experience of Service Questionnaire – CHI ESQ; Attride-Stirling, 2003) were used, as opposed to interviews or focus groups
  - the embedded researcher was a facilitator for the evaluation. This has proved to work out very well due to the research assistant knowing the implemented project very well, providing easier access to data, and there being good lines of communication between the evaluation and implementation team, enabling quick responses when needed
  - the iterative nature of the evaluation process was reported by the Compass team as having a positive effect on the implementation of the project. For example, collecting data that could be used to measure savings in real time on a month-by-month basis

was a result of the CBA analysis, and addressing the infrastructure of offices for the COS team was a result of the focus groups. In addition, the evaluation of the Compass service played an important role in securing funding for 5 more years

## **Capacity built for future evaluation and the sustainability of the evaluation**

We will work with the implementation team to feed back findings from the evaluation to ensure that lessons learnt regarding barriers and facilitators to implementation are considered when sustaining the Compass service after the end of the project. We will be particularly focused on advising how best to sustain ongoing treatment and service evaluation. This may include, for instance, recommendations about additional measures to collect (such as experience or outcome measures); embedding the use of the participant observation tool as a tool for self-reflection and evaluation or developing templates for the implementation team to update analyses when new data is collected (for example, run charts of routine clinical data).

The exit strategy will involve the implementation team reviewing the evaluation report and providing feedback; and a handover period where the implementation team can ask evaluation questions post-exit. The exit strategy will be particularly focused on ensuring the implementation team is left with the skills, understanding and planning to collect, analyse, interpret and disseminate outcomes in accordance with the medium- and long-term aims.

## **Recommendations for future evaluation**

- continuing the evaluation for a longer time frame and for a larger number of young people is recommended. Outcome results presented in this report were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained. Some of their further evaluation could be provided as part of the larger National Institute for Health (NIHR) grant
- continuing the role of the embedded research assistant. As stated above, the research assistant proved to be a facilitator for the evaluation and the extension of this role would help with the sustainability of the Compass service evaluation

# Implications and recommendations for policy and practice

## Capacity and sustainability of the innovation

The CBA report from York Consulting stipulated that: “Based on our sample, the average benefit per young person discharged to date is £17,939 (total benefits (£1,776,004) divided by 99 discharges).

- The estimated annual case closures, when the service is operating at a steady state, is 168. This equates to an estimated total annual benefit of £3,013,752 (average benefit (£17,939) multiplied by 168).
- This is perhaps a conservative estimate as data regarding additional outcomes (such as school attendance, behaviour and offending) that are sometimes linked to young people in the looked after system have not been recorded. In addition:
  - The costs of placement proceedings (which can be in the region of £90k per family) have not been included at this stage. This would require additional background and follow-up data for the young people supported by Compass Outreach.
  - For now, the analysis does not include any cases that involved returning from an out of county placement. This was because support for these cases is ongoing. Once closed, the benefits for these cases, if successful, will be significant.” (Rodger, Allan & Cutmore, 2016, slide 10).

The CBA report concluded that “This demonstrates a positive cost benefit outcome equating to a saving of £3.39 for every £1 invested in the project.” (Rodger, Allan & Cutmore, 2016, slide 11).

## Conditions necessary for this innovation to be embedded

In Norfolk there is a need for Compass to provide appropriate care for young people and families in crisis, as indicated by the findings of this evaluation. In particular, parents reported that the Compass service supports young people in a range of difficulties: for example, exclusion from education, preventing the young person from being criminalised, and maintaining a child with complex difficulties within a placement. Young people noted how Compass staff were attuned to their needs and appeared to understand their problems, and staff in focus groups described Compass as accessing children, young people, and families who would not necessarily be able to be seen by other services, and stated that the MDT work met their needs effectively.

Within this context, wider dissemination of information about Compass would help the innovation to be embedded and to reach a greater number of young people and

parents. It will be crucial to maintain the level of care with larger numbers of service users. Dissemination would also mean that more young people and families would access Compass, and hence more resources would be needed in order to cope with future staffing and demand. Parents noted this and described a need for the service to expand, as the demand for the service is growing while the capacity has remained the same. Currently, the VRS has been jointly commissioned by NCC and the 5 Norfolk CCGs for the next 5 years, in which they are required to submit data on the pupils' outcomes to ensure satisfactory performance against their Key Performance Indicators. Compass team has no reason to believe that this arrangement will not continue after that time. On the other hand, COS' funding agreed with NCC is on a recurrent budget basis, which has led to contract negotiations between NCC and NSFT. The terms of the contract are being widened to include the LAC of the CAMHS service for Norfolk and Waveney as well as the Perinatal, Infant Mental Health Attachment Team (which was initially funded by the Department of Communities and Local Government and is now operationally managed within the wider Compass Service).

In addition, it is of particular relevance to expand Compass to include all the components of the model (such as the Family Development Unit). In that way, a complete evaluation of the model, and its aim of stepping up support to stepping down need, could be conducted.

## **Consideration of future development of the innovation and wider application**

Future developments of Compass as identified in the evaluation include:

- even though the dataset for COS cases is of high-quality and captures a range of data items, since the Compass approach aims to be holistic, it might be useful for a future evaluation to add items about the particular aspects of the Compass service that the young person is attending (for example, COS only, COS plus VRS, etc.)
- results presented were mostly descriptive and our confidence in the findings is very likely to change when a bigger sample is obtained. In addition, a longer follow-up of those who access the Compass service is necessary to examine the long-term effects of the service
- further evaluation of the impact of Compass on academic attainment could be conducted using academic data from pupils in VRS
- building on the success of the cross-sector working and the multidisciplinary team, cross-sector training would be recommended to further integrate staff across both health and social care

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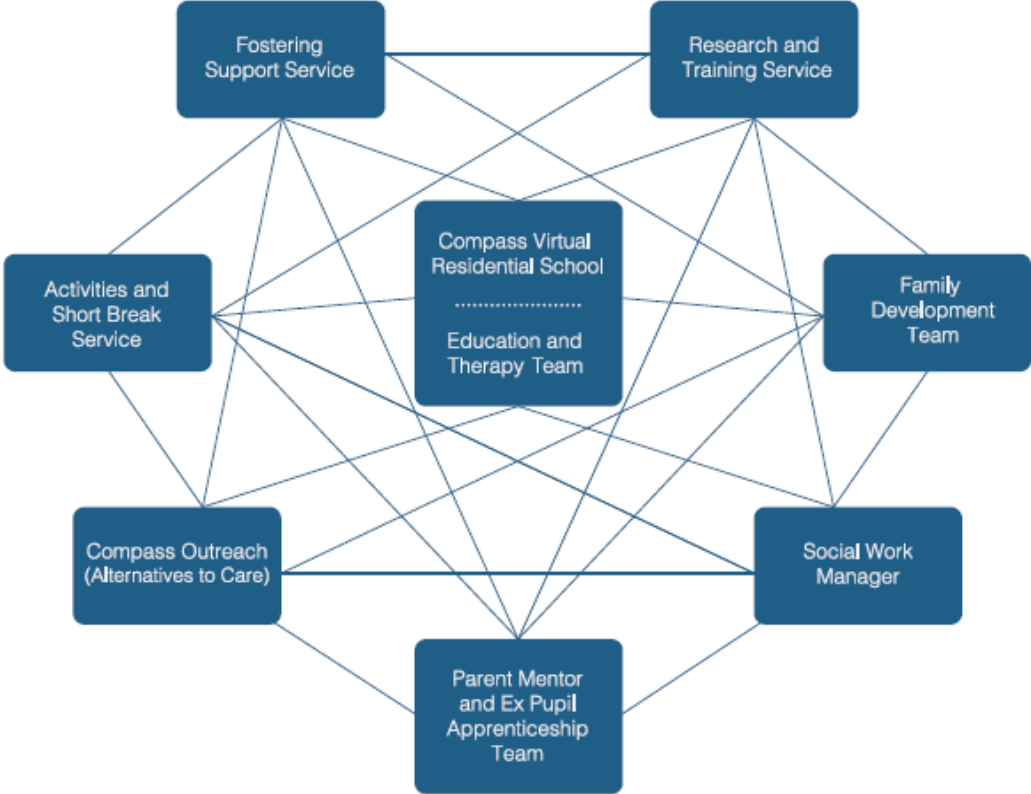
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# Appendices

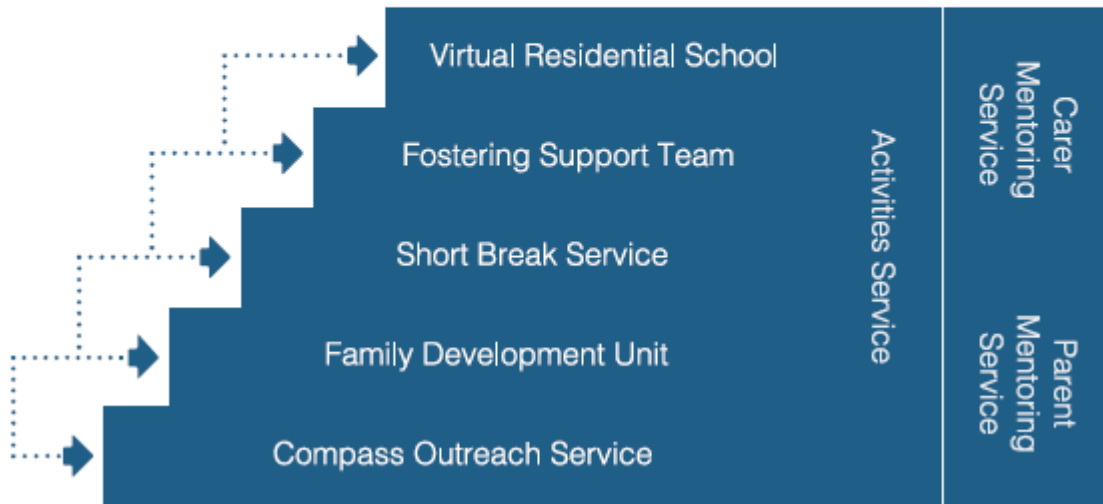
## Appendix A: Components of the Compass service once fully implemented



## Appendix B: Compass service delivery model

### Service Delivery Model

Stepping up support to step down needs



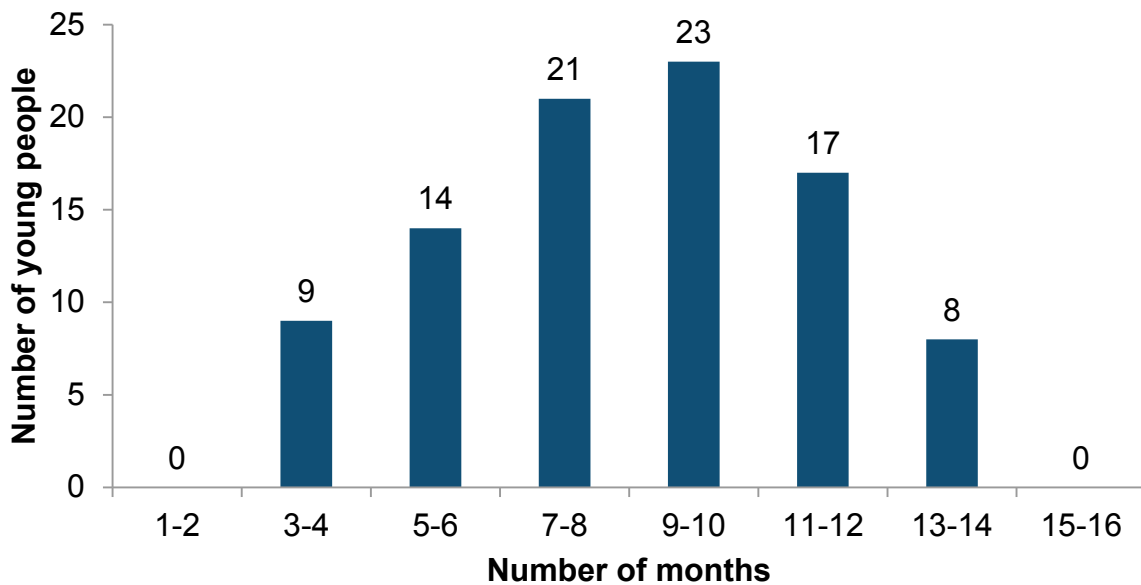
## Appendix C: Compass Outreach Service (COS) data (May 2015 to July 2016)

A total of 152 cases were seen by Compass Outreach Service (COS) from May 2015 to July 2016. The table below shows the number of young people admitted to COS per month and their status by July 2016.

**Table 9: Number of cases admitted to COS by month and their status by July 2016**

Status	2015 May	2015 Jun	2015 Jul	2015 Aug	2015 Sep	2015 Oct	2015 Nov	2015 Dec	2016 Jan	2016 Feb	2016 Mar	2016 Apr	2016 May	2016 Jun	2016 Jul	Total
Open			4		4	11	7			12	4	1	2	6	2	53
Discharged	1	5	16	21	8	17	10	3	2	10	5		1			99
Total	1	5	20	21	12	28	17	3	2	22	9	1	3	6	2	152

**Figure 3: Number of months that discharged young people were seen by COS (n=92)**



**Table 10: Number of young people by reason for referral and by months**

Reason for Referral	2015 May	2015 Jun	2015 Jul	2015 Aug	2015 Sep	2015 Oct	2015 Nov	2015 Dec	2016 Jan	2016 Feb	2016 Mar	2016 Apr	2016 May	2016 Jun	2016 Jul	Total
Family Stabilisation		4	11	8		19	11	2		14	8	1	1	6	2	87
Care placement stabilisation	1		6	12	4	2	2		1	7						35
Reunification		1	3	1	8	7	4		1	1			2			28
Step down from residential to foster care								1								1
Return or Out of County placement											1					1
Total	1	5	20	21	12	28	17	3	2	22	9	1	3	6	2	152

**Table 11: Number of young people by accommodation status at referral and by months**

Accommodation Status at Referral	2015 May	2015 Jun	2015 Jul	2015 Aug	2015 Sep	2015 Oct	2015 Nov	2015 Dec	2016 Jan	2016 Feb	2016 Mar	2016 Apr	2016 May	2016 Jun	2016 Jul	Total
Foster Care			3	4	6	7	2		1	6			1			30
Home		3	14	13	5	21	13	2	1	14	7	1	1	6	1	102
Kinship		2		4						1						7
Residential	1		1		1		1	1					1			6
Tier 4							1									1
Private Fostering Agreement										1						1
Secure											1					1
Total	1	5	18	21	12	28	17	3	2	22	8	1	3	6	1	148

**Table 12: Number of young people by legal status at referral and by months**

Legal Status At Referral	2015 May	2015 Jun	2015 Jul	2015 Aug	2015 Sep	2015 Oct	2015 Nov	2015 Dec	2016 Jan	2016 Feb	2016 Mar	2016 Apr	2016 May	2016 Jun	2016 Jul	Total
No legal status						3										3
Family Support Process (FSP)											2					2
Child in Need		1	4	6	4	9	5	2		10	1		1	5	1	49
Child Protection Plan		3	4	10		3	8		1	4	4	1		1		39
Voluntary Accommodation			5	3	3	1	1	1		4	1		2			21
Looked After Children	1	1	5	2	5	11	3		1	4						33
Adoption						1										1
<b>Total</b>	<b>1</b>	<b>5</b>	<b>18</b>	<b>21</b>	<b>12</b>	<b>28</b>	<b>17</b>	<b>3</b>	<b>2</b>	<b>22</b>	<b>8</b>	<b>1</b>	<b>3</b>	<b>6</b>	<b>1</b>	<b>148</b>

## Appendix D: Routinely collected data

### Achenbach System of Empirically Based Assessment (ASEBA)

**Table 13: Descriptive statistics of ASEBA Internalising, Externalising, and Total problems scales as reported by young people, parents and teachers**

	Young People							
	T1 N=23				T2 N=3			
	Min	Max	M	SD	Min	Max	M	SD
Internalising	4	49	24.09	12.74	23	37	29.33	7.09
Externalising	3	44	23.13	11.49	9	29	17.67	10.26
Total problems	36	152	80.09	27.09	57	97	75.67	20.13
	Parent							
	T1 N=48				T2 N=7			
	Min	Max	M	SD	Min	Max	M	SD
Internalising	1	40	17.25	10.97	3	39	20.43	12.59
Externalising	2	57	26.58	15.73	8	47	20.57	12.77
Total problems	11	138	72.52	38.30	41	113	72.43	25.57
	Teacher							
	T1 N=64				T2 N=10			
	Min	Max	M	SD	Min	Max	M	SD
Internalising	0	30	8.64	7.39	0	22	7.30	7.27
Externalising	0	46	14.61	13.65	0	35	7.80	11.72
Total problems	0	119	48.48	33.66	0	96	32.10	30.49

## SDQ

**Table 14: Descriptive statistics of all the SDQ sub-scales and Total Difficulties Scale reported by young people, parents and teachers**

		T1					T2				
		N	Min	Max	M	SD	N	Min	Max	M	SD
Young People	Emo	27	1	10	4.85	2.57	8	1	8	5.38	2.45
	Cond	27	1	8	4.74	1.93	8	0	6	2.75	1.98
	Hyper	27	3	10	6.93	2.06	8	1	6	4.88	1.64
	Peer	27	0	10	3.37	2.60	8	1	7	4.00	2.00
	Prosoc	27	3	10	6.48	2.12	8	5	10	7.13	1.96
	Total	27	9	32	20.00	5.55	8	10	21	17.00	4.78
	Impact	23	0	9	2.83	2.76	8	0	10	2.75	3.37
Parent	Emo	58	0	24	4.24	3.69	7	0	9	4.57	3.78
	Cond	58	0	10	4.83	3.04	7	0	4	2.29	1.50
	Hyper	58	0	10	5.52	2.83	7	0	6	4.00	2.77
	Peer	58	0	10	3.29	2.64	7	1	8	4.43	2.57
	Prosoc	58	1	10	5.95	2.75	7	2	10	6.00	2.77
	Total	58	2	44	17.88	9.13	7	8	23	15.29	5.91
	Impact	50	0	9	2.90	2.84	5	0	6	2.20	2.68
Teacher	Emo	75	0	10	2.96	2.52	19	0	8	2.89	2.42
	Cond	75	0	10	2.72	2.53	19	0	7	2.11	2.23
	Hyper	75	0	10	5.48	3.12	19	0	10	5.89	3.54
	Peer	75	0	10	3.16	2.68	19	0	9	2.89	3.07
	Prosoc	75	0	10	6.01	2.63	18	1	9	5.61	2.06
	Total	75	2	32	14.35	7.62	19	0	30	13.79	8.78
	Impact	61	0	6	1.72	1.84	18	0	6	1.33	1.88



**Table 15: Frequency of young people who were in the clinical and non-clinical group according to young people, parents and teachers in all the SDQ subscales and the Total Difficulties Scale**

		Young People		Parent		Teacher	
		Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical	Clinical
Emotional	T1	17	10	34	24	56	19
	T2	5	3	4	3	14	5
Conduct	T1	15	12	23	35	48	27
	T2	6	2	5	2	14	5
Hyper	T1	12	15	36	22	44	31
	T2	8	0	7	0	10	9
Peer	T1	21	6	33	25	48	27
	T2	6	2	3	4	11	8
Prosocial	T1	21	6	39	19	54	21
	T2	8	0	5	2	12	6
Total	T1	13	14	23	35	43	32
	T2	4	4	3	4	12	7
Impact	T1	9	14	21	29	34	27
	T2	4	4	3	2	12	6

**Table 16: Clinical change in young people reported by young people, parents and teachers in all the SDQ subscales and Total Difficulties Scale**

Clinical threshold	Young people			Parent			Teacher		
	Recovered	No change	Deterioration	Recovered	No change	Deterioration	Recovered	No change	Deterioration
Emotional	1	7	0	2	4	1	1	12	5
Conduct	1	6	1	3	3	1	2	14	2
Hyper	4	4	0	2	5	0	1	17	0
Peer	2	4	2	1	6	0	0	15	3
Prosocial	1	7	0	1	6	0	1	14	2
Total	1	7	0	2	5	0	1	16	1
Impact	2	5	0	3	1	0	1	13	1

**Table 17: Reliable change in young people reported by young people, parents and teachers in all the SDQ subscales and Total Difficulties Scale**

Reliable change	Young People			Parent			Teacher		
	Reliably Improved	No change	Reliably deteriorated	Reliably Improved :	No change	Reliably deteriorated	Reliably Improved	No change	Reliably deteriorated
Emotional	0	8	0	1	6	0	1	16	1
Conduct	0	8	0	1	6	0	1	17	0
Hyper	1	7	0	0	6	1	1	13	4
Peer	0	8	0	0	7	0	0	17	1
Prosocial	1	7	0	0	7	0	1	13	3
Total	3	5	0	1	6	0	1	14	3
Impact	1	5	1	1	3	0	1	11	3

**Table 18: Reliable change and clinical change in young people reported by young people, parents and teachers in all the SDQ subscales and Total Difficulties Scale**

		RCC – Young People			RCC - Parent			RCC - Teacher		
		Reliably Improved	No change	Reliably deteriorated	Reliably Improved	No change	Reliably deteriorated	Reliably Improved	No change	Reliably deteriorated
Emotional	Recovered	0	1	0	1	1	0	0	1	0
	No change	0	7	0	0	4	0	1	11	0
	Deteriorated	0	0	0	0	1	0	0	4	1
Conduct	Recovered	0	1	0	1	2	0	1	1	0
	No change	0	6	0	0	3	0	0	14	0
	Deteriorated	0	1	0	0	1	0	0	2	0
Hyper	Recovered	0	4	0	0	2	0	0	1	0
	No change	1	3	0	0	4	1	1	12	4
	Deteriorated	0	0	0	0	0	0	0	0	0
Peer	Recovered	0	2	0	0	1	0	0	0	0
	No change	0	4	0	0	6	0	0	15	0
	Deteriorated	0	2	0	0	0	0	0	2	1
Prosocial	Recovered	0	1	0	0	1	0	1	0	0
	No change	1	6	0	0	6	0	0	13	1
	Deteriorated	0	0	0	0	0	0	0	0	2
Total	Recovered	1	0	0	0	2	0	1	0	0
	No change	2	5	0	1	4	0	0	14	2
	Deteriorated	0	0	0	0	0	0	0	0	1
Impact	Recovered	1	1	0	1	2	0	0	1	0
	No change	0	4	1	0	1	0	1	10	2
	Deteriorated	0	0	0	0	0	0	0	0	1

## **Client Engagement in Child Protective Services Questionnaires (CECPS)**

Is a multidimensional measure of client engagement in child welfare services and was completed by parents/carers and social workers;

Parent: Questionnaire has 14 questions scored from 1 to 5, so possible score goes from 14 to 70.

- the mean score for parents' engagement at T1 was 51.41 (SD=11.63), and ranged from 22 to 65 (N=58)
- the mean score for parents' engagement at T2 was 57.75 (SD=5.6), and ranged from 51 to 67 (N=8)

Social worker: Questionnaire has 13 questions scored from 1 to 5, so possible score goes from 13 to 65.

- the mean score for social workers' engagement at T1 was 37.9 (SD=4.34), and ranged from 23 to 49 (N=70)
- the mean score for social workers' engagement at T2 was 37.14 (SD=3.84), and ranged from 31 to 42 (N=7)



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**Reference: DFE-RR594**

**ISBN: 978-1-78105-655-4**

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.

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