Emotional Health and Early Intervention re-design proposal

1) West Berkshire Partners - Shared Vision

West Berkshire partner agencies[1], have committed to working together to achieve a shared strategic vision summarized as 'Brilliant West Berkshire: Building Community Together' – a vision which focuses on:

- working differently with communities, not doing 'for' and not doing 'to'
- providing help and support early in communities, built on the assets, strengths and needs of individual communities
- finding solutions and seeking different ways to say 'yes'.

Representatives of these partner agencies came together on 3rd July 15 to discuss opportunities for the development of Tier 2 emotional health services; this document summarises the proposals arising from these discussions.

The key strands of this proposal arise from those partnership discussions and co-design activity; the strands are:

a) Establishing a strategic framework and series of principles for emotional health and well-being at Tier 2, that involves all partner agencies and establishes a foundation for the local 'Transformation Plan'

b) Establishing an emotional health academy e.g. to seek emotional health workers to train and grow in Tier 2 emotional health support and intervention skills; to work out in communities alongside Universal and Tier 2 partners

c) Investing in voluntary, community and faith sector delivery, including working in partnership to seek national sources of funding only open to the sector; to increase the community based provision.

2) The Strategic Context

Emotional health need is one of the most common early indications of additional need; left unsupported, early emotional health difficulties can rapidly develop into a mental health difficulty.

Currently children and young people requiring extra mental health support are referred to a CAMHs single common point of entry (CPE). If they meet the criteria and threshold they are referred to Primary CAMHs workers who work at Tier 2, or for more intense and specialist Tier 3&4 interventions.

[1] including representatives from the health economy, CCGs, education services, police force, social care services, housing services, early help services and voluntary community and faith sectors

West Berkshire's Joint Strategic Needs Analysis: Children and young people in West Berks estimates that the following number of children and young people have a mental health disorder [2]

	5-10yrs	11-16yrs	17-19 yrs
Boys	**580**	**780**	**624**
Girls	**280**	**615**	**480**

In West Berkshire, children are waiting on average a year to receive individual therapeutic care at Tier 2. Some families are reporting two years or more for an appointment to progress an ASD diagnosis; whilst additional funding has recently been made available by Berkshire West CCGs to lessen the pressures at Tier 3; this remains an early intervention gap in service, requiring early support as families await diagnosis.

Last year CPE CAMHS were contacted for help and support 3052 times in Newbury and District (West Berkshire district); and 2816 times in North and West Reading CCG areas (shared between West Berkshire and Reading). Of these contacts 571 and 554 contacts were accepted as referrals into a CAMHS service; subsequently 80% of contacts led to no further action by the CAMHS service and remained in the community for support. In this context, the additional resources made available from CCGs to support Tier 3 services, whilst very valuable, will only be of direct benefit to around 20% of the children requiring help and support. It is therefore perhaps logical, particularly in light of the national call for Transformation Plans for CAMHS services, to increase the early intervention resources available to respond to emotional health within the community.

Schools in particular, find themselves needing to meet the needs of the 80% of children who do not receive Tier 3 support, often with little additional help or support. Schools and other universal services understanding of children with emotional health needs and their families is often not effectively used within the wider referral system, which promotes a 'medical model' of analysis of need; without triangulation with other partner agency information.

A significant proportion of children and young people accessing Tier 3 and 4 services (specialist and acute levels of need) have significant underlying emotional health needs or mental health difficulties.

> *"One in ten children needs support or treatment for mental health problems. Mental health problems in young people can result in lower educational attainment and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour." (Future in Mind 2015)*

[2] Annual modeling based on ChiMat (Children & Maternal Health Intelligence Network)

One in four adults and **one in 10 children** will experience a mental health condition in any one year.

Only a quarter of adults and children with a mental health condition get any treatment for it.

The economic and social cost of mental ill health in England is **£105 billion a year**.

Up to **20% of mothers** develop a mental health condition during pregnancy or within a year of giving birth

Promoting Mental Health 4 Life
Centre for Mental Health with Ed Davie, March 2015

Our current specialist mental health services are over-subscribed and under resourced. In order to meet rising demand and levels of need it is essential that all opportunities are taken to intervene early, and to ensure that the responsibility for improving emotional health and well-being is shared and is not the sole responsibility of specialist mental health services.

> *" The economic case for investment is strong. 75% of mental health problems in adult life start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early Intervention avoids young people falling onto crisis and avoids expensive and longer term interventions into adulthood. There is a compelling moral, social and economic case for change." (Future in Mind 2015)*

Only 25% of children with a mental health condition get any professional help

72% of children in care and **95% of young people in custody** have a diagnosable mental health condition

Half of all lifetime mental health conditions first emerge **before the age of 14** and three quarters **by the age of 25**

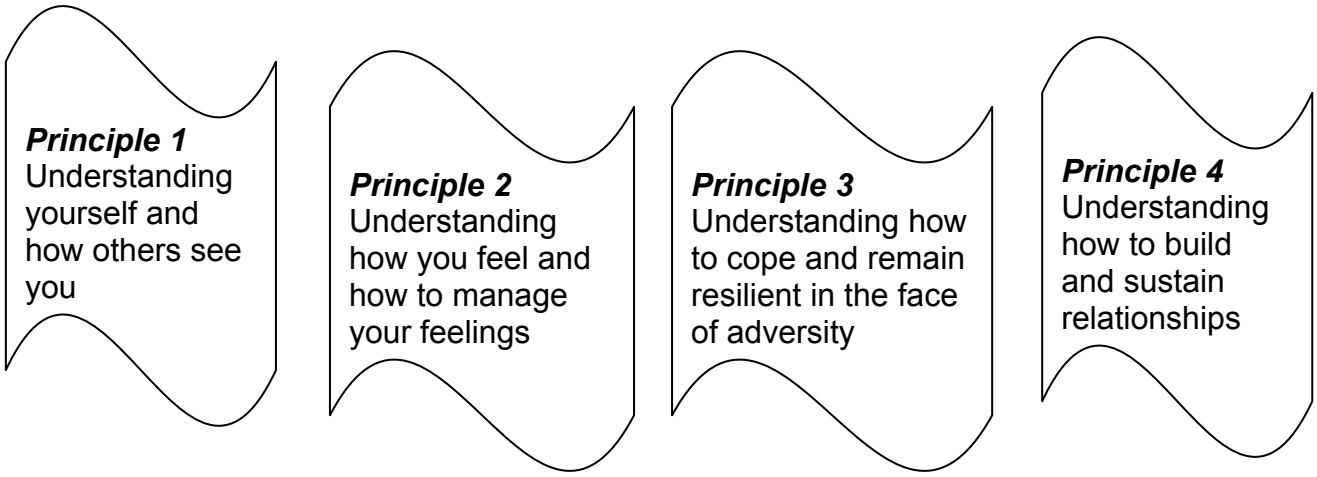
Promoting Mental Health 4 Life
Centre for Mental Health with Ed Davie, March 2015

Nationally, the Mental Health landscape is being positively influenced by, *" Future in Mind,"* a joint report by NHS England and DoH focusing on the transformation of mental health services to children and young people.
It emphasises the following issues as essential to be included in national and local mental health planning:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

3) Local strategic approach (West Berkshire Transformation Plan)

West Berkshire's strategic approach to the local Transformation Plan could be summarised includes four simple principles to build self-care skills and promote well-being these strategies form the foundation of the Transformation Plan:



These principles could be applied equally to both building the emotional health and resilience of members of the community; as well as promoting the welfare of the staff and volunteer workforce.

West Berkshire's workforce development strategy supports the wide-spread establishment of these principles through the investment in mindfulness and staff and volunteer training in restorative practices.

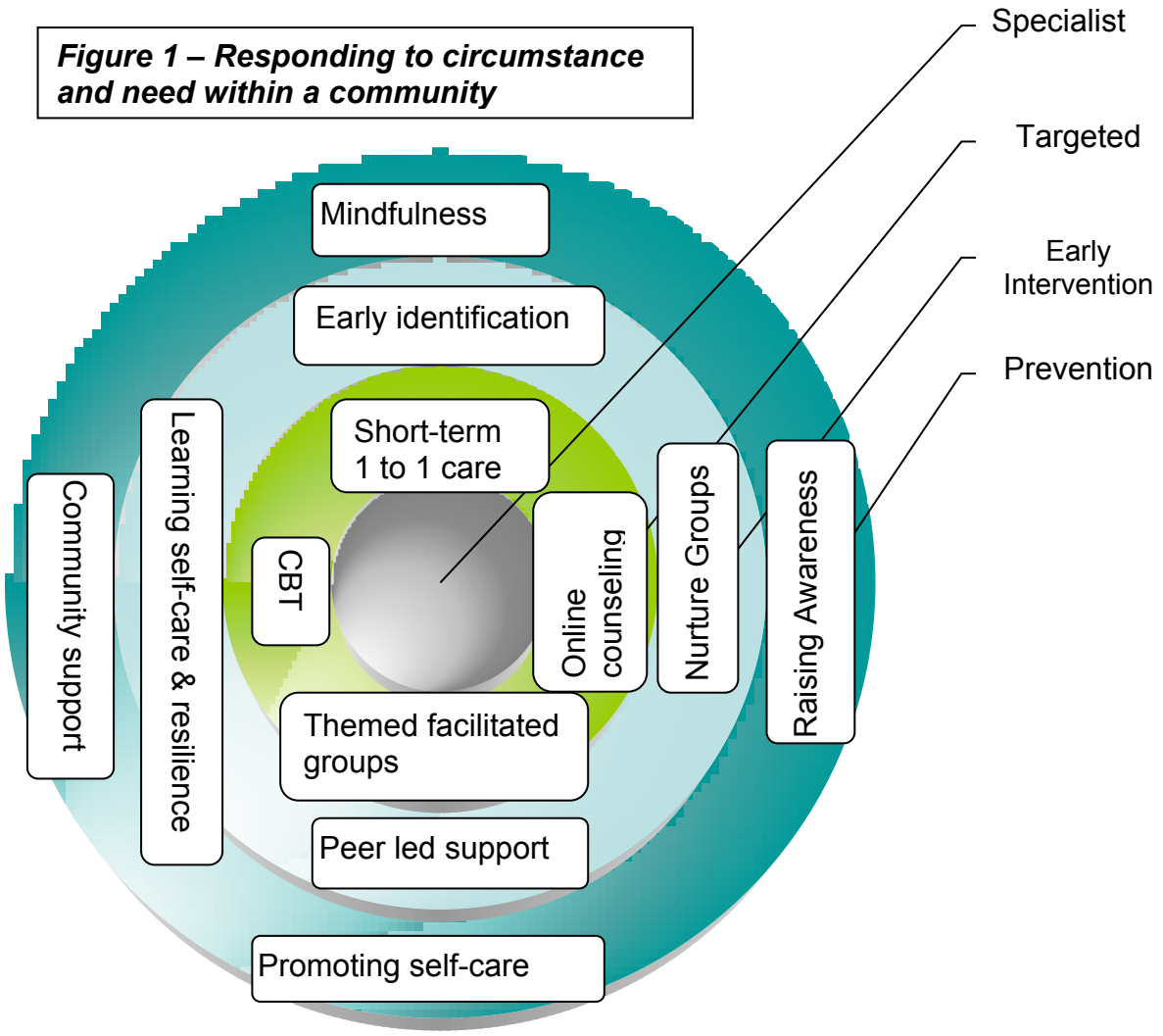


Figure 1 – Responding to circumstance and need within a community

Figure 1 illustrates how the principles to promoting emotional health and well-being can be applied to the particular needs and circumstances of a member of the community. Imagine this diagram as the layers of an onion, or the concentric circles within a tree trunk – the activity in the outer preventative layer is equally relevant to the early intervention and more specialist layers. Continuing the analogy, the more mature a system gets, the more self sustaining it becomes e.g. a thin young tree needs watering and staking and external protection, whereas a larger tree has developed self-protection and maintains itself without outside intervention. This is what we are aiming for – a growing of community resources so that it becomes more self-sustaining and less reliant on outside support.

For example, if a member of the community were to learn short mindfulness meditations as a component of their day-to-day preventative self-care; they could continue to use and grow these skills if they needed additional help or support due to an episode of severe depression; or a sudden bereavement. The evidence would suggest that the skills associated with mindfulness, would reduce the likelihood of a recurrent episode of depression.

If an individual has a history of depressive episodes, the evidence suggests that the routine use of simple mindfulness techniques can reduce the severity or longevity of any subsequent episodes.

> *"Of the treatments specifically designed to reduce relapse group-based mindfulness-based cognitive therapy has the strongest evidence base with evidence that it is likely to be effective in people who have experienced three or more depressive episodes". (NICE 2009.)*

4) Involving the breadth of the community and the workforce

Rather than simply describing 'levels of need' or 'thresholds' associated with care, where only a few services can provide interventions; this model enables the community itself and the range of volunteer and professionally led-services within West Berkshire to play an active role.

Figure 2 illustrates how we can see this as a shared responsibility

Figure 2 – A shared responsibility

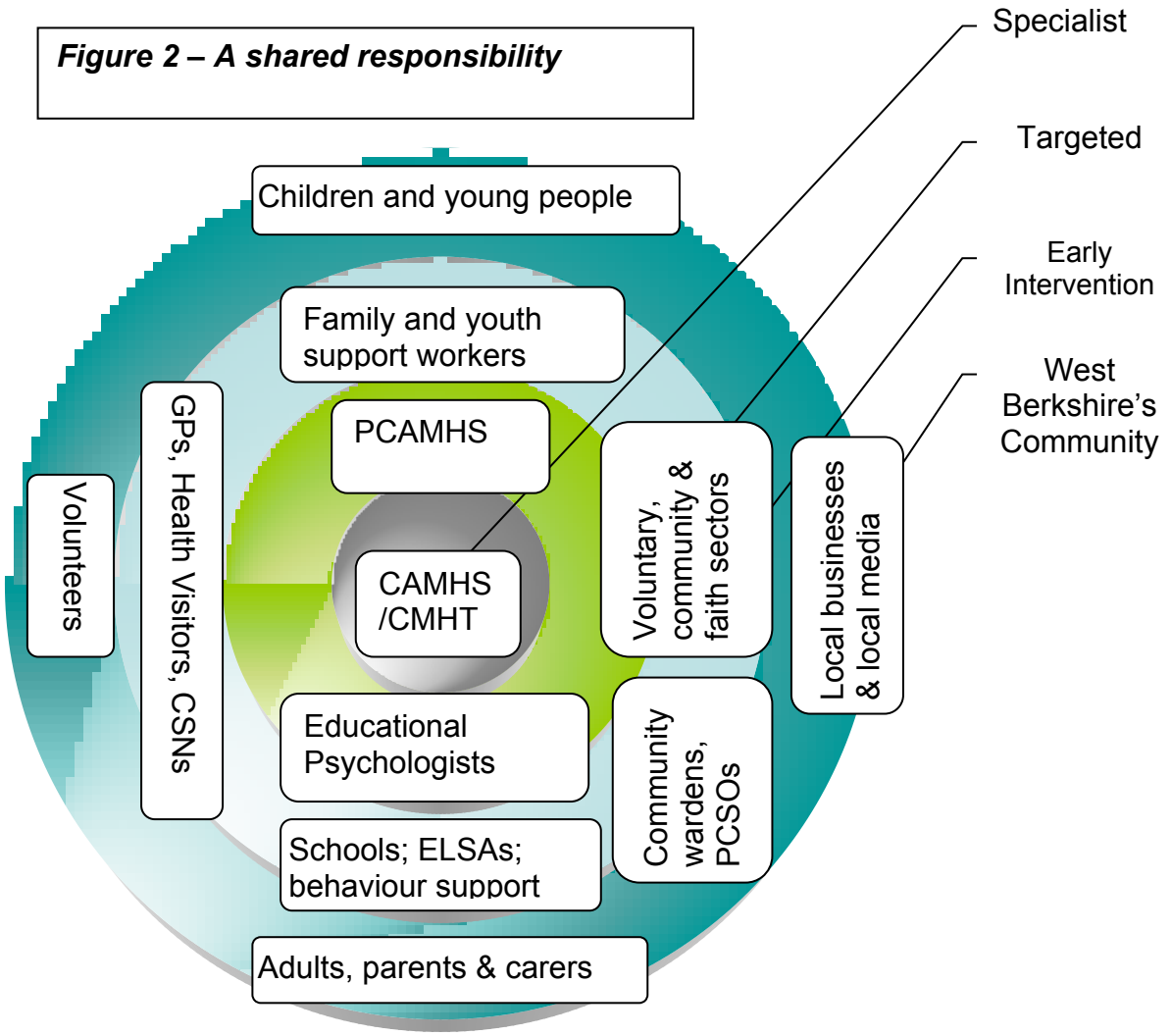


Figure 2 highlights how members of the community can receive care and support from a variety of places and from a variety of people; increasing the chances of reaching those most reluctant or least confident to access traditional services or to interact with statutory partner agencies.

There is particular dependence in this model on the pivotal role of the voluntary, community and faith sectors of reaching out into our community; and on finding volunteers from within communities to take an active role, who would be trained, supported and supervised with a voluntary community and faith sector umbrella and an Academy model.

Research tells us that the most effective way to reach the community with help and support, is by being based within the community itself. This feedback is reflected in the feedback from communities and from front-line staff and volunteers. In the context of austerity and perpetually reducing resources; it is potentially challenging to consider working in this way.

This shared partnership endeavour could be summed up in the following strategic principles:

- Building family resilience and empowering families to make sustainable changes;
- Safeguarding children and young people from harm through effective and early intervention;
- Break cycles of deprivation and poor family outcomes; and
- Reduce escalation to more specialist high cost provision.

5) Providing support frontline in communities

Leaders from schools; General Practice; the voluntary , community and faith sectors; and the Police all describe a lack of emotional health support available in communities. These proposals provide clear commitment for the resource of the Emotional Health Academy[3] to be deployed within communities, on the ground, working in partnership

Our analysis of the levels of need within West Berkshire district demonstrate that the majority of our resources; and in particular our specialist and targeted resources are deployed in the following geographical areas:

1) Calcot
2) Newbury*
3) Thatcham*
4) Greenham*
5) Hungerford & Lambourn
6) Mortimer and Burghfield

[3] See Appendix 1

7) (The Downs)

These areas could become the focus for community resources being delivered within communities. In order to ensure coverage for the breadth of the district; an additional community focus, in the 'Downs' area could be considered. It could be that locality based teams could serve more than one geographical area – for example the * areas above could combine resources in one team.

The analysis of current CAMHS referrals tells us that we have this proportion of referrals spread across the 7 districts:

1) Calcot
2) Newbury*
3) Thatcham*
4) Greenham*
5) Hungerford & Lambourn
6) Mortimer and Burghfield
7) (The Downs)

Newbury and District Clinical Commissioning Group are willing to review their voluntary, community and faith sector funding to see if it can be used to maximize financial investment within the district and be invested where impact on improving outcomes for children and families can most effectively be secured. In this context, the CCGs would also be asked to consider joint funding this emotional health and well-being service.

Longer term, these services and the skill/resources of the Mental HealthAcademy could be sold to other Local Authority areas; to generate income for West Berkshire.

6) <u>What difference will these proposals make to West Berkshire children and young people?</u>

- Currently children have to wait until their needs are 'bad enough' to receive support i.e. meet threshold – this model will enable support to be offered at the earliest opportunity and work to prevent the escalation of need

- Currently children can wait up to 18 months for an appointment – this model will enable children to be supported quickly, in their local communities; without needing to negotiate different referral systems and different thresholds in the sector

- Currently children have to travel across the district and sometimes out of district to access support, advice and care – this model will enable to receive early help, advice and support within the communities in which they live

- Children and families often identify that they feel 'done to' and confused by the system – working restoratively with children and families will increase the opportunities for children and families to feel listened to, feel able to achieve

things, or manage situations, that previously felt too difficult; experience a renewed sense of hope that change is possible

- Currently a significant number of children and young people are referred again to emotional and mental health services after completing their package of care or support – by working restoratively with children and families, and overtly focussing on strengths and interventions that bring resilience and sustainable change, involving 'significant others' around a child or family, repeat referrals will reduce

- Vulnerable children known to specialist and acute services all receive separate services from each agency individually, the level of co-ordination is variable; some of our most vulnerable children wait significant lengths of time for emotional health and support - will receive priority support, in their local area, bringing together professional analysis of risk and enabling the agreement of one shared 'bottom line' with children and families that everyone works to

- Currently we only have a few types of support available to our children and families - There will be a wider range of evidence based support and interventions for children and families; and these resources will be shared with all partner agencies working in those communities – this will include training being available to these partners and increased choice for children and families

- Our current models of support are offered district wide, with little opportunity to respond to individual needs and circumstances - support will be individually tailored to the needs of the child, family and community

- Children and families currently experience changes in professionals as their needs are assessed and transferred to different teams and departments, seeking to cover the district or county – children and families would have more opportunity to build relationships of trust with these keyworkers in their community

- We know that young people often feel 'let down' or confused at the point of transition to adult service – we will work in partnership with adult service colleagues to consider how we could work differently together with these families

- We currently have no local identified lead for perinatal mental health and we know that mothers experiencing maternal depression find it hard to access help and support – we will work in partnership to ensure that families experiencing these needs have several places in their local community to go to for help and support, with minimum standards being overseen in the new emotional health academy

- Children and families with emotional health needs often find themselves receiving inconsistent advice, help and support from different partner agencies; or 'falling between the cracks', between agencies, with no one agency providing

leadership – the emotional health academy will seek to develop greater consistency, shared planning and accountability for families and one point of contact (i.e. keyworker) for children and families needing this support

We will robustly analyse the impact on outcomes that this way of working has on children and young people

7) **Increasing capacity in the voluntary, community and faith sectors (VCFS)**

Local intelligence, review and evaluation; and national research; tells us that many members of the community will feel most comfortable accessing support from a non-statutory partner agency. For some members of the community, this may be the only option for support that they will consider engaging with voluntarily.

a) Make best use of the existing local resources; including seeking volunteers to engage in services in communities.

b) Seeking national sources of funding to expand the current emotional health services in the district.

c) That the focus would be on delivering emotional health support within communities, enhancing the use of volunteers where possible i.e. be-friending and buddying, etc.

d) A specific co-design session with VCFS partners to agree a range of 'specifications for the VCFS part of the offer, building on the particular specialisms and expertise of the sector.

e) Ensuring that the proactive engagement with in the region of 600 young people over the course of the next six months via BWB: Building Community Together proactively ensures that the voice and experience of children and young people re: emotional health and well-being directly informs the design and approach of support/services. Children and young people will be given their own commissioning budget.

8) Timeframes

In the short term (Sept 2015– April 2016):

The current system will continue but a multi-agency Triage system will be established. Primary CAMHs workers will be joined in a Triage panel of other professionals and colleagues from WBC and the voluntary sector working in partnership.

This will extend the options available for the young person and family, potentially offering support within their local community and from a variety of sources.

The advantages include:

- ✓ More robust risk assessments
- ✓ Safeguarding as paramount
- ✓ Priority given to most vulnerable children and families
- ✓ Linking in with other agencies
- ✓ Faster response times and reduction in waiting times for children and families
- ✓ Local offers of support
- ✓ Whole family support
- ✓ Reduction of waiting lists
- ✓ More local knowledge
- ✓ Bespoke packages of support
- ✓ Closer communication with school and GP where appropriate

In the longer term (April 2016 onwards):

PCAMHs commissioning will cease.

Subject to sufficient joint funding being agreed by partner agencies; the Emotional Health Academy will be recruited to and established; voluntary community and faith sector provision with professionals in communities will be able to access local support and professional advice in each community, around a school or community hub.

With the introduction of the Emotional Health Academy (see Appendix 3) providing training, resources, coordination and evaluation of outcomes across West Berkshire, emphasis will gradually shift towards prevention and early intervention with a reduction in the need for 1:1 interventions at this level. The advantages include the above and also:

- ✓ Increased support to schools, communities and GPs
- ✓ Trained workers, either as part of school staff or retained centrally.
- ✓ Increased opportunity for high quality training and coaching of staff and community
- ✓ More choice of support and involvement for schools and GPs as commissioners
- ✓ More choice and involvement for the young person and family
- ✓ More effective use of the voluntary sector
- ✓ Community sustainability

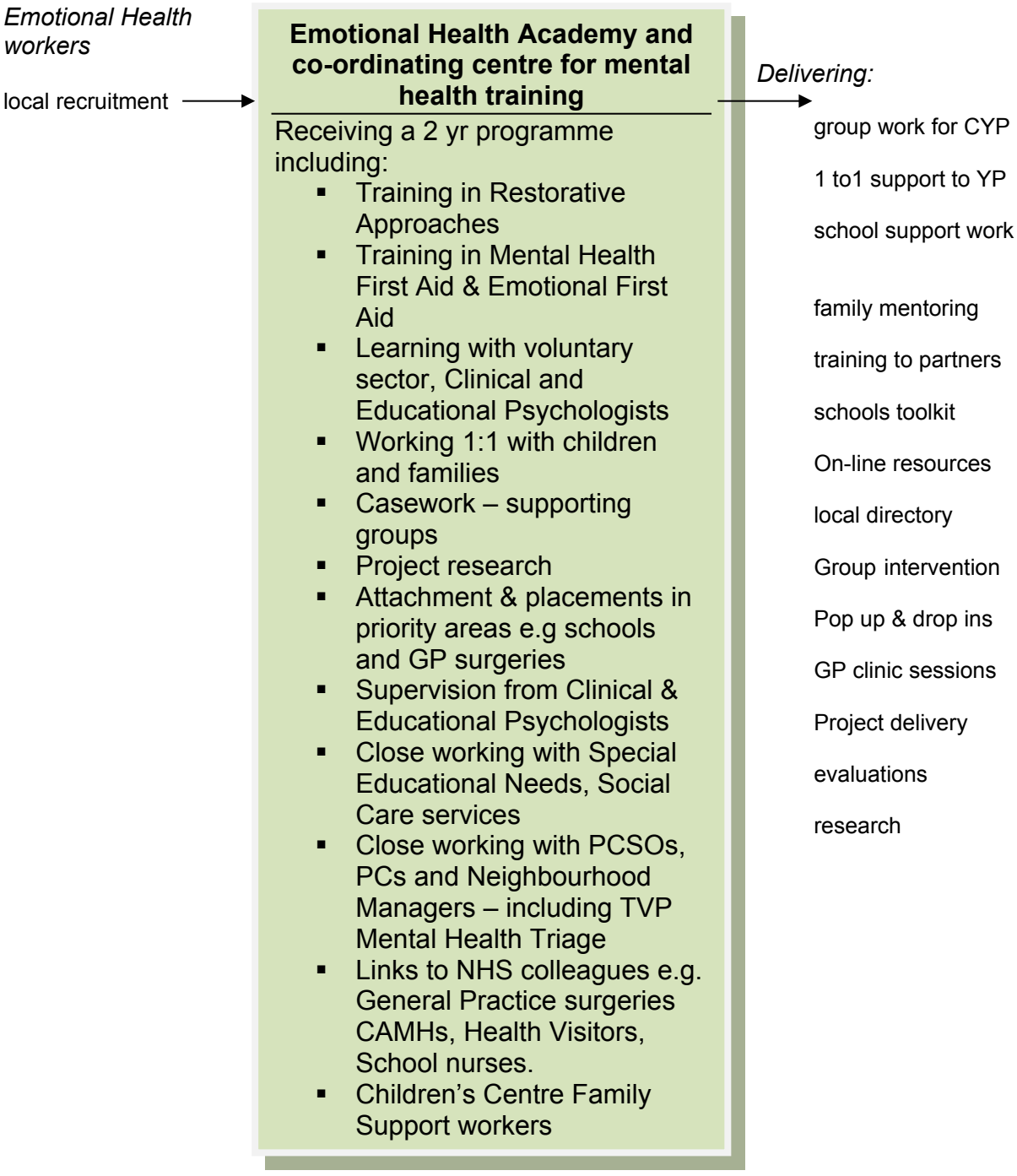
9) Review and evaluation

Academic partnership is currently being sought to external review and evaluate the establishment and impact of the Emotional Health Academy.

Appendix 1 – The Emotional Health Academy

Purpose: to provide timely support to children, young people and families, by *recruiting, training and retaining* high quality Emotional Health workers to build community resilience and support emotional health; within our communities.

Purpose: to co-ordinate information, training, and resources for all partner agencies within local communities



What are the functions of the Academy?

- To recruit, train and retain emotional health workers
- To coordinate an emotional health network for schools, GPs and community organisations
- To work in partnership with schools, GPs and the voluntary sector within local communities to extend emotional health support for children, young people and families
- To work in partnership with other agencies e.g. Police, Social Care, Youth Offending and CAMHs
- To provide and coordinate training for Local Authority colleagues, schools and local communities
- To maintain a high standard of evidence based practice, with quality assurance, evaluation and stakeholder involvement and review.

What are the roles of the emotional health workers?

1. To participate in a local triage system for children, young people and families, as set up by the community
2. To work directly (supervised) with children, young people and families with emotional health needs delivering evidence based interventions
3. To offer advice and support to schools and GPs on emotional health issues
4. To deliver emotional health awareness training to a variety of settings
5. To deliver training on specific emotional health issues
6. To offer supported group work for children and young people on emotional health issues e.g. anxiety, anger, friendships, social skills, self esteem
7. To mentor and support families and work alongside children's centre colleagues
8. To work alongside voluntary groups to ensure full involvement of community resources wherever possible
9. To work alongside peer mentors to develop peer support for emotional health issues
10. To help develop community awareness, through signposting, of the wide range of emotional health resources available locally and nationally to schools, GPs and communities
11. To create an emotional health toolkit for young people
12. To promote preventative and early intervention approaches in collaboration with other colleagues and communities
13. To promote, signpost and develop a range of online resources for young people to access
14. To design and deliver a robust evaluation of outcomes, involving stakeholders and children, young people and families
15. To review early intervention emotional health support, and the role of the Emotional Health Academy, in light of evaluations, and to participate in the continuous review of effectiveness and co-design.

Multi-agency management roles *(to include all stakeholders)*

1. To oversee the creation and design of the Academy; West Berkshire Council will work in close partnership with BHFT and CCG advisors in the design and development of the Academy.
2. To ensure safeguarding practices are robust

3. To recruit the psychology graduates who will be our emotional health workers
4. To deliver training to the emotional health workers on a range of psychological and mental health issues including ' *Emotional Health First Aid,' Mental Health First Aid'* programmes.
5. To coordinate training from other sources
6. To work alongside, as mentors and supervisors, the Emotional Health workers to extend the practical support and interventions available to schools
7. To develop and aid new opportunities for the Emotional Health workers to work in different settings e.g. GP surgeries, community centres and children centres
8. To offer regular 1:1 case work supervision and group reflective practice sessions
9. To teach the skills of working with children, young people, families and professional colleagues e.g. working with groups, presentation skills, communication, report writing, research and evaluation, project management, time management, working 1:1
10. To manage, with others, the daily organisation of the Emotional Health workers
11. To create and deliver a training package for the recruits, including full induction, opportunities for shadowing, visits and work alongside a wide range of colleagues, especially Help For Families, Children's Centres, schools, specialist settings, youth workers, YOT, voluntary groups, GP mental health practitioners, Family Resource service, Social workers, Behaviour Support team, Educational Welfare officers, SEN, college and university links.
12. To design and deliver a robust evaluation of outcomes, involving stakeholders and children, young people and families
13. To review early intervention emotional health support, and the role of the Emotional Health Academy, in light of evaluations, and to lead the continuous review of effectiveness and co-design.

What training will the emotional health workers receive?

As a minimum this will include:

- Restorative Practices
- Safeguarding and child protection
- Signs of Safety and reducing risks
- Psychological theories and evidence bases
- Mental Health First Aid
- Emotional Health First Aid
- Solution Focused thinking
- Cognitive Behaviour Therapy
- Video Interaction Guidance
- Mindfulness
- Attachment
- 5 ways to wellbeing approaches
- Awareness of SEND issues
- Specific training on working with young people with ASD and anxiety
- Basic counselling skills

- ‘dealing with difficult people’ and LA mandatory training
- Perinatal maternal mental health
- Communication, presentation and training skills
- Research and evaluation methods

a) Using existing skills and resources

In order to make best use of limited and reducing existing resources the professional skills of Clinical and Educational Psychologists will be partially deployed, through the Emotional Health Academy, in each community to:

i) Provide training to universal staff and volunteers
ii) Professionally supervise staff and oversee the activity of volunteers
iii) Analyse school and community needs and develop group or peer-to-peer led care to respond to needs
iv) Providing 1 to 1 care
v) Maintain the rigour and robustness of evidence-based practice, solution-focused thinking and restorative approaches.

b) Creating a new more cost effective service – to resource the Emotional Health Academy

West Berkshire currently invests £120,000 in PCAMHS and Help for Families therapeutic resources; which equates to 1.7 FTE staff. These resources could be reinvested in a multi-disciplinary team of psychology assistants, volunteers and FSWs under the supervision of the Educational Psychology service.

£120,000 investment would enable a realisation of at least 4 FTE Emotional Health workers. They could undertake the following functions:

a) Analysis of presenting need and undertaking non-statutory assessments
b) Leading or overseeing group or peer led support activities
c) Providing 1 to 1 support, where the level of need of the child, young person or family indicates that is appropriate for them to do so.
d) Providing training to staff and volunteers

All of these roles and functions would be fulfilled within the framework of the close supervision of Clinical and Educational Psychologists working alongside Senior Social Workers, other professional colleagues and the voluntary sector.

Berkshire Healthcare Foundation Trust are working with West Berkshire Council to ensure that Clinical Supervision support is offered to the Emotional Health Academy workers. BHFT and WBC are currently exploring both external supervisory support options and clinical staff secondment options.

c) Sufficiency within the national workforce

There are a wealth of psychology graduates seeking employment and struggling to be successful, due to lack of sufficient experience. In a recent West Berkshire advertisement for an Assistant Psychologist, 70 suitable applicants applied for 1 post.

The Emotional Health Academy will learn from the established West Berkshire Social Work Academy model and ensure that learning is shared between the two professions.

This professional investment and opportunity to work in multi-professional team would increase West Berkshire's opportunity to attract high calibre graduates. Emotional Health Workers would be asked to commit to a minimum of a two-year employment period with West Berkshire.

d) <u>What is the potential for growth?</u>

With funding, new recruits could be added every year so increasing the emotional health worker resource available to all communities.

The Academy should aim to develop a core offer to settings, with additional traded options, enabling communities to create and access bespoke support, interventions and training.

Offering support to independent schools, other organisations and neighbouring Local Authorities would be realistic options for income generation.

Appendix 2 – Emotional Health Academy Costs

Expenditure	Cost per annum
Part-time Strategic Management	£20,000 - 24,000
Operational Manager	£35,000-45,000
Emotional Health Workers in communities x 7-8 FTE	£180,000 - 200,000
1 specialist emotional health worker FTE (clinically trained)	£35,000 - 45,000
Academic Tutor (part-time backfill)	£16,000
Professional & Clinical Supervision costs	£15,000 - 20,000
External Training	£5,000
ICT equipment	£8,000
Administrative support	£9,000
Travel	£1000
TOTAL	**£324,000 - 373,000**

Accommodation costs will be absorbed by West Berkshire Council.

It will only be possible to implement the Emotional Health Academy model if partner agencies are able to make an active contribution. The scale of the Academy will be directly proportionate to the funding income received. These estimations of income are cautious.

Contributor	2016/17	2017/18	2018/19
West Berkshire Council	£120,000	£100,000	£80,000
Philanthropic investment	£120,000	£100,000	£80,000
CCGs and Schools	£120,000	£100,000	£80,000
Income generation through marketing	£0	£60,000	£120,000
Additional philanthropic or alternative national investment	£0	£100,000	£200,000

Appendix 3 - Strategic Principles and Objectives

In order to achieve our mission we are committed to working in line with the following strategic principles.

Putting children and young people first	The child and family are at the centre of all service planning and delivery at a strategic and operational level, and are involved in shaping these services to ensure they best meet their needs.
Focusing on quality and innovation	There is one front door into services for children and their families, with expert staff available to ensure they are able to access the right professional at the right time. Commissioned services are clearly targeted to meet the needs of individual children and families based on a sound analysis and understanding of need and evidence of what works best. Families are supported by expert and highly skilled professionals who use evidence-based interventions to effect change and who evaluate the impact of the interventions and obtain on-going feedback from families on the outcomes of their work. That we all invest in the early years' of a child's life; given that research has highlighted the significance of a child's development in the first years of their life and that support in these years has greater impact and is more effective and efficient.
Valuing diversity and championing inclusion	There is a 'whole family' approach based on a family assessment of need, ensuring that each family member has their individual needs identified and a clear plan is put in place to address these. Families and local communities are supported to help themselves and solve their own problems
Being a listening and learning organisation	The voice of the child or young person is heard within the assessment and intervention process and that, wherever possible, the family owns the assessment and intervention plan.

Working in partnership to improve our services	Partners should commit, wherever possible, to investing resources and funding in early intervention and prevention to ensure that children's needs are identified and responded to as swiftly and effectively as possible and to prevent the escalation of need. Families' needs are best met by an integrated and joined-up approach from all the relevant agencies in a 'team around the family' and that interventions are coordinated by an accountable Lead Professional and are reviewed regularly. Families experience a seamless and integrated approach as service users which minimises disruption and inconsistency in their experience of professionals, interventions and services. There is a common process and language for integrated working across all partners and agencies who work with children and their carers, and this is supported by: i) the restorative practice approach to working with families and with each other ii) the Signs of Safety framework iii) the Outcomes Star

Appendix 4 – Working restoratively with families

What is a restorative approach?
A restorative practice is a 'high challenge' and 'high support' approach; we work 'with' families; we don't do 'to' them and we don't do 'for' them.
The approach is most successful when all of the professionals working with a family work in a restorative way. Families lead the development of their plans. That might be through:

i) a restorative Team Around the Family (TAF) arrangement;
ii) through a Family Group Conference (FGC);
iii) through one-to-one work e.g. targeted Youth Support;
iv) or through restorative conferencing.

Restorative working also involves identifying 'significant others' who could provide support, encouragement and a shared sense of accountability and responsibility with the family, with a particular focus on owning and naming areas of risk within the family. We know from national and local learning, that plans are much more successful when:
i) the design of a plan is led by a young person/family;

ii) the plan is supported by significant people in the family's life e.g. friends, extended family, neighbours;

iii) when a family/young person feels held to account and responsible for the implementation of a plan by people they respect and trust i.e. 'significant others' and workers that they have a strong relationship with.

What are the benefits that young people and families experience from a restorative way of working?

Young people and parents/carers describe the following experience of this way of working:
 Feeling listened to, as one young person put it, 'You asked me things no one had ever asked me. I'm doing things I didn't think I could do'

 Feeling able to achieve things, or manage situations, that previously felt too difficult; and more in control e.g. of both assessment and planning

 Not being constrained by existing services – being able to work creatively to access new services and new support that is uniquely defined for their needs and circumstances

 Feeling more accountable, not just to professionals, but also to friends and family members for their behaviour and their outcomes

 A sense of hope that change is possible

Almost all families represent that the 'high challenge' elements of the restorative way of working are difficult at the time, but most families identify those challenges are instrumental in making and sustaining change.

3) Seeking informed consent

Working 'with' families means seeking their informed consent from the outset to work in partnership with workers (i.e. staff and volunteers). To give informed consent parents/carers and young people need to understand:

 Who information will be shared with and for what purpose

 That information will be shared proportionately (e.g. what someone needs to know to fulfil their role) and used appropriately

 That they have a choice e.g. to give partial consent to share information with some organisations and not others; or not to give consent at all

 That there are statutory obligations that would place a duty on a worker to share information i.e. child protection concerns, to prevent or detect criminal activity, potential fraudulent activity.

Young people can give their own informed consent if they have sufficient emotional maturity and intellectual capacity[4] to understand: i) the options they have available, ii) the choice that they are making and iii) the consequences of those choices.

Seeking the informed consent of parents/carers or young people is an essential part of the 'first conversation;' but it's also an ongoing conversation with families that can be revisited whenever it needs to be i.e. when new information emerges that needs to be shared; if sensitive information emerges that might elicit partial consent.

4) 'First conversations'

Wherever possible first conversations will be led by a worker the family know and trust; if a lead professional arrangement is already in place, this person will ordinarily lead a first conversation. A 'first conversation' includes:

- an opportunity to understand the family/young person's perspective – their strengths, their needs, any risks that need to be managed and their aspirations and hope. You could use the Outcome Star or Eileen Munro's '3 Houses' to capture your discussion and clearly highlight any risks that need continual review and management
- a description of working in partnership 'with families' e.g. family led plans;
- seeking 'informed consent';
- The bottom line – what needs to change and what the consequences of not affecting change will be (e.g. many of these families are on the cusp of prosecution, eviction, exclusion, children being taken into care, etc).

[4] [2] Referred to as 'Fraser' or 'Gillick' Competence - see http://www.nspcc.org.uk/inform/research/questions/gillick_wda61289.html for a summary of these principles

How we work together with families is crucial to our ability to influence improvements in outcomes. What families and keyworkers tell us that works is:

a) ***Persistence*** –provide frequent reminders for appointments/meetings; keep trying, don't be put off by failed attempts; most Family First families circumstances and choices appear to deteriorate, before they improve

b) ***Honesty*** and ***trust***– be open and honest and keep revisiting the 'bottom-line' together, so that families know exactly where they stand. This is particularly essential where there are concerns about child protection or safeguarding of children.

c) ***High Challenge and High Support*** – uniquely tailored to a family's situation and their needs

d) ***A sense of hope/aspiration*** – frequent encouragement that change is possible is essential, incentives and rewards to recognise progress that families make is really helpful - plans are shaped around the family's potential and aspiration for change; they are informed by the active contribution of 'significant others' around the family, who all have a role to play in the plan.

These principles apply equally to adult service users.

Appendix 5 - Brilliant West Berkshire - Extending the thinking

National and regional research on the 'causal factors' that are most often prevalent in children and young people requiring specialist interventions in their childhood include:

1) Emotional ill-health or mental illness
2) Witnessing violence/abuse in the home of the community
3) Living with an offender
4) Lack of aspiration or hope
5) Living with someone with significant physical health needs
6) Living in over crowded housing
7) Material or social poverty or isolation

Longer term, Brilliant West Berkshire partners will explore together how finite resources could be reviewed to maximise outcome change for children and families. The following strategic principles (supported by the information in Appendix 3) could provide a framework for multi-professional teams in communities

- Children, young people and families receive the *services they need*, *when they need them* and *where they can access them*;

- Services work together to provide a *coordinated whole family approach*, reducing the likelihood of the development of more complex needs;

- Commissioners work together across sectors and services to meet need in the best possible way and achieve best *value for money*; and

- We know and can demonstrate through evidence and feedback that the *services provided have made a difference* to the lives of children, young people and families and local communities.

- We will work 'with' children, young people and families and 'with' each other; using the restorative values of 'high support' and high challenge'.

- We will ensure that 'significant others' are routinely involved in assessment and planning.

By doing this, children and young people will live safe, healthy and fulfilling lives, and develop into responsible adult citizens, thereby breaking intergenerational cycles of risk and vulnerability. Families will become more resilient and develop capabilities to prevent and resolve problems. This will in turn reduce demand for higher cost specialist services and achieve greater use of community based universal preventive services.

Even where there is abuse and / or neglect and a child is removed from the family, the ultimate goal is still to work with the family and to ensure that the child is living in a positive environment e.g. special guardianship with a kinship carer or an adoptive family, where universal services will be sufficient to meet their needs.