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Vulnerability and Violent Crime Programme

Evaluation of the use of family safety plans in cases of neglect

Full technical report

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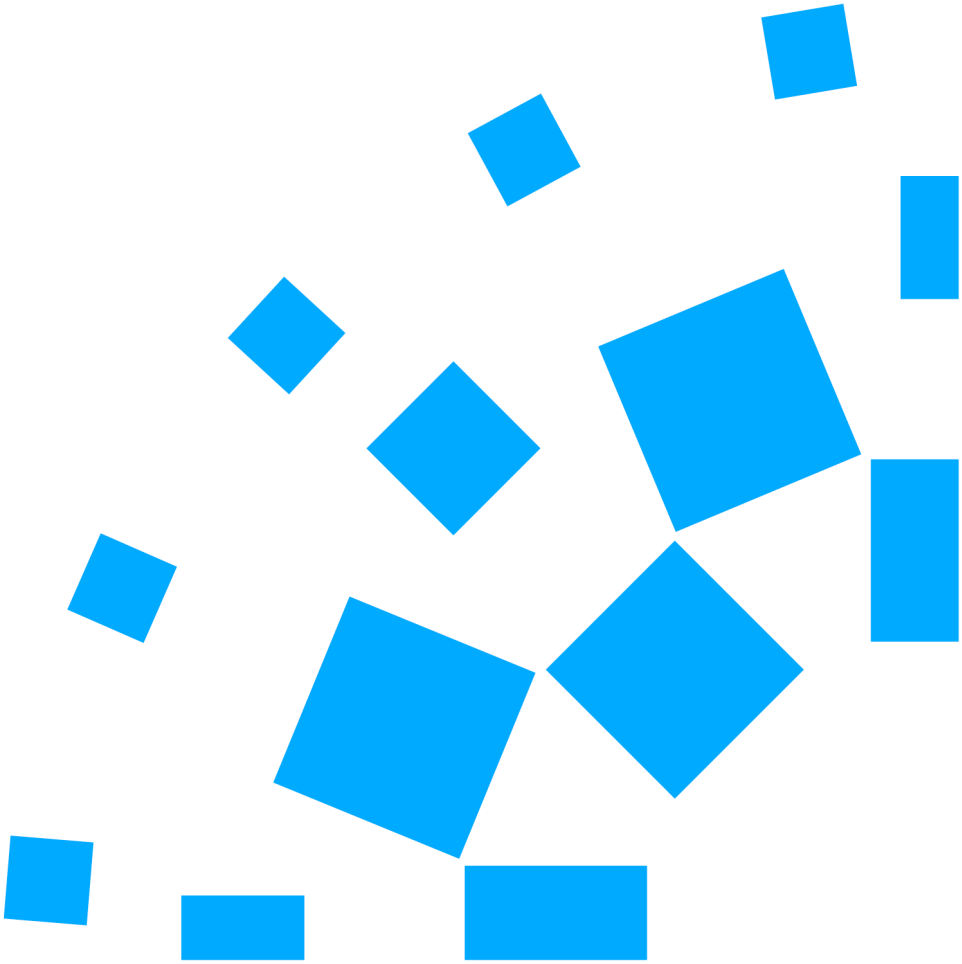

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About

This report details work commissioned by the College of Policing as part of the Vulnerability and Violent Crime Programme, funded by the Police Transformation Fund. It has been independently fulfilled by the University of Bath and the University of Birmingham. The report presents the views of the authors and does not necessarily reflect the College of Policing's views or policies.

Authors

Professor Catherine Hamilton-Giachritsis, Rosie McGuire and Megan Denne, Department of Psychology, University of Bath

Dr Kari Davies, School of Psychology, University of Birmingham

Dr Juste Abramovaite, Professor Siddhartha Bandyopadhyay and Professor Matt Cole, Department of Economics, University of Birmingham

Please address all queries to Professor Siddhartha Bandyopadhyay (overall evaluation lead) at **s.bandyopadhyay@bham.ac.uk** and Professor Catherine Hamilton-Giachritsis (project lead) at **chg26@bath.ac.uk**

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1. Executive summary

1.1. Introduction

Neglect is the most common form of child maltreatment in the UK. Recent data from the Department for Education shows that half (50.5%) of children on a child protection plan (CPP) on 31 March 2020 in England were there as a result of neglect[1]. However, physical neglect (for example, failing to provide food, medical attention, protection and supervision) and emotional neglect (failing to provide love and care) of a child have been researched significantly less than physical and sexual child abuse, and are not as well understood. This is sometimes called the 'neglect of neglect'. Negative outcomes from neglect can be severe, with onset in childhood but also across adolescence and adulthood.

In policing terms, one difficulty is that the criminal definition of neglect includes the need to demonstrate wilfulness, meaning that the action has been done intentionally or recklessly. One of the key aspects that underpinned the intervention established in Hampshire Constabulary was how to demonstrate that wilfulness. In addition, it was felt that neglect cases were often viewed less seriously and were less likely to be referred to the police than other forms of maltreatment. Therefore, the aim of the intervention was to develop a joint agency early intervention system that would enable parents to achieve better outcomes, which would ultimately be better for the child and would also enable better evidence gathering.

To achieve this, Hampshire Constabulary decided to take the following actions.

- Ensure that all cases of child neglect coming to the multi-agency safeguarding hub (MASH) would be referred into the police Child Abuse Investigation Teams (CAITs) for joint work with Children's Services.
- Implement the use of a new family safety plan (FSP) working agreement, which is completed with the family in a joint visit by police and social work, and where SMART (specific, measurable, achievable, relevant and time-based) goals are agreed.

[1] Department for Education. (2020). **Characteristics of children in need: 2019-2020** [internet]. [Accessed 5 February 2021]

- Review all neglect cases receiving Outcome 20 from the police (passed to Children's Services for management), to ensure only appropriate (minimal) use of this outcome and to ensure that neglect cases were not being overlooked.
- Encourage the use of out-of-court disposal orders (OOCDs), such as community resolutions and conditional cautions. These allow the police to deal quickly and proportionately without needing to enter the criminal justice system.

A diagrammatic representation of this process can be seen in Appendix 9.6.

This new approach was implemented fully in three regions of Hampshire Constabulary: Hampshire, Portsmouth and the Isle of Wight. The fourth region, Southampton, did not use the FSPs but did have increased attention paid to OOCDs as possible outcomes.

The new form and guidance notes were disseminated mostly via email. A short 20-minute presentation was also made about the new approach during a joint training day for police and social workers.

1.2. Aims and methods

The purpose of this research project was to evaluate whether:

- the training provided police and social workers with a clear understanding of the aim and process of FSPs
- the FSP was easy to use in practice
- the decision-making process within the intervention was leading to the correct outcomes or whether there were unintended consequences
- the new approaches in Hampshire (including the use of FSPs, reduced Outcome 20s and increased OOCDs) achieved better outcomes for children, as measured by CPP rates
- it was necessary to review how CAITs were resourced at an organisational level

In order to achieve this, a mixed methods approach was taken. This involved collecting quantitative data and interviewing police, social workers and members of MASH teams about their views on the process.

- Data was collected on all cases referred to Hampshire Constabulary CAITs between July and September 2019 (including child and parent details, outcome and difficulties within the family).
- The same data was collected on all cases from July to September 2017, as an historical comparison group.
- Follow-up data was collected on those cases from October (2019 and 2017) to March (2020 and 2018) to see if the child had been made the subject of a CPP.
- A quasi-experimental design, propensity score matching (PSM), was used to select a control group that was similar to the intervention group. This enabled the separation of the intervention effect from other factors, such as:
  - age or gender of the child
  - whether there were multiple suspects per case
  - whether the child was on the CPP before the neglect was reported
  - co-existing difficulties within the family
- Statistical comparisons were undertaken between the two groups on use of Outcome 20, OOCD and CPP referral.
- Qualitative interviews were conducted with 21 police and 21 social workers (six of whom were part of a MASH) and analysed using thematic analysis. Planned interviews with parents and children as a follow-up element of the project were unfortunately not possible, due to the increased pressure on social services created by the COVID-19 pandemic.
- A brief audit was completed on 71 cases closed with Outcome 20 that had been reviewed by a Scrutiny Panel, to establish if it had been used appropriately.
- An illustration of possible cost savings was conducted based on nationally available data on costs of implementing CPPs. The planned full economic evaluation was not possible, as data was not available to measure the full benefits of the intervention.

1.3. Key findings

The different methods allowed us not only to look at whether outcomes appeared to change for children, but also to understand the broader context and nuances of

those changes, including if there were unintended consequences. The interviews with police officers and social workers provided very rich data. Table 1 (below) provides an overview of the key findings presented under the EMMIE framework.

Table 1. Summary of the key findings presented under the EMMIE framework.

Evaluation element	Findings
Effect	▪ Compared to cases identified in 2017, under the new approach: o more cases of neglect were referred to CAITs o there was a 45% decrease in cases recorded as Outcome 20 and a 12% increase in cases resolved through the use of OOCDs o rates of CPPs decreased by 18% in the six-month period ▪ All of these were statistically significant. ▪ This worked out to approximately 40 fewer children on a CPP as a result of the intervention. In 2019, 26% of children with no prior CPP became the subject of one in the follow-up period (compared to 49.3% in 2017). For those with a prior CPP, the rates were 15.9% and 28.9% in the follow-up period for 2019 and 2017, respectively. ▪ However, interviews showed that respondents held mixed views about the FSPs (including some concerns around consistency, legal value in court, disproportionality of the outcome to the level of concern) and the consistency with which it was being used. Additional concerns regarding the implementation process are discussed below.
Mechanism	▪ FSPs used four main mechanisms: engagement, additional support, clarifying expectations and monitoring compliance.

	▪ Police and social workers **engaged** with families in setting the conditions of the FSP, and provided an opportunity to create or raise awareness about what was expected in terms of caring for children. ▪ FSPs provide earlier **support** to parents and carers, where there is a concern for the level of care that children are receiving. Any additional family needs are identified when the FSP is developed. Additional support in relation to these needs is another potential mechanism for change. ▪ FSPs aim to set **clear expectations** and to highlight the consequences of non-adherence with the agreement. SMART (specific, measurable, achievable, relevant and time-based) goals are developed for parents or carers, and police presence is deemed to support the perception that there are consequences to non-adherence. ▪ The structured use of FSPs enable better **monitoring of compliance**. Where parents do not engage or comply with the FSP, and where improvement is not observed, the FSP also provides documented evidence of wilful neglect should further action need to be taken. ▪ The risk threshold for neglect cases to be referred to CAIT was lowered at the same time as FSPs were introduced, increasing the extent of joint working between police and social services. ▪ Given the changes to the use of Outcome 20 and lowering of the neglect risk threshold (such that almost all cases of neglect were referred to CAIT), it is hard to separate the effect of the FSP from other changes.
Moderator	▪ Interview data appeared to show some individual or team differences in implementation. For example, some teams did not use the FSP when they should have, some teams outside the pilot area adopted the practice when they were

	not expected to, and joint visits were not always possible due to workload. This could potentially lead to different outcomes for families in different areas. However, this would require additional evaluation. ▪ Social workers routinely use some form of a working agreement with families. Where the FSP was not being used, social workers used their own versions of a working agreement and police officers were recording necessary conditions on OOCDs, which potentially had similar effects (but would need to be evaluated further).
Implementation	▪ In several respects, the intervention appears not to have been implemented entirely as proposed. Data from the qualitative interviews suggests that much of this potentially stems from the lack of training, which may have been a result of lack of time and/or money for implementation and requires investigation. This also has implications for the evaluation, since the FSP was not always being used consistently. ▪ Police and social workers reported that there was a lack of formal training, with many social workers appearing to be unaware of the FSP and/or reporting that they had noticed changes in approach but not been formally told about it. ▪ Some police and social workers reported that they were not using the FSP and/or they felt that others were not. ▪ Some social workers reported adapting the FSP or using their own version of a working agreement, while some police officers were using OOCDs to record conditions. ▪ Southampton was due to be a control region. However, qualitative data indicated that some police and social workers in Southampton were adopting the new approach.

	This, as well as a decision to increase the use of OOCDs in that area, caused a drift away from their original approach. ▪ Overall, there was a consensus that the broader changes led to increased workload for police. Some social workers noted that, at times, the police are unable to conduct joint visits due to workload. Similarly, practicalities of arranging joint visits (for example, different shift patterns) were highlighted as another barrier. ▪ A Scrutiny Panel within Hampshire reviewed a sample of Outcome 20 cases (usually about 10) per meeting. Police officers were aware that from 2019 onwards, Outcome 20 was not to be used routinely and any case where it was applied may be scrutinised. It is therefore possible that the reduction in Outcome 20 between 2017 and 2019 may stem in part from that process. Hence, this should be considered when interpreting the findings about Outcome 20.
Economic cost	▪ Information was not available about the costs of putting this new approach into practice (for example, police visits, increased joint working, implementing OOCDs and the support packages put in place for families, such as parenting or substance misuse programmes). ▪ Instead, an illustration of possible cost savings was conducted based on nationally available data on costs of implementing CPPs, based on a reduction of 40 children in a three-month follow-up period. ▪ This modelling shows potential yearly benefit of £182,320 for CPP costs. However, this would need to be considered in light of the costs and resources associated with the new approach.

Other key findings from the different elements of the research included the following.

- Increased focus: Officers generally welcomed the increased focus on, and recognition of, the neglect of children.
- Ethos: The ethos of the revised approach has generally been understood, but questions of fit with the police role and process specifics remain.
- Terminology: There is some confusion among police officers around the terminology in use. Not all respondents were familiar with the term ‘family safety plan’.
- Lack of clarity: There was a lack of clarity about FSPs, including how to complete them. Officers strongly expressed the need for more information about what the police are trying to achieve.
- Risk threshold: Some concern was expressed that the lower risk threshold, combined with a push for increased use of OOCDs, has led to inappropriate referrals and excessive responses to some cases.
- Parents: Officers and social workers felt that some form of working agreement was often a positive tool for families, but the findings were mixed about how effective the FSP was as a positive tool. There was also concern that not all parents understood what they were signing.
- Unintended consequences: Different police and public perceptions of OOCDs were noted by some police officers and social workers. For police, OOCDs are seen as a non-criminal route, though interviews with social work professionals suggested that parents might have still felt criminalised.

1.4. Conclusions and implications

There is preliminary evidence that paying increased attention to neglect can have positive outcomes for children and potentially have cost savings. In addition, many officers and social workers welcomed the increased joint working and collaboration. However, the efficacy of the intervention was likely undermined by the lack of training, a lack of clarity about police and social work roles, and insufficient attention paid to practicalities of implementation, such as the format of the document. In addition, attention needs to be paid to the unintended consequences (for example, stress for parents, possible disproportionate responses) and other concerns raised by professionals (for example, legal value in court of the FSP, additional workload,

parental levels of understanding). Although many police and social workers felt that the FSP form itself need not be more time consuming, there was a strong consensus that the overall changes have led to increased workloads that, at times, affected the ability to co-work cases. Longer-term follow-up data, plus views of parents and children, are required to contextualise the statistical findings fully.

Moving forward, a review of the risk thresholds[2] and use of OOCDs may be warranted, alongside additional training on the use of FSPs to ensure parity for families. A full economic evaluation taking into account the cost of establishing this programme would be beneficial, and the findings may indicate the need to review the resources allocated to CAITs to support this new initiative.

With appropriate planning and resourcing, both for research time and also operationally within the force, it would be feasible to conduct a future impact evaluation. Randomisation is not possible within this region, since the region has already adopted an approach. Even where approaches vary, associated regions do not usually remain unaffected. For example, there were suggestions of 'drift' for some elements with Southampton from their original approach (which differed from the rest of Hampshire), with an increase in use of OOCDs and some police officers and/or social workers adopting the FSP, making it more similar to the treatment area. There are also numerous ethical issues to consider in randomly allocating an intervention to children.

However, it should be possible to compare different regions or different forces, or to use appropriate historical data for a longer time period than we have done here.

[2] The term 'risk threshold' is being used here to describe the criteria by which it is determined whether a case will be passed on to CAITs or not. In the case of neglect, prior to 2019, only very severe cases of neglect met the criteria. From 2019, the threshold was lowered such that most (if not all) cases of neglect met the criteria. In the qualitative data, some police officers and social workers expressed the view that the criteria had been lowered too much and some cases were being passed to CAITs that perhaps should not have been.

2. Contents

3. Background

3.1. Context

3.1.1. The neglect of childhood neglect

According to official child protection figures, neglect is the most common form of child maltreatment in the UK. For many years, approximately two in five children on the Child Protection Register[3] have been registered for neglect. Yet, neglect of a child (either physical or emotional) is sometimes viewed as the least commonly understood form of child maltreatment. Over the last fifty years, significantly more research focus has been on physical and sexual abuse, a situation often referred to as the 'neglect of neglect' (Iwaniec, 1995[4]; Stoltenborgh et al., 2015[5]). In 2012, a report by the National Society for the Prevention of Cruelty to Children (NSPCC) and Community Care[6] found that a majority of social workers believed that neglected children were not seen as a priority, and were unlikely to receive the intervention they required when they required it. A majority of social workers also believed that there was pressure to record cases as 'children in need', rather than 'child protection'. A child is seen as being 'in need' (section 17 of the Children Act 1989) if they require additional local authority support to achieve a reasonable level of health and development. Support can range from financial to practical and emotional support, such as respite or day care. In contrast, child protection investigations take place when there is reason to suspect that a child is suffering, or likely to suffer, significant harm (section 47 of the Children Act 1989).

However, in recent years, the risk of significant negative outcomes following both physical and emotional neglect has received more focus, not least because professional practice has shown that neglect within families can last for many years and affect several children over a long period of time. In addition, there has been a

[3] Department for Education. (2018). **Working together to safeguard children: A guide to interagency working together to safeguard and promote the welfare of children**. London: TSO.
[4] Iwaniec D. (2006). 'The emotionally abused and neglected child: Identification, assessment and intervention: A practice handbook'. Chichester: John Wiley & Sons.
[5] Stoltenborgh M et al. (2015). **The prevalence of child maltreatment across the globe: Review of a series of meta‐analyses**. Child Abuse Review, 24(1), pp 37–50.
[6] Community Care. (2012). **Social workers unlikely to act quickly on neglect cases** [internet]. [Accessed 15 March 2019]

push more generally to consider what are termed ‘adverse childhood experiences’ (ACEs), into which all forms of childhood maltreatment fit. Outcomes from neglect can be severe, with onset in childhood but also across adolescence and adulthood. There has also been a question of whether neglect can be a vulnerability factor for child sexual exploitation[7].

3.1.2. Definitions

In terms of practice definitions, professionals working within the field of child maltreatment follow national guidance[8], which defines neglect as:

> ‘The persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
>
> a. provide adequate food, clothing and shelter (including exclusion from home or abandonment)
> b. protect a child from physical and emotional harm or danger
> c. ensure adequate supervision (including the use of inadequate caregivers)
> d. ensure access to appropriate medical care or treatment
>
> It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.’

The offence of cruelty to persons under 16 years incorporates neglect, as set out in section 1(1) of the Children and Young Persons Act 1933.

> ‘If any person who has attained the age of sixteen years and has responsibility for any child or young person under that age, wilfully assaults, ill-treats (whether physically or otherwise),

[7] Hanson E. (2016). **Exploring the relationship between neglect and child sexual exploitation: Evidence scope 1**. Dartington: Research in Practice, NSPCC and Action for Children.
[8] Department for Education. (2018). **Working together to safeguard children: A guide to interagency working together to safeguard and promote the welfare of children**. London: TSO.

> neglects, abandons, or exposes him, or causes or procures him to be assaulted, ill-treated (whether physically or otherwise), neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health (whether the suffering or injury is of a physical or a psychological nature), that person shall be guilty of an offence […]'

There is no statutory definition of 'wilfully', but the term 'wilful misconduct' has been interpreted by the courts as 'deliberately doing something which is wrong, knowing it to be wrong or with reckless indifference as to whether it is wrong or not'.[9]

The definition of neglect is outlined in section 1(2)(a) of the Children and Young Persons Act 1933. The offence is committed if:

> 'a parent or other person legally liable to maintain a child or young person, or the legal guardian of a child or young person, shall be deemed to have neglected him in a manner likely to cause injury to his health if he has failed to provide adequate food, clothing, medical aid or lodging for him, or if, having been unable otherwise to provide such food, clothing, medical aid or lodging, he has failed to take steps to procure it […]'

As outlined above, with no statutory definition of wilful neglect, the burden of proof required to demonstrate wilfulness can present an issue for police and partner agencies in seeking to safeguard children. This is in part the underpinning rationale for the neglect intervention proposed and implemented by Hampshire Constabulary. The intervention is designed to address the key question of how to gain appropriate evidence of wilfulness, particularly when there is often less involvement of the police, with an emphasis on early intervention by social care and health.

3.1.3. Problem definition

The evaluation was based on work by the Child Abuse Investigation Teams (CAITs) in Hampshire, Southampton, Isle of Wight, and Portsmouth (Hampshire Constabulary).

[9] Attorney General's Reference (No 3 of 2003) [2005] 1 Q.B. 73.

Within Hampshire Constabulary, the CAITs receive child protection referrals in cases where the risk to the child is considered to be high. However, with respect to cases of alleged neglect, anecdotal evidence from within Hampshire Constabulary indicated the following two possible issues.

- Neglect cases were often viewed as less serious than other forms of referral. This was possibly due in part to an apparent higher threshold of risk, where the multi-agency safeguarding hub (MASH) classified fewer cases of neglect as requiring police involvement compared to other forms of child maltreatment.
- When referrals did come to the CAITs, there was high use of Outcome 20 (see definition below). Between April 2017 and March 2018, the vast majority of referrals to these teams for neglect and cruelty to children led to either Outcome 20 (63% of 790 outcomes) or no further action (NFA; 30%). The application by Hampshire Constabulary to implement this intervention noted that frequent use of these disposals had potential implications for:
    - preventing further neglect against the child (because the family may not recognise their seriousness)
    - ensuring that sufficient evidence is available to progress to charge if required (because the police were not remaining involved in collecting evidence for Outcome 20 and NFA cases)

In September 2017, a multi-agency Scrutiny Panel was set up in Hampshire to review the use of Outcome 20 in cases of child abuse. There are 21 possible outcomes for police to choose following referral. The definition of Outcome 20 is:

> ‘Further action resulting from the crime report will be undertaken by another body or agency subject to the victim (or person acting on their behalf) being made aware of the action to be taken.’

The panel identified a lack of a clear decision-making process, an over-reliance on other agencies and possible missed opportunities to prevent re-referral of families. Furthermore, there was a lack of understanding around the burden of proof in cases of criminal neglect and in how to demonstrate wilful neglect. It also showed that Outcome 20 was being used sometimes after a joint visit, rather than NFA (which

would be the correct outcome[10]). Senior managers felt that this was an issue for correct auditing of outcomes and provided potential misinformation about appropriateness of actions. One concern about the frequent overuse of Outcome 20 was that it might be being used incorrectly and that, inadvertently, neglect cases were not being given the level of scrutiny they required.

3.2. Rationale for the intervention

The aim of the proposed intervention was to adopt a new joint agency approach to neglect offences against children that enabled the police to maintain responsibility for cases, find a suitable outcome and enable better evidence gathering, but also ensure that the best outcome was reached for the child, which is not necessarily criminalisation of parents.

To this end, the following goals were set:

- increase the policing role in proactive, early intervention, with more clearly defined expectations set for parents
- reduce the use of Outcome 20
- make greater use of out-of-court disposal orders (OOCDs)[11] as part of the early intervention, particularly community resolutions (the lowest level of formal action without commencing the criminal justice process)
- increase ease of prosecution (where required) due to formalised evidence gathering

In child neglect cases, OOCDs predominantly relate to the following two outcomes:

- community resolutions
    - non-statutory disposal

[10] Outcome 20 should be used to classify those cases where the police have received a referral but, without undertaking a joint visit, have deemed that the most appropriate course of action is for future work to be undertaken by an agency other than the police (most usually Children's Services). More rarely, it can also be used after a joint visit, where it is clear on attendance that police action is not required and neither parents nor children have been interviewed. NFA has the same outcome (authority is left with another agency), but should be used after a visit has been carried out.
[11] 'Out-of-court disposals allow the police to deal quickly and proportionately with low-level, often first-time offending which could more appropriately be resolved without a prosecution at court.' Ministry of Justice. (2013). **Quick reference guides to out of court disposals**. London: TSO. p 4.

  - proportionate for lower-level crime
  - the offender has admitted an offence
  - aimed at encouraging offenders to face up to the impact of their behaviour and take responsibility
  - may show up on an enhanced DBS check
- conditional cautions
  - statutory disposal
  - caution with conditions attached that can be rehabilitative, reparative or financial
  - must always be achievable and proportionate
  - offender admits the offence
  - sufficient evidence for a realistic prospect of conviction, but this is in the public interest
  - offender must agree
  - recorded on the Police National Computer (PNC) and would show up on an standard DBS check

To achieve the intervention aims, a family safety plan (FSP) working agreement was proposed that would be completed with a family during a joint police–social work visit with the development of clear (SMART) goals for families.

FSPs were proposed as:

- a form of earlier support to parents and carers, where there is a concern for the level of care the children are receiving
- an opportunity to create or raise awareness about what was expected in terms of caring for children
- a means to highlight the consequences of non-adherence, with the police presence deemed to support that perception
- documented evidence of wilful neglect (should further action need to be taken), where parents do not engage or comply with the FSP and where improvement is not observed

3.2.1. Overview of dissemination, training and materials

The FSP template was developed jointly by Hampshire Constabulary with Hampshire and Portsmouth social services, along with guidance notes, which were reviewed by legal teams from the local authority and the force (see Appendices 9.1 and 9.2). The new approach was presented to senior managers initially, who then cascaded it down to teams via email (Appendix 9.3). In addition, a continuing professional development (CPD) training day was held in December 2018 (agenda available at Appendix 9.4) for CAITs, social services managers, Crown Prosecution Service (CPS) representatives and police MASH staff, where a presentation was given on the new approach (see Appendix 9.5 for a copy of the slides).

3.3. Anticipated outcomes

As a result of the proposed changes (to a proactive, early intervention via the FSP, in a joint visit with more clearly defined expectations), it was expected that there may be:

- greater use of OOCDs (as opposed to Outcome 20)
- reduction in court-related referrals
- better evidence for prosecution, where necessary

This research evaluated the effectiveness of these joint visits and FSPs against the stated aims of:

- increasing engagement of families with services, compliance with the FSP and improved outcomes for families
- increased effectiveness of evidencing wilfulness (avoiding repeated child neglect offences against children)

3.4. Theory of change and logic model

The overarching theory of change proposed at the onset of the project was that the introduction of the FSPs would result in:

- reduced use of Outcome 20 and increased use of community resolutions and OOCDs

- reduced outcomes related to the criminal justice system (CJS), due to the more structured and earlier multi-agency method of intervention
- cases that progress to CJS-related outcomes being easier to prove, because of the use of the FSP as evidence of wilful neglect
- it being easier to monitor compliance and understand family need through the more structured use of the FSP, which will in turn help to reduce negative outcomes and promote positive outcomes

This is outlined in Table 2 below.

To develop a logic model for this theory of change, the following four elements were considered:

- implementation
- mechanisms for change
- outcomes
- context – external factors that might affect the intervention operation (Public Health England, 2018[12])

3.4.1. Implementation

3.4.1.1. Proposed implementation

There were two proposed stages to the implementation.

First, dissemination of the new approach to police and social workers in the four regions of Hampshire Constabulary (Hampshire, Portsmouth, Isle of Wight and Southampton).

Second, the actual implementation of the programme, with FSP working agreements completed with families during joint visits involving a police officer and a social worker. This occurred formally in three of the four regions (Hampshire, Portsmouth, Isle of Wight). The fourth region (Southampton) chose not to implement FSPs and was due to act as a control group.

[12] Public Health England. (2018). **Introduction to logic models** [internet]. [Accessed 15 March 2019]

3.4.1.2. Changes to planned intervention

As noted, the initial intervention proposal from Hampshire Constabulary focused on the low referral of neglect cases into CAITs, the overuse of Outcome 20 and the use of the new FSP using joint police–social work visits as a means of trying to address those concerns. However, during the project evaluation, some changes to the proposed intervention became apparent.

- By the start of the evaluation, there had already been a reduction in the use of Outcome 20. This may have been influenced by the fact that a selection of cases with Outcome 20 were referred to the Scrutiny Board for review and approval (usually around 10 cases were reviewed per meeting). Information from the intervention lead indicated that there was an increased use of Outcome 21 (since officers felt Outcome 20 was no longer available) and/or NFA.[13]
- Feedback received by the intervention leads also identified that the FSP form itself was not found to be very user-friendly (for example, lack of space to write in boxes on paper copies). As such, some officers were reporting using alternative means of recording the plan, but following the underlying ethos. This was also reported in the interviews with police officers and social workers.
- The interviews with police and social workers appeared to show that there had been some crossover of information into Southampton, with a small number of professionals reporting using the FSP alongside a push for increased use of OOCDs in that region. Hence, it was unclear whether the use of Southampton as a control group remained valid.
- Finally, it became apparent that the FSP is devised during a joint visit, with the outcome (for example, OOCD) issued within a day or two, rather than after a longer period of time. The case is considered closed by the police, with the actual implementation of the FSP being undertaken by the social worker and fed back to the police. If the family fails to meet the conditions of the FSP (or other formal record), then the case is referred back to the police, who would reopen the investigation and proceed down the prosecution route.

[13] Outcome 21 is used when no other outcome is appropriate.

Hence, rather than a long-term involvement, the police role appeared to potentially cause an impact due to their presence at the initial visit (for example, raising awareness for the parent of the seriousness of the investigation) and their input into the conditions being set for families, either via the FSP or via OOCD.

For clarity, the research team has produced a process map from initial referral to MASH through to possible outcomes (Appendix 9.6), to understand the different routes through for a family referred into the system. This process timeline was initially constructed bottom-up (based on information gathered from the interviews with all professional groups). Feedback was then provided by the intervention leads, who pointed out minor discrepancies between the established process and the timeline. These were reflected on, checked with the interview data and adjusted accordingly. Any remaining inconsistencies are highlighted within the timeline (for example, which professionals lead the initial joint visits).

3.4.1.3. Theory of change model

For the theory of change, this translated into three questions to be answered. These are listed below with a brief statement of how the evaluation planned to answer them (and how this was adapted according to new information).

- **Does the training provide police and social workers with a clear understanding of the process of FSPs?**
  - Police and social workers need to be aware of:
    - how to decide a case is suitable for an FSP
    - how to develop an FSP collaboratively with families
    - how to ensure the outcomes are correct and the correct evidence is collected when to escalate to the CJS
  - Planned evaluation: Views on the training ascertained in interviews with police and social workers. The quantitative planned pre- and post-training evaluation was not possible, given that only one training day took place.
- **Is the FSP easy to use in practice?**
  - Planned evaluation: Views on ease of use (the form itself, engagement with families, construction of the goals and conditions) were ascertained in

interviews with police and social workers who have received the training and used the FSP.

- **Does the decision-making process within the intervention lead to the correct outcomes or are there unintended consequences?**
  - Concern about the overuse of Outcome 20 (expressed also by the Scrutiny Panel) was a key driver in the development of this intervention.
  - Planned evaluation: Whether the correct decision was reached cannot be determined by external researchers. However, data on 71 reviews of Outcome 20 cases from November 2017 to January 2020 by the Hampshire Scrutiny Panel was made available to the research team.

3.4.2. Mechanisms

Through discussions between the research team and intervention lead, as well as initial interviews, the following mechanisms were identified, through which the intervention should produce the intended change.

- **Engagement** – Working with and engaging the family in the process of setting conditions of the FSP should assist in raising awareness of the identified neglectful behaviour, as well as having a formally demonstrated behaviour of agreeing those conditions (through the family signing the agreement) and subsequently complying with the conditions of the FSP.
- **Additional support** – The FSP should identify where additional support for the family is required, so the provision of that support can be a mechanism of change.
- **Clarity of expectations** – The emphasis of the new approach is on providing early intervention and support. However, the process will ensure that the family understand the ramifications of not complying with the FSP, which should also contribute to producing the intended change.
- **Monitoring compliance** – The more structured use of an FSP should make monitoring compliance easier, which will in turn:
  - help to reduce negative outcomes and promote positive outcomes
  - lead to improved quality of evidence

Planned evaluation: Family engagement, as reported by police and/or social services. Comparison of community resolution, conditional caution or CJS, comparing 2019 data with historical 2017 data. In addition, a comparison was made between Southampton and the other three regions (with the caveat that knowledge of the FSPs and new approach was known in Southampton, with an increased impetus to make use of OOCDs).

3.4.3. Outcomes

It was expected that a positive outcome would be seen as successful resolution of neglect cases through the use of early family intervention (FSPs), as opposed to an increase in use of the CJS. However, a secondary outcome might be an increase in ability to charge, as a result of implementing FSPs to gather evidence of wilful neglect.

Planned evaluation: Based on the intervention goals, the relevant outcomes were:

- comparison of 2019 data with historical data (eg, OOCDs issued; outcomes)
- quantitative data regarding numbers of FSPs co-developed and outcomes
- qualitative data from police and Children's Services social workers (planned recruitment of 10 parents and 10 children aged 8 to 16 years for interviews to gain their views of the FSPs could not take place due to COVID-19)

An additional key outcome highlighted for consideration was the impact that FSPs may have on the child. FSPs may have a positive impact, due to earlier intervention by police and Children's Services to stop a child experiencing neglect, therefore improving the child's home life and experience more quickly than may previously have been the case. This was assessed via outcomes for the child (for example, removal of a child, use of emergency protection measures, re-referrals).

FSPs may also have a negative impact, due to the possibility that requesting details of neglect from a child as part of the FSP may have adverse effects on the amount of information that the child provides, and in how they feel if the parent(s) is subsequently deemed not to have complied with the agreement.

Finally, at organisational level, the information gained may provide information regarding:

- whether the introduction of this new approach to child neglect cases necessitates a review of how CAIT is resourced
- the decision-making process and how that affects the quality of the FSPs

3.4.4. Context

Several contextual factors were considered to have the potential to act as facilitators and barriers.

- One facilitator was the drive within Hampshire Constabulary to ensure that neglect is appropriately managed and to address the concern of the Outcome 20 Scrutiny Panel. However, one regional lead was less enthusiastic about the new FSP approach, which created a barrier in that region. This was assessed via interviews.
- The quality of training may affect perceptions about the FSPs and motivation to use them. This was assessed via qualitative interviews with police and social workers.
- Time pressures in undertaking the joint visits for police and social workers, and in co-developing the plan, may affect the quality of the FSP. This was assessed via interview.
- Uncertainty about the process (assessed via interviews with police and social workers), leading to lack of clarity about:
    - which cases should follow this route
    - how to set appropriate, realistic and reasonable goals and plans for the parent(s)
    - timeframes for how long a parent should have to show change
    - what factors determine that the FSP has not been met
    - seeking an alternative outcome
- A document review of about 20% of randomly selected cases was planned to compare comparability of outcomes. However, given limitations of researcher access to certain data, it was not possible for the research team to review the conditions set in comparable cases. This is being undertaken by Hampshire Constabulary.

- The process being experienced by parents and families as highly stressful, to the extent that it becomes difficult to enable any to engage meaningfully. This was assessed via interviews with police and social workers.

The logic model is presented in Table 2.

3.5. Economic evaluation

Economic evaluation entails building a cost-benefit model relating the change in outcomes following the intervention and translating the outcomes in to monetary units. The aim was to provide a full-picture modelling of the costs of the intervention through mapping the costs of personnel, referral agencies (where appropriate) and any other costs of supporting the families, as well as costs of charging for those cases that reach the charging threshold. The changes in these costs following the intervention will be compared against the benefit to the child. This is a complex intervention and hence the benefits are not easy to measure and quantify. There is very little work on the costs of child maltreatment and neglect, but the evaluation was devised following Conti et al. (2017)[14] to map out the benefits of reduced child neglect.

The benefit should be reduced cases of child neglect, and possibly more effective prosecution (with the expectation that fewer cases would need to go to the CPS). As is done for domestic violence, the neglect cases should ideally be broken down into seriousness and estimate the degree of harm for each category. However, in the study by Conti et al. (2017), while there is a break-up of the various cost components across sectors, the average costs can only be calculated for fatal and non-fatal cases and confidence intervals provided. There are also strong assumptions around 'steady state' (how we extrapolate from incidents of neglect to how long the neglect continues). With all its limitations, we still use the study by Conti et al. for illustration, as it is not possible to collect individual data on the treated sample over the lifetime as part of this evaluation. Indeed, some of the healthcare impact (for example, mental health) has been found to be similar in studies that use different datasets to

[14] Conti G et al. (2017). **The economic cost of child maltreatment in the UK: A preliminary study**. London: NSPCC.

estimate the impact of child maltreatment (for example, Chandan et al., 2019[15]). It should be noted that interventions can increase initial police and social work involvement, but also lead to better longer-term outcomes, as well as a systems change once in place where 'better' outcomes are achieved with the same resources.

These potential benefits would need to be compared to costs. Data was requested on the cost of:

- the training
- overseeing the FSPs (on police and Children's Services)
- different types of cases for prosecution (so that if they decrease, we would have been able to estimate the benefit as reduced cost of these)
- the support to families

However, the data was not available. In practice, decomposing these costs can be difficult. In addition, some data would have been required from Children's Services, such as providing the cost of intervention programmes for families, which had to be attended as part of the conditions in the FSP. As such, in the absence of this data, estimations have been made on CPP numbers, using nationally available data on associated costs.

[15] Chandan JS et al. (2019). **The burden of mental ill health associated with childhood maltreatment in the UK, using The Health Improvement Network database: A population-based retrospective cohort study**. The Lancet Psychiatry, 6(11), pp 926–934.

Table 2. Logic model for the neglect evaluation.

Aims and principles	Activities	Outputs	Outcomes
■ Introducing the family safety plan (FSP) will result in reduced use of Outcome 20, as well as reduced outcomes related to the criminal justice system (CJS), due to the more structured and multi-agency methods of intervention. ■ Cases that do receive CJS-related outcomes will be easier to prove because of the use of the FSP as evidence of wilful neglect. ■ Monitoring compliance, understanding family need and multi-agency cooperation will be easier through the structured use of an FSP, which will help to reduce negative outcomes and promote positive outcomes. ■ Increased training for officers about issues of neglect.	■ Cases are referred to the Child Abuse Investigation Teams (CAITs) for potential intervention via a multi-agency safeguarding hub (MASH). ■ Cases are assessed to ensure they are suitable for FSP issue. ■ An FSP is co-developed and signed by the family. ■ Monitoring of approximately 135 cases in a three-month period (based on previous rates). ■ Frequent liaising with external agencies. ■ Cases receive outcomes at the end of the process, including no longer being monitored, an out-of-court disposal order (OOCD) or being progressed through the CJS.	■ An FSP for each family, with clearly defined goals, behaviours and expected outcomes. ■ Reports of engagement, compliance and improvement. ■ Outcome report or summary when cases referred or closed. ■ Follow-up data (three months and six months).	■ Reduced neglect behaviour demonstrated within targeted families. ■ Improved positive outcomes for children and families. ■ Easier monitoring due to the structured way in which the FSP is worded and process structured. ■ Improved understanding of neglect issues in officers, which results in better handling of cases. ■ Better multi-agency cooperation, leading to more effective intervention work with families. ■ Reduced re-offending due to better engagement with families or better evidencing of wilful neglect. ■ Increased positive relationships with families. Fewer children on child protection plans and fewer children in need, better engagement and recognition early on about acceptable parenting.

4. Methods

4.1. Aims

The overall aim of the research was to provide an evaluation of the introduction of FSP working agreements to cases of child neglect in Hampshire Constabulary.

Specifically, the research aimed to evaluate the stated intervention aims that FSPs will lead to:

- improved outcomes, defined as:
  - reduced use of Outcome 20
  - greater use of OOCDs
  - fewer child protection outcomes
- increased effectiveness of evidencing wilful neglect and increased ease of monitoring compliance

The mechanism for the primary outcome had three key components identified by Hampshire Constabulary as central to addressing their purpose:

- families' engagement
- compliance
- improvement

Secondary success was defined as the ability to progress evidence to meet the evidence threshold test and offer OOCD or charge for the offence of neglect.

However, the research also evaluated whether this led to 'better' outcomes for the child, in terms of how the process was experienced by children and their families.

4.2. Research design

To achieve these objectives, a mixed methods approach was adopted. Quantitative data collection was based on police outcome statistics (for example, use of Outcome 20 and child protection outcomes), which also fed into an economic evaluation.

Qualitative methods were utilised to provide contextual factors and to provide a richer understanding of the implementation of the process, as well as how it was experienced by professionals and families.

4.2.1. Quantitative research questions

- In comparing FSPs with treatment as usual (the previous approach):
  - Have the rates of Outcome 20 declined?
  - Have the rates of OOCD orders increased?
  - Have the rates of cases meeting the threshold of wilful neglect changed?
- Compared to the historical data (2017):
  - Is there a difference in the rate of OOCDs (community resolutions and conditional cautions) issued?
- At three-month and six-month follow-up:
  - Have the rates of re-referral of a family to Children's Services and/or the police declined?

4.2.2. Qualitative research questions

4.2.2.1. Case level

- What is the quality of the decision-making process in deciding to develop an FSP?
- What are police and social worker views about the training and its effectiveness?
- How effective were the FSPs in developing engagement with parents?
- What are the views of the police officers and social workers who are involved in the joint visits, including whether there is consistency across goal setting and outcomes between cases?

4.2.2.2. Family experience

The overall aim of the interviews with parents and children would have been to establish:

- what the FSP experience is like for families and their children

- whether its use leads to successful outcomes that are understood by and meaningful to parents and children, making tangible differences to the lives of the children involved

Specifically, the following areas would have been explored (and should also be explored in future work):

- What are the experiences of families being involved with an FSP?
- Did they feel engaged in developing the FSP?
- Did it increase their understanding of professionals' expectations of them?
- Are parents aware of what would happen if there were another concern raised about their child (or children)?
- Do they think this is a good way to work with their social worker and police, and did it help?
- What are the parents' experiences of receiving an OOCD and its effectiveness?

4.2.2.3. Organisational level

- Are more cases being referred to the CAITs?
- Has the threshold of risk changed, such that there is a change in level of referral to CAIT and/or outcomes applied?
- Is work being allocated based on resources or risk (determined via analysis of interviews with police officers and social workers)?
- What is the decision-making process when issuing the OOCD or FSP and the conditions contained within?
- Is there a need to alter resourcing levels or numbers to handling neglect cases as a result of FSPs?

4.3. Ethical considerations

This project has received ethical approval from the University of Birmingham STEM Ethical Review Committee [ERN_15-0004A; ERN_15-0004B; ERN_15-0004C; ERN_19-0244] and the University of Bath Psychology Research Ethics Committee [PREC 19-201; PREC 19-262; PREC 20-003]. It was also reviewed by Hampshire Constabulary to ensure that, in particular, the data management plan was sufficiently robust.

This research project had numerous ethical elements to consider. Most importantly, the research team aimed to ensure that opportunities were provided to all to participants (police officers, social workers, parents and children), while ensuring that the research did not create additional stress or distress in a situation that is already difficult. The underlying ethos was to enable all to have a voice but to do no harm and, ideally, to provide a positive experience.

Ethical considerations were addressed via the development of comprehensive information sheets and consent forms, which covered areas such as the right not to take part, to answer questions or to withdraw from the study at any point without explanation. The boundaries of confidentiality were explained – specifically, that data would be anonymised and reported with no names, but that any information that led to concerns about risk to the participant or another person (child and/or adult) would need to be reported. Data management (confidentiality, storage length and location, transcription process) was also included in the information sheet.

4.4. Sample

4.4.1. Quantitative data collection

4.4.1.1. Current data (2019)

Data was collected on all neglect cases investigated by Hampshire Constabulary in July, August and September 2019 (N=258). Each case had a victim and a suspect. If there were more than one suspect for each child, more than one case would be recorded for the same victim. The number of cases is therefore greater than the number of victims.

In summary, within the 258 cases, there were 258 suspects for 201 victims (children), with 48 of those 258 cases having more than one suspect (18.6%). The average age of the child was 6.5 years, with the youngest being 0 years old and oldest being 16 years old. In terms of victim gender, 87 victims (43%) were female and 114 (57%) were male. Out of 258 suspects, 165 (64%) were female and 93 (36%) were male. The average age of the suspect was 34 years (range 17 to 67 years old). Suspects' relationships with the victim were mainly identified as mother (62% of all suspects) and father (30%). The rest (8%) were identified to be a stepfather, mother's ex-partner, mother's current partner, childminder, family friend

or grandparent. Almost all suspects (98%) were identified to be residents at the same address as the victim. The biggest number of neglect cases investigated were in Southampton (21%), followed by Isle of Wight (12%) and Portsmouth (10%). The remaining 57% were small districts spread across the Hampshire region.

Looking at child protection status, 51 (25%) victims had a CPP at least once in the three years before the index neglect case (during July to September 2019), but 150 (75%) had not.

4.4.1.2. Historical control data (2017)

Data was collected on all neglect cases investigated by Hampshire Constabulary in July, August and September 2017 (N=268).

For the purposes of this research, data was rearranged to be represented by the child (not parent). In total, the 268 cases related to 193 victims (children) because 62 of these had more than one suspect (23%). The average age of the child was 6.2 years, with the youngest being 0 years old and oldest being 16 years old. In terms of victim gender, 95 victims (49%) were female and 99 (51%) were male. Out of 268 suspects, 163 (61%) were female and 93 (34%) were male. The average age of the suspect was 34 years (range 19 to 54 years old). Suspects' relationships with the victim were mainly identified as mother (61% of all suspects) and father (30%). The rest (9%) were identified to be a stepfather, mother's ex-partner, mother's current partner, childminder, family friend or grandparent. Almost all suspects (98%) were identified to be residents at the same address as the victim. The biggest number of neglect cases investigated were in Southampton (15%), followed by Isle of Wight (12%) and Portsmouth (11%). The remaining 62% were small districts spread across the Hampshire region.

Looking at child protection status, 44 (23%) victims had a CPP at least once in the three years before the index neglect case (during July to September 2017), but 149 (77%) had not.

It should be noted that there is a high degree of similarity between the 2019 and 2017 data for the same three-month period. For example, on prior CPP status, 2019 was 25% (yes) and 75% (no), compared to 23% and 77% respectively in the 2017 data.

4.4.1.3. Scrutiny Panel case review

Since November 2017, a selection of cases closed with Outcome 20 have been reviewed by a Scrutiny Panel[16] to ensure that the correct decision was reached. The Scrutiny Panel used the national outcome framework about recording, grading and professional judgement to reach a consensus about the right outcome, and then compared this with the outcome that was reached.

In addition, the authority to issue a community resolution or conditional caution has to be authorised by a supervisor. In 2019, there were 155 cases, of which approximately 40 were in the July to September period under review. These cases are being reviewed within Hampshire Constabulary to ensure parity across the different regions.

4.4.2. Qualitative data collection

4.4.2.1. Police

Interviews were conducted with 21 police officers from the four regions: eight from the Hampshire region (North), five from the Portsmouth region (East), six from the Southampton region (West), and two from the Isle of Wight (South).

The majority of police interviewed were police constables (N=8). Other police interviews were with four detective constables, three police staff investigators, and six detective sergeants, detective chief inspectors or detective inspectors.

4.4.2.2. MASH and social workers

Interviews were conducted with 21 social workers in total. Most social workers came from Hampshire, Portsmouth and Isle of Wight, with very limited response from Southampton. Six were members of three different local MASH teams (roles have not been included to avoid being inadvertently identifying) in two areas, and 15 were social workers from the three regions.

[16] The Scrutiny Panel consists of professionals in relevant fields, for example from the CPS, from the police, the Crime Recording Manager, the Review Team inspector and magistrates who are experienced in the field of child abuse law, policy and procedure.

4.4.2.3. Parents and children

Ethical approval was obtained at the end of December 2019 from the universities. The aim was to collect data from 10 parents and 10 children (aged 8 to 16 years) from any region in Hampshire who had experienced the new approach. Their views are incredibly important to include. Unfortunately, delays from the ethical approval process meant that the agreement and support from Children's Services with recruitment of families became interrupted by the 2020 COVID-19 pandemic.

4.5. Procedure

4.5.1. Evaluation of training

The research planned to evaluate the FSP training, including (if possible), gaining pre- and post-training questionnaires, as well as qualitative interview responses. As noted in 3.2.1, it transpired that details of the FSP were outlined in senior meetings. The information was cascaded down prior to the start of the research project via email and a one-day training event (see Appendices 9.3, 9.4 and 9.5).

Evaluation of the training therefore came from perspectives obtained in the qualitative interviews with police, social workers and members of MASH, including some regional leads.

4.5.2. Outcome data

A list of required variables was agreed in discussion with Hampshire Constabulary and included in the memorandum of understanding. Following later discussions, these were revised somewhat to ensure feasibility in the time available (for example, variables on family environment that were likely to have high rates of missing data were excluded) or because it was not felt appropriate (for example, Troubled Family status). The variables collected were those that were required to meet the research requirements and were feasible to collect within the available timeframe and access.

To obtain this data, a member of Hampshire Constabulary conducted a business object search to interrogate NICHE. For example, the following types of variables were extracted:

- occurrence numbers (reported date)
- types (cruelty to children)

- district
- aggrieved nominal out of hours system
- age of child
- gender of child
- status of investigation
- relationship between offender and victim
- CPP status
- re-referrals
- key features of the case (for example, mental health difficulties in the family)

4.5.2.1. Historical data (2017)

Data was listed by the occurrence number and contained information about:

- the victim (age, gender)
- suspect(s) (age, gender, relationship to victim)
- district
- outcome
- occurrence summary

Occurrence summaries were read and binary variables (Yes/No) were created to specify the type(s) of neglect reported and/or additional difficulties in the family. These were as follows:

- an adult with mental health difficulties in the household
- substance difficulties – drinking-related problems in the family or incident related to a suspect being drunk
- substance difficulties – drug-related problems in the family, incident related to a suspect being under the influence of drugs, or drugs-related activities are suspected (such as selling of drugs)
- domestic violence in the household
- physical assault of the victim
- poor living conditions discovered (including dirtiness of the place, lack of food, bedding, children recorded to be unkempt and dirty) and documented in the case

- medical problems (including when neglect happens due to carers not meeting medical needs of the victim)

Data on CPP referrals for the three years prior to, and for three and six months following, our sample period of July to September 2017 were collected and each child was cross-checked. In addition, the following variables about CPP history were added.

- Was the child on a CPP in the three years prior to July to September 2017?
  - If yes, how many times? For how many months?
- Was the child on a CPP within three months and six months following the index referral for neglect?
  - If yes, how many times? What was the date of the first CPP after the index referral?

4.5.2.2. Intervention data (2019)

Data for 2019 are outlined as above (see 4.5.2.1 Historical Data (2017)).

4.5.3. Interviews

4.5.3.1. Recruitment of police officers

Recruitment of police officers was established through contact with the CAIT lead in all four regions of Hampshire Constabulary. Information about the project was provided and a suitable time was arranged for the researchers to visit in order to speak with the team. Upon arrival, an information sheet was given to potential participants outlining the purpose of the study and ethical procedures, to ensure that informed consent was obtained (for example, right not to take part, right to withdraw, anonymity and data management). Members of the team who were then willing to take part let the researcher know. Interviews were conducted on an opportunistic basis, as it was a normal working day. This led to one interview being conducted with two officers at the same time.

Where possible, interviews took place in a separate room. Otherwise, they took place in a quiet area away from other staff where they could not be overheard, so that participants felt they had the opportunity to be honest in a confidential space. At the start of the interview, the information sheet was revisited with the opportunity to

ask further questions and consent was provided. All interviews were audio recorded and later transcribed.

4.5.3.2. Recruitment of social workers

For the recruitment of social worker participants, the intervention lead liaised with Directors of Children's Services (as appropriate) for permission for emails introducing the project to be sent to social work managers. This occurred either via the police intervention leads, or from CAITs. In turn, social work team managers distributed the invitation to their teams.

For the Hampshire local authority, the district manager organised for social workers (mainly team managers or deputy team managers) from different teams across the region to meet at a central location for the researcher to conduct interviews with them altogether.

In some instances, interviews with social workers were pre-arranged with team managers, who provided details of the study to social workers in the team who had recently worked on neglect cases. For most cases, however, social workers were recruited via opportunity sampling (the research team visited the social work office on a set day, as arranged in advance with team managers, and interviewed social workers who were available for interview that day). There were no exclusion criteria as to who could be interviewed.

As with the police, prior to the interview commencing, an information sheet was given to participants outlining the purpose of the study and ethical procedures, to ensure that informed consent was obtained (for example, right not to take part, right to withdraw, anonymity and data management). As per the procedure with the police officers, all interviews were carried out face-to-face in a private space.

4.5.3.3. Interview details

Interviews were semi-structured and ranged in duration, with the shortest interview lasting 14 minutes and the longest lasting 67 minutes.

Interviews were recorded with Dictaphones, property of the University of Bath, and uploaded onto secure encrypted USB drives shortly after the interview had taken place (and subsequently deleted off the Dictaphone memory). They were then sent via secure email to a professional transcriber, hired specifically for the project. Once

received back, the transcripts were exported into NVivo 11 for thematic analysis undertaken by the research team, to identify key themes within the data.

4.5.3.4. Families

The process of recruiting parents from Hampshire and Portsmouth had begun via social workers, who would have provided details to families with whom they were working to gain parental consent to be contacted by the research team. However, due to the COVID-19 pandemic, the resulting national lockdown and the attendant additional pressures on families and services, the planned recruitment did not go ahead. No interviews were possible with any parent or child.

4.6. Measures

4.6.1. Measure of engagement

In order to evaluate the family engagement with the process, a measure of engagement was developed (adapted from the Engagement Measure[17]). Ethical approval was obtained for this to be completed by a police officer or social worker for every case worked in the three-month period. No measures of engagement were returned from Hampshire, despite the intervention lead's best efforts.

4.6.2. Parenting Stress Index

In order to gain a measure of parental stress, it was planned that the Parenting Stress Index (PSI, version 4, short[18]) would be completed with each family that police worked with related to concerns about neglect in the three-month intervention period. This would provide a measure of parenting stress, as well as environmental and life stress. However, due to delays in obtaining the necessary approvals to begin the project, it was not possible to start this data collection within the relevant three-month period.

[17] Hall M et al. (2001) **Brief report: The development and psychometric properties of an observer-rated measure of engagement with mental health services**. Journal of Mental Health, 10(4), pp 457–465.
[18] Abidin R. (2012). **Parenting Stress Index, fourth edition short form**. PAR Inc.

4.7. Data analysis plan

4.7.1. Outcome data

Intervention data was analysed, with both outcome variables (neglect case outcome and CPP referrals three and six months after the sample period) compared with the control data of the historical sample from July to September 2017. The analysis used the historical control sample to compare the outcomes before and after the intervention took place, as well as to identify the average treatment effect using a quasi-experimental design, propensity score matching (PSM).

The reason for using PSM is that outcomes can be influenced by many factors (for example, age or gender of the child, whether there were multiple suspects per case, whether the child was on the CPP before the neglect was reported, or co-existing difficulties within the family). Therefore, in order to calculate the effect that the treatment (intervention) had on the outcome variables, we can exercise statistical control over the conditions by selecting a group that has similar characteristics to the treatment group[19]. This is achieved utilising a PSM method. Matching is done by calculating a propensity score for each case and then matching intervention and control data by the closest scores. This allows us to form a control group that is statistically similar to the group that received the intervention by selecting a subsample of individuals who are observationally similar, so that a valid average treatment effect can be calculated.

Using PSM, cases were matched from the intervention data with the 2017 historical group data on their main covariates (age and gender of the child, multiple suspects, type of neglect recorded).

In addition, further analysis compared grouped cases in Hampshire, Portsmouth and Isle of Wight (intervention) with Southampton (comparison), since the FSP has not been formally introduced in that region.

[19] Apel RJ and Sweeten G. (2010). 'Propensity score matching in criminology and criminal justice'. In: Piquero AR and Weisburd D, eds. 'Handbook of quantitative criminology'. New York: Springer. pp 543–562.

4.7.2. Interviews

4.7.2.1. Analysis strategy

All interviews were transcribed by an authorised transcriber (transferred using secure CJSM email). Transcriptions were entered into, and then analysed using, NVivo 11. Thematic analysis using a bottom-up technique was undertaken, whereby data was analysed based on the content, without overlaying a pre-existing theory or construct[20,21]. The research team familiarised themselves with the data and began generating initial codes (known as 'nodes') for each interview transcript. Each line of data was assigned a node that described the content of the text. Duplicate or similar nodes were removed and remaining nodes were categorised into themes. Through this process, an initial network of nodes was generated from the interviews.

4.7.2.2. Inter-rater reliability

Thematic analysis is an iterative process and the themes were developed, checked, merged and re-developed during a considerable, detailed progression involving three researchers.

With the police interviews, two researchers coded half each (n=10; n=11). One researcher coded all MASH interviews, while both researchers coded social work interviews. To ensure inter-rater reliability, two interviews were double-coded by both researchers. The two coding sets of nodes were then checked by the lead researcher and, through discussion, similar or duplicate nodes or themes were merged. As an additional reliability check, a second phase of reviewing took place at the start of the social work interviews.

The police data underwent several iterations and key themes were identified. Similarly, following coding and reliability checks, MASH and social work interviews were considered in relation to existing codes generated by the police data and the new codes arising from these data sets. After the final themes and sub-themes were agreed, the data set was divided into three groups (police, social workers and MASH

[20] Braun V and Clarke V. (2006). **Using thematic analysis in psychology**. Qualitative Research in Psychology, 3(2), pp 77–101.
[21] Braun V and Clarke V. (2019). **Reflecting on reflexive thematic analysis**. Qualitative Research in Sports, Exercise and Health, 11(4), pp 589–597.

members), to enable comparison between the three groups for similarities and differences.

5. Findings

- **Training** – Information was disseminated by email and a guidance document, with little (or no) formal training.
- **Terminology** – There is some confusion among police officers around the terminology in use. Not all respondents were familiar with the term 'family safety plan'.
- **Increased focus** – Officers generally welcomed the increased focus on, and recognition of, the neglect of children.
- **Ethos** – The ethos of the revised approach has generally been understood, but questions of fit with the police role and process specifics remain.
- **Lack of clarity** – Respondents strongly expressed the lack of clarity about FSPs (and how to complete them), as well as the wish for more information about what the police are trying to achieve.
- **FSP form** – FSP forms were seen by the police as a social work document, while 'we have the OOCD'. Social workers see the FSP as another version of working agreements that they have used for a long time.
- **Intervention** – The FSP is, in fact, only one element in a broader series of changes, such as revised decision making for neglect cases at MASH, and initiatives around changes in outcomes, including scrutiny of all Outcome 20s. However, in terms of the experience of families, their understanding of the change will relate to the use of the FSP, which may include greater use of OOCDs.
- **Risk threshold** – Some concern was expressed that the lower risk threshold, combined with a push for increased use of OOCDs, has led to inappropriate referrals and excessive responses to some cases.
- **Parents** – Officers and social workers felt that some form of working agreement was often a positive tool for families, but the findings were mixed about how well this was achieved using the FSP working agreement.
- **Unintended consequences** – Different police and public perceptions of OOCDs were noted by some police officers and social workers (police viewed

it is a 'non-criminal' route, but some professionals felt that this is not the view of parents). An OOCD could show up on an enhanced DBS check and may have implications for employment.

- **Outcomes** – Children on CPPs reduced significantly in the three-month follow-up in 2019, alongside an increase in use of community resolution (OOCD). This was a stated aim of the intervention, in that it was seen as reducing the number of cases that may need to follow a criminal justice route (ie, go to court). However, the qualitative data was mixed. For example, some police officers felt it was too extreme a response. Hence, whether this is a positive outcome or not is open to debate.
- **Analysis** – Statistical analysis indicated that 40 and 36 fewer children were referred for a CPP in the follow-up three-month and six-month period, respectively. Based on national data regarding costs for CPPs, a possible modelling scenario shows a potential yearly benefit of £182,320 to local authorities in Hampshire. However, this does not account for additional costs and resources associated with the new approach, which would reduce this net benefit.
- **Organisational impact** – Although many police and social workers felt that the FPS form itself need not be more time consuming, there was a strong consensus that the overall changes have led to increased workloads that, at times, have affected the ability to co-work cases.
- **Moving forward** – A review of the risk thresholds and use of OOCDs may be warranted, alongside additional training on the use of FSPs to ensure a consistent approach (and, therefore, parity) for families.

5.1. Implementation of the intervention

5.1.1. Evaluation of the intervention

Police and social worker perspectives on the FSP working agreements expressed in the qualitative interviews covered the themes of:

- the extent of training
- understanding of the purpose of FSPs

- how that purpose translated into practice
- views on the FSPs
- issues related to creating and implementing them

These are presented in Figures 1 and 2. Comments in relation to specified research questions are listed in the theory of change model (Section 3.4.1).

Note that sometimes, social workers used the term 'working agreement' or 'WA' in interviews to refer to either the FSP or another form of working agreement. Where the comment is generic, this will be referred to as 'FSP or other working agreement' from hereon in. Otherwise, FSP will be used.

5.1.1.1. Did the training provide police and social workers with a clear understanding of the process?

5.1.1.1.1. Views on training

Figure 1 shows that officers perceived that there was relatively little training provided. While at least one police officer felt that the training was sufficient, the majority felt that they required more and they had 'just…became aware, and sort of learning on the job really' (Police 01). As indicated previously, dissemination of the intervention to most police officers consisted of an email with the FSP and guidance notes attached, as well as attendance by some at a lecture at an inter-disciplinary CPD training day. Several police said they recalled receiving the email with the FSP form and instructions, but had not thought any more about it since and have not used it:

> 'No, no formal training, and I personally haven't dealt with the paperwork, but I'm…I'm aware now, in looking at it, that I have – it's something that I've opened up on an email, I've seen it, and thought, oh, okay.' (Police 15)

Some officers said that they did not find the guidance sent out with the document useful and queried how useful it was in practice:

> 'There's extensive guidance and training on these two pages I've handed you here – this is it…this extensive… But I think it's

> written by someone who's never been out to a joint visit and done it in the hard real life, I think.' (Police 07a)

Regarding the training day, one officer who attended said 'they spoke a little bit about [the FSP] then, but, no, I wouldn't deem it as training, no' (Police 10). Another said that when discussing the new FSP form, it was seen as a Children's Services tool:

> 'I just remember them going through the form, because it was a training day with Children's Services there as well, erm, and I just remember people going, "Well, this is what Children's Services do, so why are we doing it?", but they were saying, "Well, you must do them for neglect cases."' (Police 11)

Perhaps for this reason, one social worker noted that while it was spoken about positively on the training day, it had yet to be translated into change:

> 'I've certainly been on joint training with the police, where I've heard about it and people are very up for it and feel it's a very good thing. I just haven't seen it in practice yet.' (Social worker 04)

Social worker respondents said that they had not had any training, other than those who attended the 20-minute lecture at the inter-disciplinary CPD event (Appendix 9.4). More broadly, social workers noted that they have used working agreements in some form for many years anyway. Several social workers said that although the working agreement is a tool they often use, they have not had training in how to create one. Instead, they have learned on the job from other social workers:

> 'No, I've never been taught how to do one. We kind of just share the knowledge between…between the team, and when somebody's not put one in place before. So, normally, you wouldn't go out on a Section 47, on your own[22], the first few times. You would have shadowed and learned from others, erm, and then somebody will shadow you for your initial ones, so

[22] For definition, see Section 3.1.1 above.

> you're supported in that way, but you're not ever sat down and formally shown how to put a written agreement in.' (Social worker 02)

Given these comments, it is perhaps not surprising that some police officers feel that there needs to be more training, particularly together with Children's Services, 'because then we can identify whose role is what' (Police 05). Highlighting the different roles of police and social services was a common theme, but it was emphasised that the same messages about the FSP should be sent out to all agencies.

> 'And whilst I accept that everybody who is involved from each of those agencies has a slightly different role to play, the message that we're sending out about what we've got, why we're doing it, and how we should be using it should be the same across all of the agencies. So, I think training is a big issue, for me.' (Police 04)

It was also acknowledged that people might forget or not pay attention to the original delivery of information (whether a training day or email), so refreshers may be needed:

> 'I think, eh, it doesn't matter how much you deliver training, you have to keep delivering it, because it is not just a one-hit wonder. You have to keep – it's that refreshing, isn't it? It's a bit like, eh, the more you repeat, the more people get it, the more people understand.' (Police 04)

In contrast, a couple of social workers said that specific training in putting an FSP in place is 'not something that we would do anyway because every condition is different, so every case is treated as an individual case' (Social worker 08). Hence, they felt that, due to the individualised nature of FSPs and other working agreements, they would need to learn this on the job. Similarly, there were some police officers who mirrored the view that training was not needed, as they could learn how to do an FSP 'on the job':

> 'But, actually, then, when you've done a few, it's sort of then, oh, yeah, that wasn't so bad, that was quite straightforward and,

> actually, it's there now, it's done, erm, and so, yeah, [I've] grown in confidence from that really.' (Police 10)

A minority of respondents felt that there was no need for any guidance, as it is just common sense. For example, one officer noted:

> 'I mean no training, [you] don't really need training to just kind of go through a form though, do you, just to cross off stuff and write stuff?' (Police 12)

Hence, the training perhaps needs to highlight the skills required to construct appropriate and consistent SMART (specific, measurable, achievable, relevant and time-based) goals for families.

5.1.1.1.2. Ownership of the form

Comments on training also fed into discussions about ownership of the FSP form, highlighting that some held the view, among both police and social workers, that working agreements belong to social work. Social workers felt that, in turn, this view about ownership informs the extent to which police are involved (or not) in the FSP process. This view was echoed by some police who did use the FSP but also said that:

> 'I hear other people going, "That's not us to do – it's [up to] Social Services to do it, so I'm not going to do it, they should do it!"' (Police 10)

Social workers feel that a working agreement is an integral part of their work:

> 'I'd say it's one of the most important documents that we have because we're setting out our stall to families and what our expectations are of them, because if we're not clear in what we've agreed, then actually you're setting parents up to fail.' (Social worker 01)

When we began discussing the new FSP document specifically, which was designed by police, the response of social workers was that:

> ‘It’s fairly new…, probably about three or four months old, that version, but we always had a version, ever since I’ve worked for Children’s Services.’ (Social worker 05).

Hence, from the interviews with social workers and police, it appeared that the uptake of usage by social workers of the new FSP document is considered to be limited, in part because it has been designed by police. Some police feel this is potentially because social workers are unaware of it, which would tie in with the lack of training that has been provided:

> ‘I think it needs us, erm, to promote it better [with] Social Services. So, instead of saying, “Are you going to do a working agreement?” it’s to actually say, “Are you going to use the document that you have?” So, we don’t do that enough, and I think we need to start promoting that more, so they do have those documents and they’re readily available, rather than use the old ones that they’ve had. So, it’s just all about becoming more aware and knowing what’s…what’s available.’ (Police 08)

It is important to note that our sample of social workers was small, so we cannot draw firm conclusions about usage. However, it appeared that differences might exist by locality, with social workers in Hampshire County more familiar with the form, potentially because they are closer geographically to the police who created it. However, there also seemed to be a degree of personal or team manager preference that determined whether the form was used, changed or not used.

5.1.1.1.3. Understanding of aims and process

Regarding whether the intended aims were well understood, most officers expressed the main aims of the new approach as being related to safeguarding, evidence collection and supporting families. However, different views were expressed as to whether this was achieved or not. For example, there were mixed views about whether evidence collection was more effective, with some officers believing that the new approach was helpful and others believing it was not. Furthermore, the lack of clarity about FSPs they actually consisted of, how to complete them, and the wish for more information about what the police are trying to achieve were strongly expressed. For example:

> ‘We’ve never had these fully explained, I don’t think, why we use them, and there does seem a big overlap with Children’s Services because this is what they’ve always put in place beforehand, and I’ve never really thought of that as a police document.’ (Police 17)

In terms of purpose, both police and social workers said that the FSPs or other working agreements are most often used as ‘an immediate safeguarding tool’ (Police 17). This encourages families to ‘make some immediate improvements, erm, before anything else is stepped up’ (Police 13), as it is important ‘to give the family a chance before matters are escalated, either with social services or police’ (Police 02). Therefore, the conditions included in them are ‘very basic and enough to make sure children’s immediate safety is met’ (Social worker 03). However, while many respondents said that FSPs and other working agreements can be used ‘to manage the risks, erm, the identified risks’ (Social worker 06), a minority of police officers felt that the tool is not useful in that way:

> ‘If it’s so bad in the house that you think there’s a significant risk of harm, you wouldn’t be using a working agreement to keep children safe because a bit of paper is not going to stop that level of behaviour.’ (Police 07a)

In summary, the ethos of the revised approach appears to have been generally successfully transmitted. However, questions remain about the specifics of the process for some police officers, and about how it fits with the traditional police role, which was more investigative and less about joint visits to develop support packages. It could be queried whether this role actually mimics a traditional policing approach in some ways, by not remaining involved with the family in the long term and by police presence being used, in part, to emphasise the seriousness of a crime.

5.1.1.1.4. Legal value and usefulness in court

Another element of the process raised by police and social workers was the legal value of the FSP in court. Some police officers said they felt that the FSP is a useful tool to demonstrate wilful neglect and some social workers noted that it was useful in family court. However, other police and social workers queried whether it would be legally binding and/or its usefulness for police prosecution.

Some police felt that an FSP could be used in court, because ‘from a criminal point of view, if they’re breached, we might be able to use it as evidence to support our investigation that it’s then wilful’ (Police 02). Some officers felt that the form could be useful as evidence because first, the document looks more professional, and second, there is a push for it to be used more consistently:

> ‘Well, they [FSPs] would certainly, I would suggest, support a prosecution, from a police perspective. We would have something tangible, signed, erm, by parents, and if they were to go and assault or neglect their children again, we would have that tangible evidence, erm, and it would be a much more professional document to take to a court of law than a scrap bit of paper, and we could evid… – we could exhibit that document, erm, for the court process.’ (Police 08)

> ‘They haven’t adhered to it, so that is ammunition for us to say, “Actually, you’re not working with the agreement, you’re not adhering to anything, the children were being neglected then, but now, you’re showing that actually this is wilful, more wilful, because you know what you’ve got to do and you’re not doing it.” So, yeah, it does help, and we’re trying to do that a bit more I think now.’ (Police 17)

In contrast, other officers noted that the FSP is ‘not a police document. It has no legal power’ (Police 21). Indeed, many officers said that they felt it would not be accepted by the CPS. For example:

> ‘At the moment, and it’s only my opinion, but I don’t think CPS would take what is a piece of paper to say you need to tidy up Johnny’s room or whatever. I just don’t think they would see that as a…as a piece of evidence and good enough.’ (Police 13)

The distinction some police made is that their documents (for example, OOCDs) are ‘led by admissions as well, so you wouldn’t use the… that would be evidence, but it wouldn’t be the sole evidence, and I certainly haven’t gone to CPS with a neglect’ (Police 05). Hence, most police officers appear to believe that OOCDs are a better form of evidence, as the parent has admitted the offence by signing the OOCD,

which offers more of a legally binding contract, as the consequences for non-adherence are clearly laid out. This is why many officers feel that the FSPs are ‘a great idea, in practice, but they aren’t…they aren’t in any way legally binding’ (Police 02). Furthermore, many police officers noted that this view was widely held:

> ‘But like a lot of people say here, they’re not really worth the paper they’re written on. So, what’s the point? And everyone here – well, [maybe not] “everyone”, people here sort of say, “Well, it’s a Children’s Services thing – why are the police doing it?” But we’ve been told to do them.’ (Police 11)

> ‘I think you’ll have, definitely have some officers who will come in and say, “Oh, it’s not worth the paper it’s written on.” You’ll probably hear that. You’ve probably heard that already I think a few times.’ (Police 12)

That sense was supported by interviews with social workers, one of whom noted that:

> ‘It’s not legally binding in any way, shape or form, and there’s nothing in here that says that if you don’t stick to it, we’re going to swoop in and grab your children.’ (Social worker 01)

For some social workers, this led them to change their practice:

> ‘I like to…we like to do things quickly so that there is robust intervention in place rather than trying to put [up] a safety plan that you cannot guarantee that the parents are not going to do [what they do] because it’s not…it’s not a legally binding agreement.’ (Social worker 08)

Similarly, a view expressed by several police officers was that an FSP ‘adds some strength to the case, but it’s not going to make the difference of whether or not we get a charge or a prosecution, no way’ (Police 02). For many police, upon consideration of how useful an FSP may be in court, they seemed to enter a cyclical argument and could ‘see both sides’:

> ‘I can see that it’s not worth the paper that it’s written on, but at the same time, it could support a case, our case, quite nicely, if

> they haven't done it, or they've agreed to it and then haven't done it, or haven't signed it or whatever. But I don't know how much… . Because I've not dealt with a case or I've not really heard anyone dealing with a case with a working agreement, I'm not really sure how much weight it has.' (Police 11)

Indeed, the lack of a precedent for using them in court seemed to be an issue, since officers were unsure how an FSP would be received by the CPS. One officer said that they feel:

> 'It doesn't have as much punch as the bosses think it does. It's more to have in the background as bad character and try and get it in that way. But, arguably, is a statement by a police officer better than a…a bit of paper that has no legal binding?' (Police 09)

Again referring to precedent, one officer noted that if FSPs were used more often in the CJS, they might be more likely to be considered, and therefore more useful:

> 'I wonder if we have a culture of having them though… We might make a habit of looking at them when we're doing outcomes because we know it's going to be there and we'll actually think about it a bit more. But then, you still don't know whether they've complied with it or not. Just because they've signed it, we don't know if they complied with it because we… probably haven't got any way of checking. So, yeah, probably not, actually [laughing], I don't know…!' (Police 21)

Some police did say that they felt it would be more useful in family court than criminal court:

> 'Yes, I do believe, especially in the family court, they…they do like these, and they're more likely than a criminal court to say, "Do you know what, you had your chance – now, no."' (Police 02)

Similarly, some social workers noted that FSPs can be useful in family court as evidence that the family have been set expectations, and not abided by them.

> ‘From our perspective, the court quite like them in…when we’re in care proceedings, they always quite like working agreements because they’re just really clear for parents about what we expect of them.’ (Social worker 05)

One social worker said that the letterhead is particularly useful:

> ‘The person has read and signed and said, and it’s Hampshire County Council official safety plan document, yes, totally, because it was your word that you told us – that was the reason why we felt the need that it is okay for us to close the case, with that in place. So, if that had been breached, then clearly… and it goes to court, it would be very useful.’ (Social worker 08)

In summary, although the FSP is seen by some as potentially useful to add strength to a case and may be useful in family court, there is a consensus that the document is probably not legally binding. The lack of precedence of seeing it used in the CJS adds to this worry.

5.1.1.2. Is the FSP easy to use in practice?

Comments from police officers regarding ease of use in practical terms fell into a superordinate theme about creating and implementing the tool, with sub-themes related to content, format, delivery and potential improvements (see Figure 1). In addition, however, themes that were related to the success of joint working in practice (see Figure 2) also provided information that addresses ease of use.

In Figure 1, it can be seen that officers perceived that when creating the content of an FSP, the goals needed to be very specific and clear, and that this was achieved to the best effect when there was good collaboration and communication between the two agencies. In this new FSP approach, there is increased co-working with Children’s Services on cases that would not previously have been co-worked, as well as increased police involvement in generating a clear plan for families. In Figure 2, a positive theme of police–social work collaboration highlighted that there are often positive experiences, with good communication, shared aims and the opportunity (as two overstretched services) for each to offer support to the other. It was felt that this then had follow-on effects in terms of working well with families.

In contrast, however, there were several references by both police and social workers of seeing differences – both in terms of the extent of communication between the two organisations, and also individual (officers and social workers) differences in expectations of required standards and goal settings. These different approaches were seen as having implications for working with families, and issues were raised about parity of how the goals and conditions within an FSP were constructed. It was questioned whether two families with similar circumstances would always receive similar conditions, because different individuals held different ideas about what should be included. Potentially, such individual differences could be minimised (at least to some extent) by additional, clear and experiential training on FSPs, including practice exercises.

These concepts are discussed in more detail below, with collaboration and co-working as strong interlinking themes.

5.1.1.2.1. Content

Almost all police and social workers said that Children's Services usually lead:

> 'We would discuss whether there's kind of any additional things they [the police] want to add in or, erm, you know, usually they'd have a read through as well and we'd agree what we're asking them to do.' (Social worker 05)

This is because normally 'there's nothing specific that they [the police] would want on the working agreement, erm, outside of what we would [want] on as Children's Services, but we do check in with them if they want to' (Social worker 02). Many respondents agreed that this seems to work well, and an indicative quote from one police officer was that:

> 'It's kind of their product, and what they think should be on it, and we sort of agree with them, em, yeah. It's never sort of the other way round.' (Police 13)

Police officers did feel, however, that if they chose to contribute, then their suggestions were listened to:

> 'Before we make final decisions on things, we'll often step outside with the social worker and just have a chat about

> whatever. They will generally phone their team manager, and we will sometimes call our sergeant. And then, yeah, the…sometimes, it can be a bit of a joint kind of, well, you know, "Maybe consider popping this on the form…", and they say, "Oh yeah, yeah, that's a good one," or something.' (Police 07)

For some officers, they felt that this went further and that on some occasions, they needed to give social workers more guidance:

> 'Some of the social workers do, they'll put their conditions on, because you know you're both singing from the same hymn-sheet, whereas, others, they really need guiding as to what to put on there. I mean, I've been to some jobs where I've actually written the working agreement because the social worker didn't… know what one was.' (Police 05)

However, a minority of police said they were not involved at all in working agreements, so would not be engaging in conversation with social workers about it to decide conditions:

> 'Erm, the only way that I've ever had an input is when I've actually spoken to the social worker myself and said, "If you're considering a working agreement, then you need to consider these points." I don't actually know if those points were put into the working agreement because I'm not privy to them.' (Police 14).

Police and social workers typically agreed that the main priority is that conditions 'need to be really prescriptive and really specific about these are…you know, about your expectations and about… It needs to be measurable and it needs to be specific, definitely.' (Police 06).

In setting these basic, realistic expectations, professionals (particularly social workers) emphasised the importance of breaking a big goal down into smaller steps that are easier for the family to achieve:

> 'When they've always done something a particular way, to suddenly stop doing it, it's not, you know, it's not that realistic. So, I think we have to be mindful that, you know, whilst we might

> want to achieve a goal at the end, we might need to give them some steps along that way, rather than just go for the overall goal.' (Social worker 05)

Both police and social workers discussed the importance of making FSP and other working agreements bespoke to the family:

> 'You may have two families with similar incidents, but they're written a bit differently, and that's fine – it's whatever is going to work for that individual family.' (Social worker 04)

By taking individual circumstances into account, it's fairer and more empowering for the family:

> 'You accept that their outlook is possibly different from yours or mine or the attending officer's or what have you – you take into account all these kind of factors…I think it's also about empowerment and allowing them to understand that they, em, that they can achieve these, and they can actually turn their lives around.' (Police 06)

Figure 1. Police officers' perspectives on family safety plans (N=21).

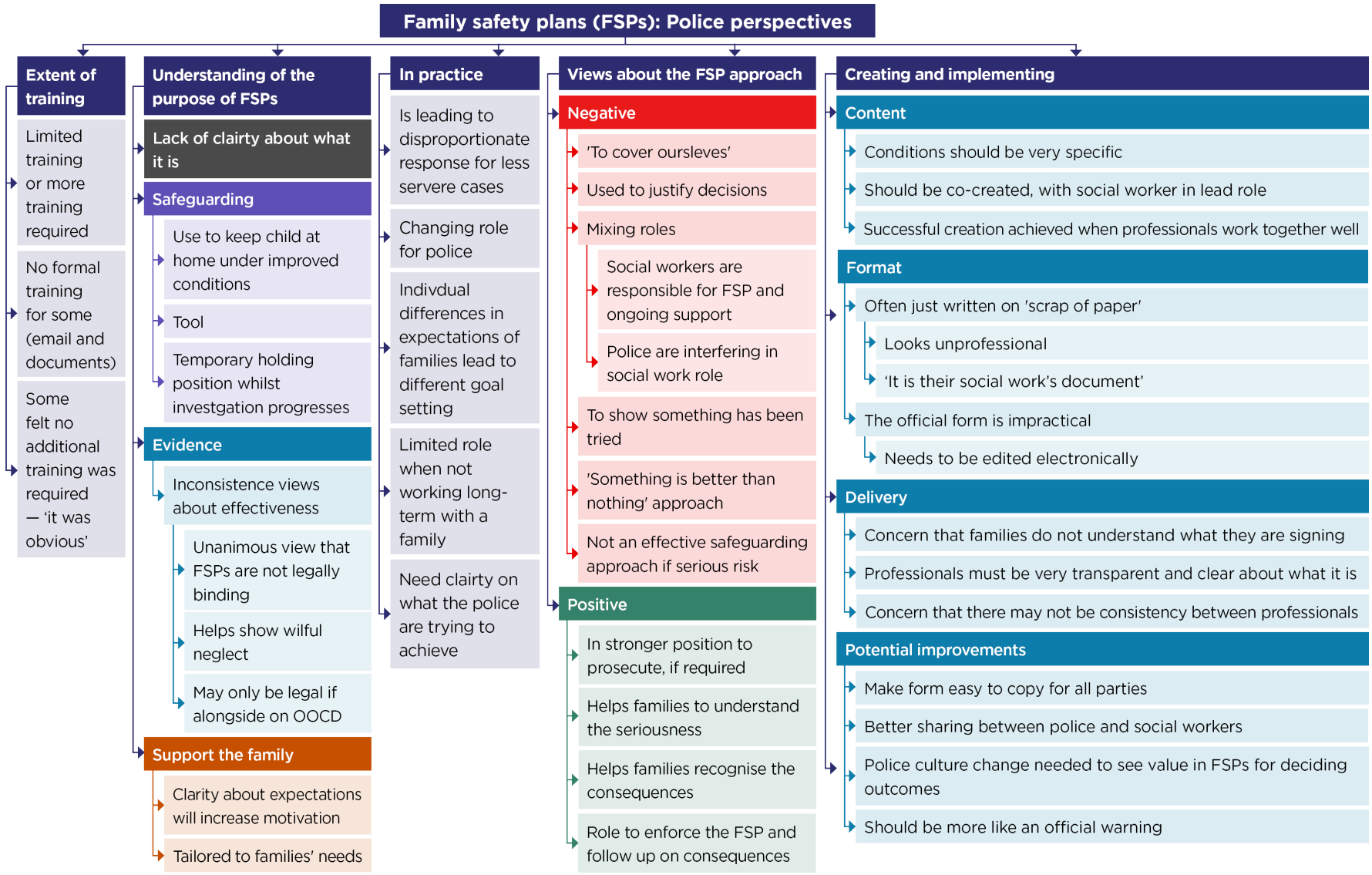
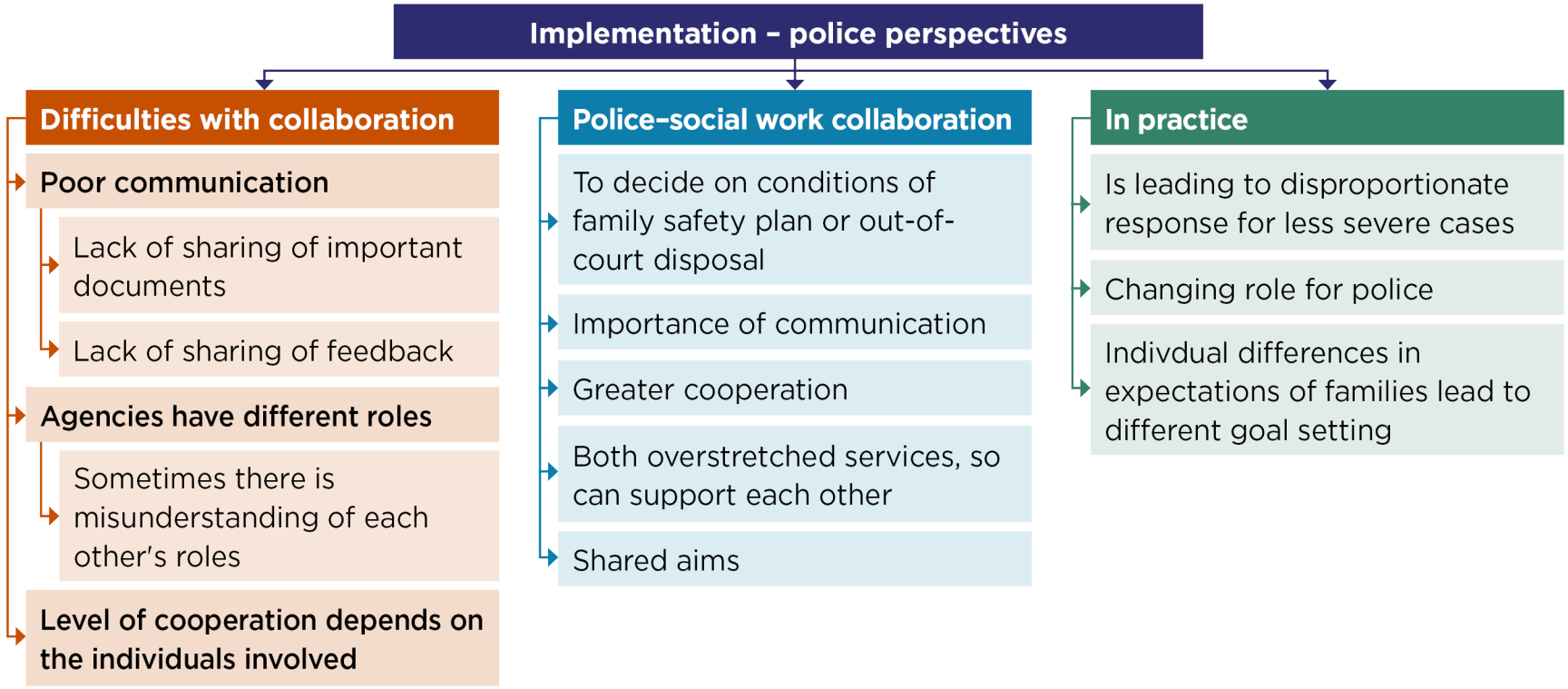


Figure 2. Police officers' perspectives on implementation of family safety plans through joint working with Children's Services (N=21).



5.1.1.2.2. Role of the family

Some professionals, social workers in particular, felt that it was important for parents to be involved in coming up with the conditions that go on the FSP or other working agreement, because 'as long as it's in their words and it's achievable, then… the only reason really that they're not adhering to it is… because they don't want to [laughing]!' (Social worker 01). Many social workers said that they come up with conditions collaboratively and that families have a better chance of sticking to conditions if they come up with them. For example:

> 'We all come together and meet in the middle, if you like, em, not just from us but from them as well, because, clearly, if it's not from them, it's not going to be successful.' (Social worker 08)

In contrast, other social workers said that families are not involved in coming up with conditions for an FSP or other working agreement:

> 'Generally, they're not overly involved because…about deciding what goes in because…they've…most of the time, they're coming from a point where parents aren't recognising or accepting the concerns, they're not doing anything to address them, and it's kind of a… they're being… I can't think of the word…but they're… We're putting those expectations in because we're not seeing that the parents can meet them without a formal agreement for them to do it, so, more often than not, they're not involved in putting a written agreement in place.' (Social worker 02)

Similarly, many police respondents felt that parents are seen as receiving the conditions, rather than contributing to them. For example, one officer noted that:

> 'My understanding is the parents shouldn't have overly a say on that because it's what the professional agency are telling the parents they need to do in order to prevent further professional intervention.' (Police 02)

For some, that was seen as the correct approach:

> ‘I don’t mean to sound too dictatorial here, but I think…I think, by the time we get to that stage, I think you have shown your inability to parent properly, and I think you need to be now told that these are the expectations that are on you.’ (Police 06)

One social worker pointed out that families in joint agency investigations are less likely to be involved in coming up with conditions than when there is single agency work:

> ‘There are some incidents, but probably not cases that involve the police, when we do do them with families, but I’m thinking about cases that we do with the police.’ (Social worker 05).

In terms of involvement of the child in establishing conditions, the majority of both police and social workers emphasised the importance of considering the voice of the child:

> ‘So, whenever you do the joint visits to the children, the team will say to the children, “What do you want to happen? What would you like to happen?” So, the voice of the child is a big thing.’ (Police 04)

However, ways that the child’s views are taken into account may be indirect, which is seen by some respondents as the child partaking in goal setting, but not by others:

> ‘Sometimes we’ll take the information from having the interview with the child, because they’re always asked, “What do you want to happen?” so if they say, “I don’t want mummy to hit me anymore”, that’s in the written agreement. So, although they’re not sat down formally and “We’re going to put this in place, what do you want?” kind of…the information they’ve given us is what informs what goes in the written agreement.’ (Social worker 02)

> ‘I think that would be a dangerous road to go down because a child, at five, six, seven, eight years old, who has grown up in a neglectful environment, that’s his reality, and I think that’s what they get used to, and then do they know…do they know what would be better? You know, if we’ve interviewed the child and the child says, “I want mummy to play with me more” or “I want

> daddy to stop hitting me" or, you know, we can…you know, we can…so, the child is not ignored, but they're not an active part in the…The conditions would take account of what the child said to us maybe in interview, but the child wouldn't really be involved in setting those conditions, I don't think.' (Police 06)

Older children were more likely to have an active role:

> 'From about 12…although it depends on situations about whether some information…it will be safe for the child to hear.' (Social worker 08)

5.1.1.2.3. Format

The format of the FSP form itself was routinely referred to as very difficult to use. It appears from the interviews that many officers and/or social workers do not use it. For example, it needs to be completed electronically, since in paper format there is little or no space for comments to be written. One officer referred to this sometimes being replaced with 'a scrap of paper', commenting that it looked unprofessional but also that they perceived this as the social worker's document and not for them to interfere with.

Some professionals appear to be using another template based on the 'assessment framework for children' (Social worker 06) or using an amended version of the FSP form:

> 'We use this template, yeah, and we just change it as we need to…I mean we take out all of this bit…and we literally have kind of concerns, expectations… (Social worker 05)

There was mention of how sometimes there are exceptions to not being able to use an official form, for example, when there is 'limited time beforehand' (Social worker 02) or when an urgent situation at the home visit means a verbal agreement is set, then followed up by an official document signed by the family:

> 'But if it's urgent…I like to do it verbally, and then put in place…what I like to do with the family is draft it with them and then put it properly together.' (Social worker 08)

> However, there were expectations expressed that social workers would have least use 'letterhead paper, unless there are…real circumstances where…they've gone out late in the evening…they didn't know they were going and they've had to kind of…scrape something together there and then.' (Social worker 05)

Similar differences were noted by police officers, who commented on the range of ways in which social workers construct an FSP. This included handwritten, verbal and written as a formal contract on an established template:

> 'I've seen these written on the back of a piece of paper, just literally handwritten…then signed by the child's social worker and then the parents…others I've seen, they've [the social worker] gone along already with almost a contract, signed and typed.' (Police 15)

The general feeling about the agreement being handwritten is that it doesn't 'display any kind of professionalism at all' (Police 05). One social worker commented on the use of technology in writing up the FSP (on a tablet), but that this is not exercised by everyone just yet:

> 'We do have technology to type it up and get it signed on the…tablet, but not everyone's great at doing that.' (Social worker 04)

A recurring theme through these comments was the ownership of the form by Children's Services, as highlighted above.

Finally, both police and social workers emphasised the need to take parental abilities into account:

> 'And, bearing in mind that not all of the people we go to see read and write, so we do need to be, you know, open and honest and really transparent with them as to why we're now entered their lives.' (Police 05)

One social worker took issue with the fact that the new FSP form has professional language on which they may not understand, particularly in a stressful situation:

> ‘Look, you’ve got basic care, ensuring safety, access to education…Already, this…this is…is professional language, isn’t it? It’s not families’ language. When you’re in a situation where you’ve got a Section 47 and you’ve got both the Police and Children’s Services involved, you’re in a stressful situation for the family already.’ (Social worker 01)

5.1.1.2.4. Delivery

Concerns about the delivery of the intervention were expressed by some officers, perhaps linked to the lack of clarity. As well as the inconsistencies in goal setting that are referred to above, it was felt by some that the process is not clear for families and they often do not know what they are signing. This is potentially a very serious concern and needs additional investigation.

> ‘If you’ve got police and social workers sat in your front room, you’re not…your anxiety is going to be quite high and you’re not necessarily going to take on board everything that’s been said and hear the bits you think you need to hear.’ (Social worker 02)

> ‘Sometimes, they’re like rabbit in the headlights, when we turn up, Children’s Services turn up, and sometimes there’s three or four of us round at someone’s house, and they will just sign something, but, actually they…they can’t remember what they’ve signed for, and it’s like, “Well, I’ve signed this bit of paper, but what does it mean? You’re going to come back and take my children?” Well, no, it doesn’t mean that at all.’ (Police 05)

In these situations, it is important that professionals clearly explain to parents what they need to know. However, there is a balance because:

> ‘You can’t give too much information at once, erm, because you’ll overwhelm them, so you have to prioritise. You have to think: what are the most important things we need to deal with immediately?’ (Social worker 04)

One police officer said they feel that social workers do a good job of explaining things to parents:

> ‘I think so, yeah. It’s normally explained really well by Children’s Services. They’re normally, you know, they stay behind after us if they need to and explain it all thoroughly.’ (Police 17)

However, when the police are responsible for explaining to families, one officer was unsure whether their explanations were consistent with their colleagues:

> ‘I would like to think so, yeah. I think the way I explain it, the way I explain it is always consistent, but I can’t say, if I explain it, it would be the same as my colleague sat down there. Because we’re not working together all the time, you don’t…you don’t know.’ (Police 05)

In terms of delivering the FSP and a copy of it to families, many professionals said that an FSP or other working agreement would typically be put in place on the initial joint visit:

> ‘This will go in place on the initial visit. So, the first time Children’s Services and the police respond, written agreement, straight away, on the doorstep before we leave.’ (Police 21)

However, other professionals highlighted some confusion around whether it should be done straight away with families at that visit, or if they should go away and write it up:

> ‘What I’m interested in, practically and logistically, is actually, do you do one of these there and then with the family on your tablet, or do you get the information, go away, collate it, and then do it a day or two or even a week later?’ (Social worker 03)

Some social workers try to do both of these things for a working agreement, potentially due to confusion and to cover all bases:

> ‘I will usually…do it on a handwritten bit of paper, A4 lined paper or whatever, em, in a very informal way, to address the matter that night, and then, day two, three, four, five days later, you’ll physically write it up on a letter-headed bit of paper and get parents to re-sign. They get a copy and we get a copy, em, and do it that way. That’s the way I do it.’ (Social worker 03)

5.1.1.2.5. Potential improvements

The suggestions for improvement related to the training and the form itself. An appropriate form that can be completed with pen or electronically, as well as easy to copy for all parties, seem to be the preferred route. As one officer noted, the impact of the FSP is reduced if it is not completed properly:

> 'We'll phone them later on to be like, "right, so has the working agreement been issued?" "Yeah…did a verbal one with them." "What?!" How is that a working agreement? …You've basically given them words of advice – I could have done that…I just think it should be a document you have on you, not one that you need to go and print off, not one that you're going to write on a piece of paper, and not one you're going to do verbally, because I think it null and voids the impact of one.' (Police 02)

However, one social worker noted that formal FSPs seem to be becoming more common than they used to be:

> 'I think teams…are much better at, kind of, taking stuff out with them or being prepared…we know we're going to ask them to sign a working agreement before you even go, so you can actually just jot that up and tweak it when we're there.' (Social worker 05)

For one social worker, the new form is less likely to be completed on time:

> 'We used to have a document that used to be useful there and then. You can draft the safety plan straightaway there and then…Before, that's how it used to be. But…this new safety plan came into place and…it is a bit more in-depth, so…you can't just go and do it straight away anymore…' (Social worker 08)

Furthermore, it was not uncommon in the interviews to find that officers and social workers did not recognise the term 'family safety plan', sometimes referring to a 'working agreement' (which sometimes was the FSP and sometimes was another document). Hence, an easier-to-use form with greater visibility and additional training may affect the uptake. In addition, there were also queries as to whether police

response that mimicked an official warning rather than an OOCD would be more appropriate.

5.1.1.3. Intended and unintended consequences of the intervention

Concern about the overuse of Outcome 20 (expressed also by the Scrutiny Panel) was a key driver in the development of this intervention. Data from Hampshire Constabulary indicates that between November 2017 and January 2020, eight review meetings took place related to 76 cases where Outcome 20 had been recorded. Of these 76, decisions were made about 71 cases. In total, the panel agreed with Outcome 20 decisions in 34 cases (47.9%), did not agree in 36 cases (50.7%) and could not agree in one case (1.4%). Over the eight meetings, the percentage of cases recorded as an inappropriate use of Outcome 20 ranged from 22% to 90% (22%, 30%, 33%, 50%, 57%, 60%, 67%, 90%). Across the meetings, at times it was suggested that Outcome 15 would have been more appropriate (there was insufficient evidence to proceed, but the victim supported prosecution). It was noted in later meetings that Outcome 21 was being used to a greater extent (but not necessarily appropriately), and sometimes it was suggested that cases should be revisited.

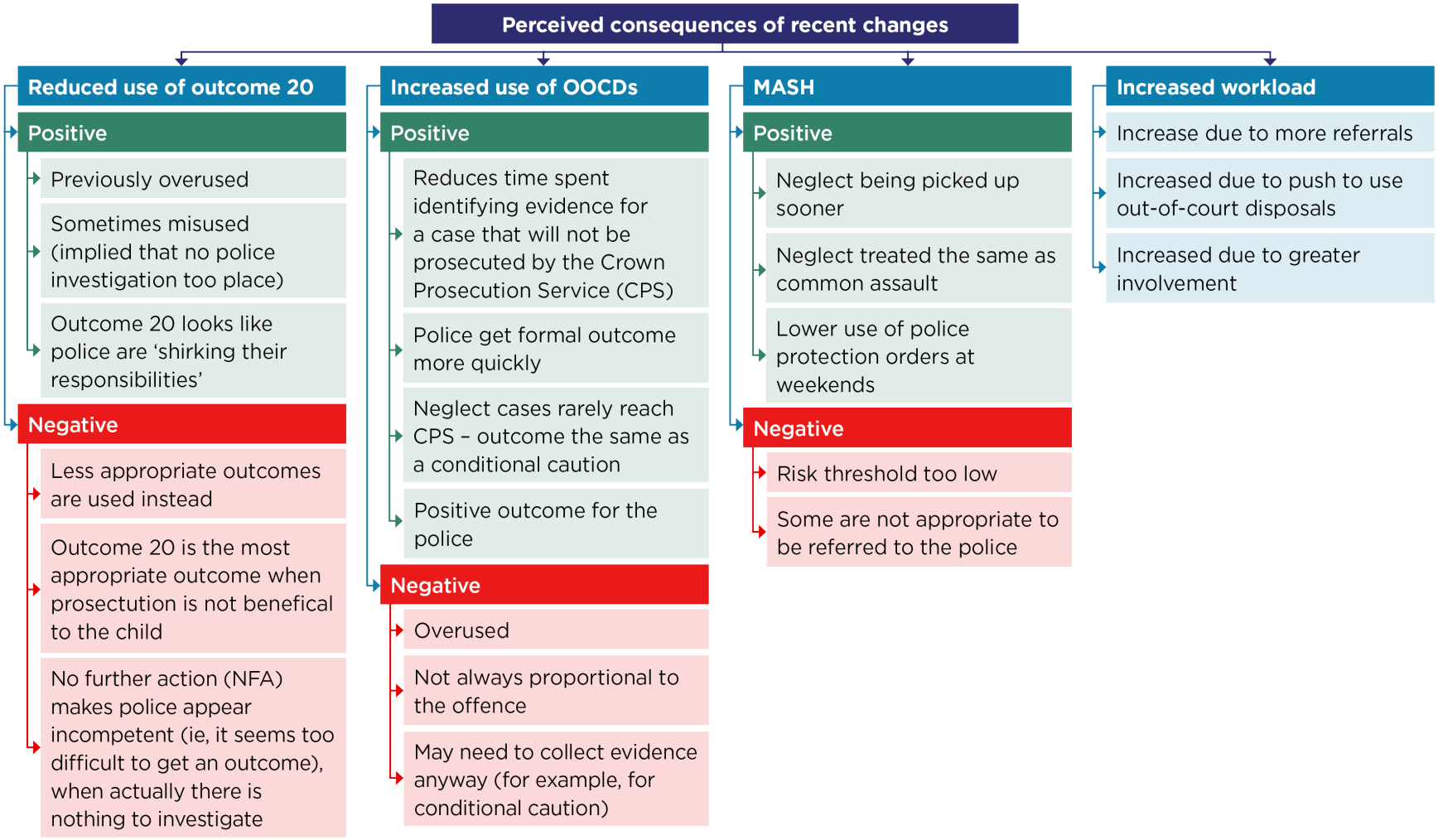
As well as the Outcome 20 review, police officers spoke about their perceptions of the consequences of FSPs and the wider changes in terms of policing neglect (see Figure 3), but also highlighted the changes in risk thresholds (Figure 4; see section 5.2.1 below). There was a unanimous sense from many officers and social workers that this has led to an increased workload, due to increased rates of referrals coming through MASH, increased use of OOCDs and increased time spent with families. This related to the broader changes, and there were more mixed views in relation to the use of the actual FSP form. However, there was a substantial proportion of respondents who either were not using it or believed that others were not using it.

The broader changes in decision-making and processes were also discussed by officers in terms of both positive and negative outcomes, and views were sometimes contradictory. For example, the reduction in Outcome 20 was seen positively by those who felt it had been overused or misused, or that it implied the police were ‘shirking their responsibilities’. However, others felt that sometimes it was the most

appropriate outcome and had been replaced by other, less appropriate outcomes. An extension of that was the expressed view that the use of OOCDs was not always proportional to the offence (ie, that it was disproportionally harsh) and was now being overused. Figure 5, which shows perceptions of the impact on families, also highlights this point and will be discussed further below.

Overall, police officer respondents often welcomed the increased focus on, and recognition of, the neglect of children. However, this went alongside a concern that the risk threshold had been lowered to the extent that police were receiving inappropriate referrals that were perhaps not ‘serious’ enough for police involvement and would more appropriately be dealt with by social care. Combined with a reduced option to use Outcome 20 and increased push to use OOCDs, this was seen by some as an excessive response to some cases.

Figure 3. Police officers' perceptions of positive and negative consequences from the introduction of family safety plans (N=21).



5.2. Process and mechanisms of change

The proposed process and mechanisms for change included changes to risk thresholds[23] and decision-making processes, as well as engagement with families.

5.2.1. Risk thresholds and process decisions

Figure 4 shows police officers' reflections on changes to risk thresholds and decision making within the MASH and the CAIT units. As noted above, there were concerns about the lowered risk threshold and some queries about the appropriateness of all referrals. Officers felt that there had been a move away from receiving only more serious cases (including repeat referrals) to, sometimes, relatively minor cases that felt more appropriate for additional family support from social workers. As well as the increased time taken on cases, there was concern for families that this may be disproportionate.

While some questioned whether MASH panels had previously had good decision-making processes for cases of neglect, officers spoke of a 'push' to list many more cases of neglect as Section 47 (child protection) issues, and highlighted that all Section 47 cases came to CAITs for review (see Appendix 9.6 for process map).

5.2.2. Engagement of families

The engagement of families in the process, along with clarity of expectations and greater support, was seen as a key driver in the mechanisms for change.

Figure 5 highlights police officers' perceptions of families' level of engagement. Many felt that most families respond positively to FSPs and knowing what is required in order to keep their children at home with them. It was seen as more informal than an OOCD but could be a positive tool. Other officers noted that some families saw it as a way to get social workers 'out of the door' or were reluctant to sign it. In contrast, officers felt that OOCDs were viewed as formal, as a criminal record (because it would show up on an enhanced DBS check), and led to worry among parents that it might affect their employability. The different police and public perceptions of OOCDs were noted by some police officers, who felt that OOCDs are seen by police

[23] See footnote 1 for more detail about risk thresholds.

as a ‘non-criminal’ route, but the officers felt that this view is not shared by families. Similar views were expressed by social workers.

Figure 4. Police officers’ reports of changes in risk thresholds for cases of neglect within multi-agency safeguarding hubs (MASHs) and policing (N=21).

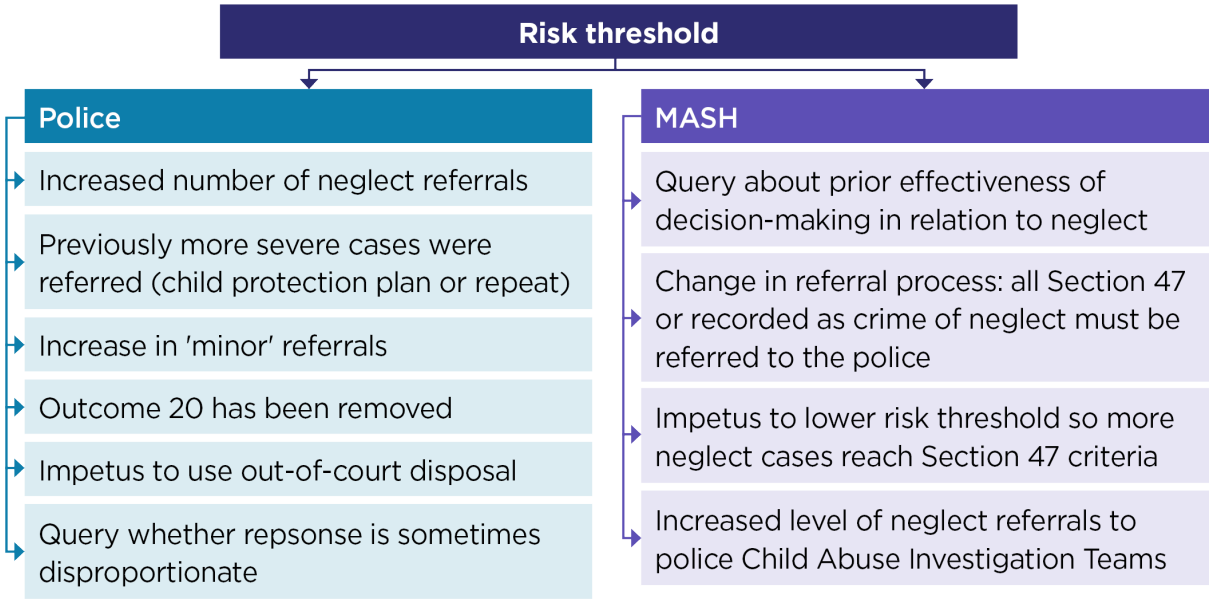
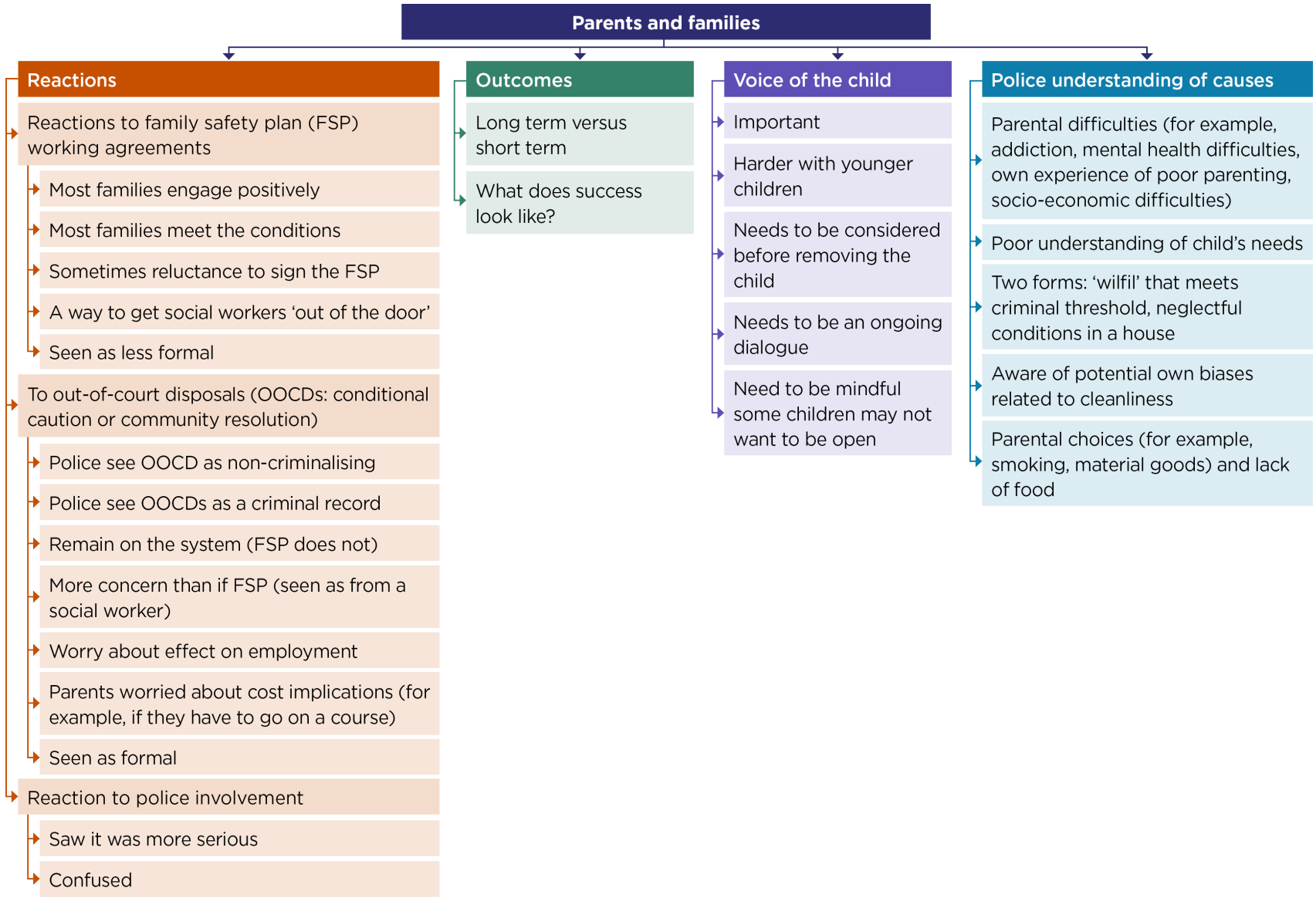


Figure 5. Police officers' perceptions of the experiences of parents and families in the new approaches to neglect (N=21).



5.3. Outcomes

5.3.1. Quantitative outcome data

The main aim of this analysis was to identify the effect of the intervention on:

- the use of Outcome 20[24]
- the use of community resolution
- the outcomes on children by looking at the CPP referrals three and six months after the index neglect referral in July to September

Descriptive statistics of both samples are provided (the intervention group from 2019 and the historical sample from 2017), with comparisons of type of neglect recorded (severity grade) and key family characteristics. Pre-post analyses were conducted. Finally, the average treatment effect was calculated using PSM for the outcome variables (use of Outcome 20, the use of community resolution – a form of OOCD – and the CPP referrals three and six months after the index referral. The findings are presented for a pooled sample (aggregated across all three intervention areas and then for subsamples by area and by history of CPP for each child).

5.3.1.1. Description of 2019 CPP data

There were a total of 201 children included in the data. Of these, 51 (25%) children had a CPP at least once in the three years before the index neglect referral (July to September 2019). Of those children with a CPP, 43 (84%) were on the plan once and eight (16%) were on twice, for an average of 11 months (range 1-22 months). The majority of these 51 children did not have a further CPP following the index referral (n=43, 84%) compared to eight children (16%) who were again subject of a CPP in the three-month follow-up period. Of the 150 (75%) children who did not have a prior CPP, around a quarter (n=39, 26%) of them became the subject of a CPP within three months of our sample period (see Table 3).

[24] A reduction in the use of Outcome 20 was listed as a key outcome measure for the intervention and, partly to support that, a review of Outcome 20 decisions was made by a strategy board in Hampshire.

5.3.1.2. Description of 2017 CPP data

There were 193 children in the data from this period. Similar to 2019, 44 (23%) children had a CPP at least once in the three years before the index neglect referral (July to September 2017). Of those children with a CPP, 35 (80%) were on the plan once, eight (18%) were on twice and one child (2%) was on three times, for an average of 12 months (range 1-21 months). The majority of these 44 children did not have a further CPP after the index referral (n=31, 70%) compared to 13 children (30%) who were again subject of a CPP in the three-month follow-up period (one of whom had this occur twice in three months).

Of the 149 (77%) children who were not subject to a CPP before the index referral, about half (n=73, 49%) became the subject of a CPP within three months of our sample period (see Table 3).

The percentage of children who were on the CPP prior to the index referral was 25% and 23.1%, respectively, for 2019 and 2017. However, CPP in follow-up was higher in 2017 compared to 2019, irrespective of whether the child was previously on the CPP or not.

Table 3. Rates of child protection plan (CPP) for child prior to the index referral (July to September) and in the three-month follow-up period (October to December).

	2019 (N=201)		**2017 (N=193)**	
	n	**%**	**n**	**%**
Prior CPP	51	25.4	44	22.8
Prior CPP plus CPP in follow-up	8/51	15.7	13/44	29.5
No prior CPP	150	74.6	149	77.2
No prior CPP but CPP in follow-up	39/150	26.0	73/149	49.0

5.3.1.3. Frequency of grade of neglect and family difficulties

Neglect cases investigated varied by the severity of neglect and difficulties within families. Most cases had been graded to show the level of response required according to perceived level of risk[25]. For example, Grade A is seen as requiring specialist skills within the CAIT and a partnership approach due to higher perceived risk. It can be seen from Table 4 that, in 2019, a majority (89%) of neglect cases were graded as Grade A and very few were graded as B, C or D. However, in 2017, approximately one third (34%) were Grade D, which has the use of Outcome 20 as a main outcome. Hence from 2017 to 2019, there was a significant shift in the reduction in use of Grade D and increase in Grade A, indicating that neglect is being viewed more seriously in 2019 (and referred to CAIT), compared to 2017.

In terms of key family difficulties (Table 5), unsurprisingly, poor living conditions were noted in most cases in both years, followed by physical assault and drinking.

Table 4. Grading of neglect cases (number and percentage) in 2019 and 2017.

	2019 (N=157)		**2017 (N=151)**	
	n	**%**	**n**	**%**
Grade A	145	92.4	90	59.6
Grade B	8	5.1	3	2.0
Grade C	1	0.6	4	2.6
Grade D*	3	1.9	54	35.8

[25] Grade A: Investigations are likely to require officers with specialist child investigation skills and training (CAIT). Necessarily requires a partnership approach.
Grade B: CAIT may be allocated investigations that are not graded A but require an initial response by two or more partner agencies and are serious or complex, with the child being under 13 years old.
Grade C: Allocated to the appropriate Safeguarding Team and/or the local neighbourhood team, depending on the level of risk. A criminal investigation is not required based on the information known at the time, or may be required but more information is needed to determine the nature and seriousness of the offence, or a care home is the repeat premise or location. In all cases, a police response is required to ensure the safeguarding of a child or children.
Grade D: Allocated to the appropriate partner agency. Such grading will, in the majority of cases, result in Outcome 20.

* Such grading will, in the majority of cases, result in Outcome 20.

Table 5. Presence of family difficulties* (number and percentage) in 2019 and 2017.

	2019 (N=201)		**2017 (N=193)**	
	n	**%**	**n**	**%**
Poor living conditions	70	34.8	66	34.2
Physical assault	52	25.9	27	14.0
Excessive alcohol	32	15.9	37	19.2
Medical problems	25	12.4	24	12.4
Drugs	22	10.9	26	13.5
Domestic violence	12	6.0	11	5.7
Mental health	7	3.5	5	2.6

* Note that more than one difficulty may be reported for a family.

5.3.1.4. Frequency of outcome measures

Table 6 reports the averages of the outcome measures (out of total outcomes in a given time period), specifically the mean number of cases that resulted in Outcome 20, where a suspect received a community resolution, and how many children became the subject of a CPP referral within three and six months.

Table 6. Outcome data (2017 and 2019). CPP = child protection plan.

	July to September 2017			July to September 2019			Difference	t	p
	Mean	**SD**	**N**	**Mean**	**SD**	**N**			
Outcome 20	0.48	0.50	193	0.005	0.07	201	-0.47*	13.22	0.00
Community resolution	0	0	193	0.11	0.02	201	0.11*	-4.86	0.00
CPP after 3 months	0.45	0.50	193	0.23	0.42	201	-0.21*	4.55	0.00
CPP after 6 months	0.45	0.04	193	0.25	0.48	201	-0.19*	4.07	0.00

* Statistically significant (at least 5% level).

As can be seen, the differences across the intervention and historical control samples are statistically significant across all outcomes, with reduced use of Outcome 20, increased use of CRs and reduced rate of a child being on a CPP. These findings suggest that, in at least some ways, the broader intervention is having the planned effect, albeit that these need to be contextualised by the qualitative data and concerns about some elements (for example, appropriateness, excessive response). However, the treatment and control group may not be statistically comparable. A PSM analysis was conducted to address this possibility.

5.3.1.5. Propensity score matching

The intervention and control groups were matched on the following covariates:

- age of the child
- gender of the child
- presence of the multiple suspects per child
- if the child was on the CPP in the past three years
- adult with excessive alcohol consumption

- drugs marker
- domestic violence marker
- physical assault marker
- poor living conditions marker
- medical difficulties marker

We started by matching the treatment and control group samples and then checking if matching made differences between them insignificant. Table 7 below shows the descriptive statistics of the matched and unmatched samples.

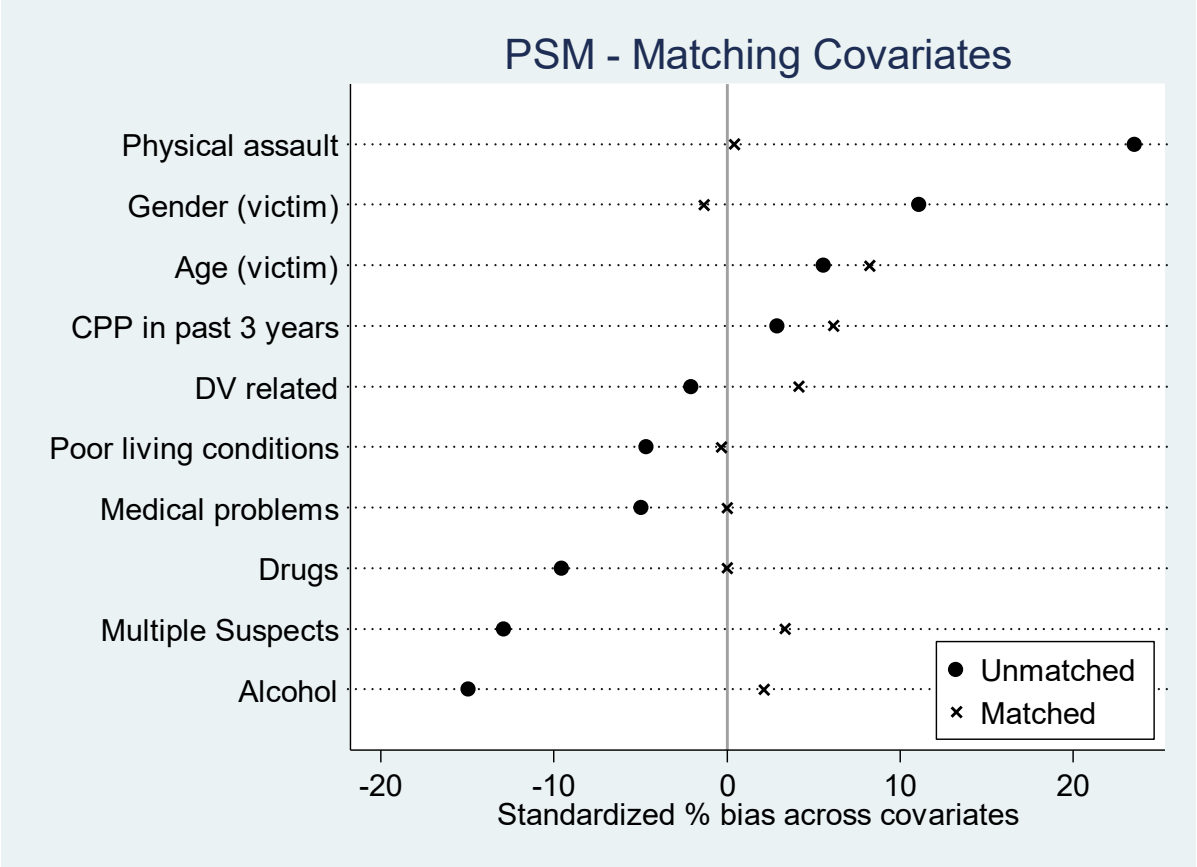
Table 7. Descriptive statistics of matched and unmatched samples. CPP = child protection plan.

	Unmatched or matched	**Mean**		**% bias**	**T-test**	
		Treated	**Control**		**t**	**p > |t|**
Physical assault	Unmatched	0.25	0.16	23.6	2.24	0.03
	Matched	0.25	0.25	0.4	0.01	0.97
Gender (victim)	Unmatched	1.57	1.51	11.1	1.07	0.29
	Matched	1.57	1.57	-1.3	-0.13	0.89
Age (victim)	Unmatched	6.55	6.31	5.6	0.54	0.59
	Matched	6.53	6.17	8.2	0.81	0.42
CPP in past 3 years	Unmatched	0.25	0.24	2.	0.28	0.78
	Matched	0.25	0.22	6.2	0.63	0.53
Related to domestic violence	Unmatched	0.06	0.06	-2.1	-0.20	0.84
	Matched	0.06	0.05	4.1	0.44	0.66
Poor living conditions	Unmatched	0.35	0.37	-4.6	-0.45	0.66
	Matched	0.35	0.35	-0.3	-0.03	0.97
Medical problems	Unmatched	0.12	0.14	-4.9	-0.48	0.63

	Unmatched or matched	**Mean**		**% bias**	**T-test**	
		Treated	**Control**		**t**	**p > |t|**
	Matched	0.13	0.13	0.0	0.00	1.00
Drugs	Unmatched	0.11	0.14	-9.6	-0.92	0.36
	Matched	0.11	0.11	0.0	0.00	1.00
Multiple suspects	Unmatched	0.25	0.31	-12.9	-1.24	0.22
	Matched	0.26	0.24	3.3	0.35	0.73
Alcohol	Unmatched	0.16	0.22	-14.9	-1.44	0.15
	Matched	0.16	0.16	2.1	0.23	0.82

We can see from Table 7 that matching led to both groups (treatment and control) having more similar characteristics. Means of matched and unmatched groups are presented on the left of the table. We can see how close the characteristics between treatment and control groups after the matching are. Standardised bias after matching is under 10% for all covariates and t-tests demonstrate that all the differences after matching were not significant (see Figure 6).

Figure 6. Propensity score matching (PSM) matching covariates illustration. DV = domestic violence.



After matching intervention and control groups, a nearest-neighbour matching method[26] with replacement with common support[27] was used to calculate the average treatment effect of the use of Outcome 20, the use of community resolution and the CPP referrals three and six months after neglect was reported. There were 200 matched pairs found and results are reported in Table 8 below.

[26] There are alternative matching criteria, but we have chosen one-to-one nearest neighbour matching with replacement to get the closest matches possible to our treatment group. Sensitivity analysis was done with caliper (0.01) matching method and results remained the same.
[27] This option imposes a common support by dropping treatment observations whose propensity score is higher than the maximum or less than the minimum of the controls.

Table 8. Propensity score matching (PSM) for Outcome 20, community resolution and child protection plan (CPP) in the three-month follow-up: average intervention effect.

Variable	Sample	Treated	Control	Difference	SE	T-stats
Outcome 20	Before matching	0.005	0.46	-0.45	0.04	-12.73*
	After matching	0.005	0.44	-0.43	0.05	-8.88*
Community resolution	Before matching	0.11	0	0.11	0.02	4.56*
	After matching	0.11	0	0.11	0.02	4.96*
CPP in 3 months	Before matching	0.23	0.45	-0.22	0.05	-4.57*
	After matching	0.24	0.44	-0.20	0.06	-3.55*
CPP in 6 months	Before matching	0.25	0.45	-0.20	0.05	-4.10*
	After matching	0.26	0.44	-0.18	0.06	-3.17*

* Statistically significant (at least 5% level).

Before matching, the rate of Outcome 20s in the intervention group was 1% and the control group was 46%. After matching, it was 44%. The difference in Outcome 20 between intervention and control groups was 43 percentage points (decrease) and was statistically significant.

Regarding the OOCDs (community resolution), there were no instances of this outcome in the control group either before or after matching. In contrast, the rate in the intervention group was 11% before matching and 11% after matching. Therefore, the difference in the use of community resolution after matching was an increase of 11 percentage points, which was statistically significant.

Finally, with respect to CPPs in the three-month follow-up period, the rates before matching were 23% for the intervention group and 45% for the control group. After matching, these were 24% and 44% respectively. The difference of 20 percentage

points is statistically significant, indicating that the intervention led to the statistically significant reduction in the CPP referrals three months after the neglect case was investigated, which is equivalent to around 40 fewer CPP referrals as a result from three months of index offences. CPP referrals showed significant reductions within six months as well, with the intervention leading to 18% (roughly 36) fewer cases being referred. CPP referrals are the most important outcome measure in this analysis, as they have the biggest impact on children's lives (of those it was possible to measure). CPP referrals should ideally be avoided through early intervention and providing support to help families before children have to be put on protection plans.

In summary, all three of the outcome measures showed statistically significant change in the desired direction. The biggest change was the reduction in use of Outcome 20 but, arguably, the most important change was the reduction in the use of CPPs.

Having compared all four regions together, a second set of analysis was conducted to establish whether similar results hold across different regions (specifically, if there were different findings for Southampton, where the FSP was not formally adopted but there was a move to increase the use of OOCDs). For Southampton, matching was done on the following covariates:

- age of the child
- gender of the child
- drugs marker
- poor living conditions marker

Table 9 below and Figure 7 present descriptive statistics and illustration of matching. In all, 35 matching pairs were identified (see Table 10 below).

Table 9. Descriptive statistics of matched and unmatched samples (Southampton only).

	Unmatched or matched	**Mean**		**% bias**	**t-test**	
		Treated	**Control**		**t**	**p > |t|**
Gender (victim)	Unmatched	1.63	1.42	42.6	1.68	0.1
	Matched	1.54	1.53	1.9	0.08	0.94
Age (victim)	Unmatched	7.19	6.45	16.4	0.65	0.52
	Matched	6.31	6.01	6.9	0.29	0.77
Poor living conditions	Unmatched	0.37	0.58	-42.6	-1.68	0.1
	Matched	0.46	0.43	5.8	0.24	0.81
Drugs	Unmatched	0.05	0.17	-38.9	-1.66	0.10
	Matched	0.06	0.08	-6.2	-0.32	0.75

Figure 7. Propensity score matching (PSM) matching covariates illustration for Southampton only.

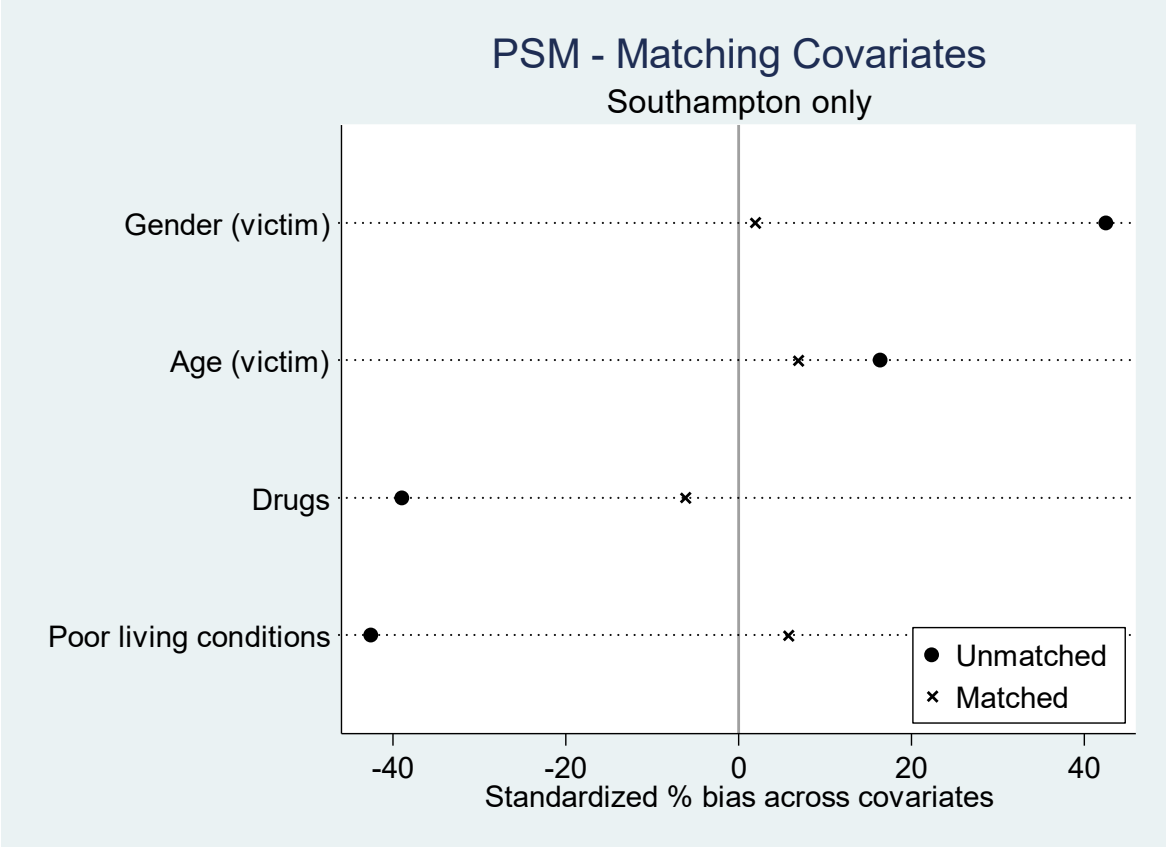


Table 10. Propensity score matching for Outcome 20, community resolution and child protection plan (CPP) in the three-month follow-up in Southampton: average intervention effect.

Variable	Sample	Treated	Control	Difference	SE	T-stats
Outcome 20	Before matching	0	0.17	-0.17	0.06	-2.89*
	After matching	0	0.26	-0.26	0.09	-2.78*
Community resolution	Before matching	0.12	0	0.12	0.07	1.75
	After matching	0.14	0	0.14	0.06	2.38*
CPP in 3 months	Before matching	0.14	0.42	-0.28	0.10	-2.64*

Variable	Sample	Treated	Control	Difference	SE	T-stats
	After matching	0.14	0.44	-0.30	0.14	-2.17*
CPP in 6 months	Before matching	0.14	0.42	-0.28	0.10	-2.64*
	After matching	0.14	0.44	-0.30	0.14	-2.17*

* Statistically significant (at least 5% level).

In Southampton (Table 10, above), Outcome 20 results are consistent with the main findings and there is a statistically significant difference of 26 percentage points after matching. The use of the community resolution increased by 14 percentage points (after matching) and the result is statistically significant. Before matching, CPP referrals after three months were 14 percentage points for the intervention group and 42 percentage points for the control group. After matching, these were 14% and 44% respectively. This difference of 30 percentage points was statistically significant. The difference in CPP referrals between treatment and control after matching was 30 percentage points after six months' follow-up as well.

For the rest of Hampshire, matching was done on the following covariates:

- age of the child
- gender of the child
- multiple suspects
- poor living conditions marker
- physical assault marker

Table 11 below and Figure 8 present descriptive statistics and illustration of matching. There were 158 matching pairs identified and results are presented in Table 12 below.

Table 11. Descriptive statistics of matched and unmatched samples (Hampshire, excluding Southampton).

	Unmatched or matched	**Mean**		**% bias**	**T-test**	
		Treated	**Control**		**t**	**p > |t|**
Physical assault	Unmatched	0.27	0.18	2.9	0.25	0.80
	Matched	0.27	0.27	0.0	0.00	1.00
Gender (victim)	Unmatched	1.55	1.53	4.0	0.35	0.73
	Matched	1.55	1.55	0.0	-0.00	1.00
Age (victim)	Unmatched	6.38	6.25	2.9	0.25	0.80
	Matched	6.38	6.19	4.3	0.41	0.68
Poor living conditions	Unmatched	0.34	0.34	0.3	0.03	0.98
	Matched	0.34	0.34	0.0	0.00	1.00
Multiple suspects	Unmatched	0.27	0.34	-16.2	-1.41	0.16
	Matched	0.27	0.27	0.0	0.00	1.00

Figure 8. Propensity score matching (PSM) matching covariates illustration for Hampshire (excluding Southampton).

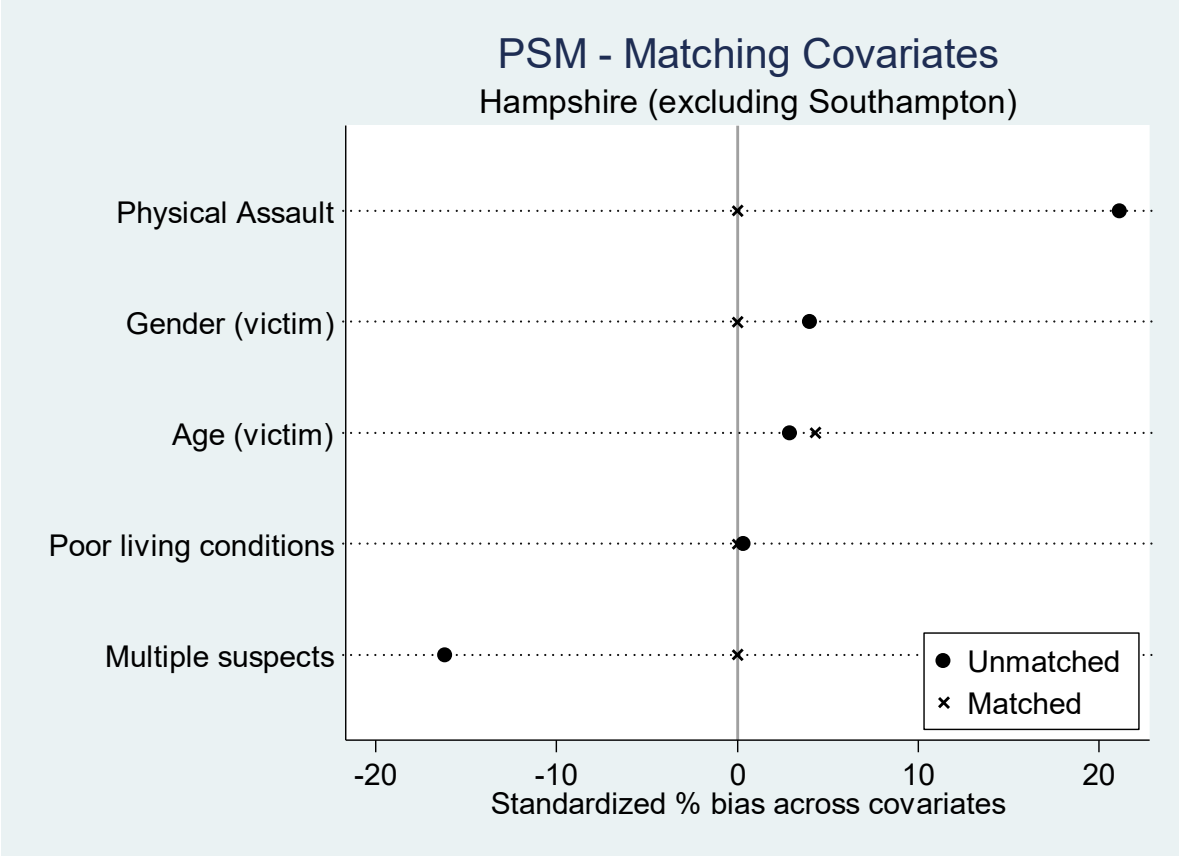


Table 12. Propensity score matching for Outcome 20, community resolution and child protection plan (CPP) in the three-month follow-up in Hampshire, Portsmouth and Isle of Wight: average intervention effect.

Variable	Sample	Treated	Control	Difference	SE	T-stats
Outcome 20	Before matching	0.01	0.51	-0.50	0.04	-12.46*
	After matching	0.01	0.54	-0.53	0.06	-9.46*
Community resolution	Before matching	0.11	0	0.11	0.03	4.20*
	After matching	0.11	0	0.11	0.02	4.35*
CPP in 3 months	Before matching	0.26	0.46	-0.20	0.05	-2.77*

Variable	Sample	Treated	Control	Difference	SE	T-stats
	After matching	0.25	0.40	-0.14	0.05	-2.19*
CPP in 6 months	Before matching	0.28	0.46	-0.18	0.05	-3.26*
	After matching	0.28	0.40	-0.12	0.07	-1.79

* Statistically significant (at least 5% level).

For the rest of the Hampshire Constabulary regions (Hampshire, Portsmouth and Isle of Wight), the use of Outcome 20 was 1% before and after matching for the intervention group and 51% before matching and 54% after matching for the control group. The difference after matching of 53 percentage points was statistically significant. The use of community resolution was 11% before and after matching for the intervention group and 0% for the control group. This difference of 11 percentage points was statistically significant. CPP referrals in the three-month follow-up before matching was 26% for the intervention group and 46% for the control group. After matching, this was 25% and 40% respectively. The difference of 14 percentage points was statistically significant, indicating that the intervention led to a statistically significant reduction in the CPP referrals in the three-month follow-up period. The result remained very similar at the six-month follow-up but the difference after matching was not significant. Overall, the results across all regions are very similar and most of the differences are statistically significant. There was a significant reduction in the use of Outcome 20 across all areas, significant increase in the use of community resolution and significant reduction in CPP referrals. In conclusion, there were significant changes in the three outcomes analysed, suggesting that the intervention was having an effect. However, this change included the Southampton region, which was not using officially using the FSP (although a query remains about the amount of ‘drift’ between regions).

5.3.2. Economic evaluation

The quantitative impact evaluation provides some indicators of positive impact of the intervention but, with only three and six months of post-intervention data at the time of writing the report, extrapolating to understanding the lifetime reduction in neglect cases would be based on considerable assumptions. In addition, only three

outcomes were considered. Thus, while it is not possible to estimate quantitative measures of the benefits, we can work out illustrative examples that consider reductions in neglect and what benefits that might lead to.

Of the changes in three outcomes that occurred in the desired direction (decrease of Outcome 20 and CPP, increase in use of OOCDs), we could potentially use the reduction in CPP referrals as a proxy of lowered neglect, although that is far from perfect. Importantly, the decrease over three months cannot be taken to suggest that such a reduction would continue over a victim's lifecycle, although this can be taken as a best-case scenario. Our statistical analysis shows that there have been 20% fewer CPP referrals in the three-month follow-up period[28], which works out to around 40 fewer children. An illustrative example of the potential cost savings is provided below, although this is with the caveat that no clear estimates of the costs associated with implementing the programme were included. Those costs would include such things as additional police time (in meetings with the family, issuing conditional cautions, higher workload, liaising with Children's Services), as well as the need to provide interventions to support change (for example, parenting classes, alcohol and/or drug programmes).

Based on national data[29], the average total cost of case management processed for different types of children in need over a six-month time period are known to be as follows:

- £1,864 for children (7+ years) who have a CPP
- £3,069 for children aged 6 years or under who have a CPP
- £192 unit cost to social care process ongoing support if CPP (non-London)
- £263 for children aged 6 years or under and on a CPP (non-London)
- £186 for initial contact and assessments cost, identified as unit cost to social care initial contact and referral (non-London)
    - £207 if no further action (non-London)

[28] The data for six months shows a similar effect.
[29] Holmes L et al. (2010). **Extension of the cost calculator to include cost calculations for all children in need**. Report to the Department for Children's Schools and Families. Loughborough: Centre for Child and Family Research, Loughborough University.

- £271 unit cost to social care initial assessment standard cost (non-London)
    - £334 if child previously known to social care

Hence, an estimate of reduced costs through a reduction in 40 cases could be calculated as:

- 40 cases of initial contact and referral (at £186 each) = £7,440
- 40 initial assessments (calculated using standard cost of £271 each) = £10,840
- 40 times one month ongoing support (at the rate of (£192 + £263) / 2) = £9,100
- Total cost = **£27,380**

These would be crude proxies for the cost savings from the intervention to date, but with the caveats above and including the need to consider the findings within the wider findings from qualitative data.

If these represent (permanent) reductions in neglect, the benefits would be enormous, as each case of non-fatal neglect is estimated to cost £89,390 (95% uncertainty interval £44,896 to £145,508). Data from six months' follow-up shows that there are 18% less referrals, while there were 20% less after three months when compared to the control group, suggesting fairly stable reductions over time.

Taking the same assumptions and assuming that each quarter there will be around 40 fewer cases referred to the CPP as a result of this intervention, an illustration of potential cost savings over one year for local authorities in Hampshire can be calculated:

- 40 fewer cases per quarter being referred to the CPP, making it 160 in total (assuming the same success rate)
- Initial contact and referral costs: 160 at £186 each = £29,760
- Initial assessment costs: 160 at £271 each = £43,360 (assuming cheaper cost per assessment when child is not known to social care)

- Assuming that one child will stay on the CPP for around three months a year and that half children on the CPP were aged 6 and under and half children were over 6[30], ongoing costs are:
  - 80 at £192 each per month for three months = £46,080
  - 80 at £263 each per month for three months = £63,120
  - Total cost = **£109,200**
- Not allowing for additional costs and resources associated with the new approach, which would reduce this net benefit for local authorities in Hampshire, the possible total yearly savings are:
  - £29,760 + £43,360 + £109,200 = **£182,320**

These estimates are net benefits and therefore include the costs of neglect over one year. However, this estimation has not taken into account the costs of increases in police and social work involvement (including assessment, joint visits, time to issue OOCDs, costs for providing the additional support and/or programmes for families to attend). Allowing for costs would mean that the net benefit is lower than calculated above. However, a crucial question is whether the new approach leads to better longer-term outcomes for children and/or systems change once in place, where 'better' outcomes are achieved with the same resources.

5.3.3. Organisational responses

It is important to consider whether this new approach to cases of childhood neglect necessitates a review of how CAIT is resourced.

Looking specifically at the use of FSPs, views were mixed between those who felt that the FSP had increased their workload, reduced workload or had no impact.

Those who felt it had little impact reported that:

[30] Based on our data from the three years prior to the index referral, each child stayed on the plan for 11 months on average in that 36-month period, which gives an average of 3.6 months per year. The average age of a child on the CPP is around 6 years.

> ‘It takes no time at all. It might make them a bit aggro, a little bit, the parents, when they get shown one, takes a bit of explaining, maybe five minutes or so, 10 minutes max maybe.’ (Police 12)

> ‘Quite often, we’d have gone by then. Quite often, the social worker would stay and they would do a bit more work and then they would write it out. Just, yeah, it all depends on the situation.’ (Police 13)

At least some of those police officers who reported minimal impact were those who were not really getting involved in the process in that way that was intended. Some social workers saw this as just another version of something always undertaken:

> ‘It’s just part of what we do, yeah. They don’t take very long to create. You know, it takes…minutes… You know, they use them all the time. They’ve been used to using them, most of them, since they became social workers, albeit, you know, they get different templates every now and then, but it’s not…it’s just part and parcel of what we do.’ (Social worker 05).

One social worker noted that, for them, the FSP has no impact in the case timeline:

> ‘I would say, the majority, whether you do one or not, I’m not sure if that will have any impact on time.’ (Social worker 03)

One explanation given for this is that:

> ‘If the concerns were there with a working agreement, you’d follow the same process as if the concerns were there without a working agreement.’ (Social worker 02)

Senior officers mostly felt that police involvement in the FSP or other working agreement has had no impact on workload:

> ‘[It has] provided another option by which we can achieve an outcome, but in terms of their workload as such, em, I don’t think it’s made… I don’t think it’s decreased or increased their workload, either way, to be honest.’ (Police 06)

Workloads were seen as being related to broader issues:

> ‘I don’t think we can narrow it down with the working agreement. Staffing levels in the police in general are too low. Resources are too low. Resources are too low in Child Abuse Teams. Em…so…I don’t think you can…single out the working agreement connected to staffing levels, yeah, not at all…’ (Police 08)

In contrast, other professionals said that it does increase their workload, either because they take a lot of time doing it: ‘Massively, yeah. Yeah, it’s very time-intensive’ (Social worker 10), or because ‘it is another document that we need to do, another thing that we need to put together before we go out the door’ (Police 10).

It was also seen as creating additional work for social workers due to the need for additional visits or duplicating effort by doing something verbally and then physically:

> ‘I suppose then the way that I do it is that, actually, when you go back to the office, you’ll physically have to write it, but you won’t actually post it, you’ll have to go and physically take that round because you need them to sign it as well. So, that then creates an extra visit.’ (Social worker 03).

Lack of experience was also seen as leading to additional time required, or where a police officer felt they were doing the role because the social worker on the case was not:

> ‘Erm, we have, like, a template. So, we’ve all been sent one, and then you delete the bits that you don’t need. I mean, for me, things like that always take me a while. If I was doing it every day, then it would be fine... Em, yeah, if I had to do one again, it’s not like a five-minute job for me, but I would have a bit more of a clue of what I’m doing.’ (Police 11)

> ‘Yeah, if you’ve got to do it, then, yeah. If the social worker’s not doing it and we’re doing it, then yeah. I mean, it might only take you 10 minutes, but it’s still something you’ve got to do. Erm…the one I put together, yeah, I had to leave the address, come back, I was late off anyway, leave the address, come back, and because I hadn’t done it before, I’d got to find the

> form, work out what I'm doing with it and so, like…and then drive back and get it all signed. So, like an hour later, oh, the working agreement is sorted. Erm…yeah, I mean, that's something maybe you could prepare before you go, if you know what you're going to, em, but it's…, like, I didn't do it at the time [with that one].' (Police 11)

A minority of police said the FSP 'probably does [decrease their workload] in certain circumstances, yeah, yeah, [it] probably does' (Police 06). However, no detail was provided as to the way in which the FSP led to time reduction and, when asked why, another officer spoke more about the sense of reassurance provided:

> 'Because it's part of the safeguarding plan, and if you've got a child that you're not happy to…really to leave there, or you're worried, to know they've signed a working agreement, a safety plan, is part of the safeguarding, so it actually takes that load off slightly because you know that if they don't adhere to it, we can do something the next day.' (Police 17).

Looking more broadly at the wider changes and moving beyond just the impact of doing an FSP, relevant findings from the qualitative interviews show the following.

- Neglect has been given a clearer, improved focus across Hampshire Constabulary, which is generally welcomed by officers.
- However, officers feel that they are under increased workload and pressure due to the new approach. This view is supported by data from social workers and the upgrading of many cases shown in the shift from use of Grade D (lowest) to Grade A (highest, requiring CAIT and joint work).
- The training was limited and some officers felt that this might have affected perceptions of its usefulness and led to poorer quality control. This is supported by the finding that different officers have different terminology for the same thing. Hence, FSP is not universally understood by all as the same thing.
- Cultural change is required to implement the new approach fully, not least to ensure that both police officers and social workers understand this somewhat revised role of the police (involvement in developing a working agreement in the form of the FSP).

- Uncertainty about the process has led to some officers feeling there is a lack of clarity about the police role, and that they require better understanding of how to set appropriate, realistic and reasonable goals and plans for the parent(s), particularly since this is seen by many officers as a non-policing role.

Moving forward, a review of the risk thresholds and use of OOCDs may be warranted, alongside additional training on the use of FSPs to ensure parity for families.

6. Discussion

6.1. Implications

There is preliminary evidence that paying increased attention to neglect can reduce the number of children becoming subject of a CPP, with the associated cost savings. In this project, the reduction in cases resulting in CPPs was 20% and 18% after three and six months respectively, which is a substantial reduction.

There were several positive benefits expressed by both police and social workers regarding co-working and the increased focus on neglect, including two services under significant pressure being able to offer support to each other.

However, the efficacy of the intervention was likely undermined by the lack of training and poor usability of the FSP form itself. There is also a need for additional discussion about the roles of the two services, including ownership of the form, practicalities of managing joint visits (for example, due to differing shift patterns) and follow-up of cases.

A number of concerns were raised by professionals, largely around:

- individual and/or team differences in approach, including whether the FSP was used or there was a greater reliance on OOCDs
- inconsistency between conditions set for families
- the legal value of the document in court and/or poor understanding by parents of what they were signing
- lower risk thresholds meaning that almost all cases of neglect met the threshold for referral to CAITs, which then resulted in an increase in workload, but also potentially inappropriate referrals that were more likely to receive a disproportionate response due to the pressure to reduce the use of Outcome 20
- potential additional stress for families, including the view that OOCDs are seen by parents as a criminal justice route and may affect employment

Longer-term follow-up data is required to contextualise the statistical findings fully, as are the views of parents and children.

6.2. Feasibility of future impact evaluation

With appropriate planning and resourcing (both for research time but also operationally within the force), it would be feasible to conduct a future impact evaluation. Randomisation would not be possible, since it is necessary for a whole region to adopt an approach and it can be difficult for associated regions to remain unaffected. For example, there were suggestions of 'drift' for some elements with Southampton. However, it should be possible to compare different regions or different forces.

6.3. Challenges in delivery of the evaluation

There were significant challenges in delivery of this evaluation. These largely arose from the complexities and time taken for data access and ethical approval, but also related to resourcing for personnel within Hampshire Constabulary to collate and anonymise quantitative data for the research team.

Agreeing a memorandum of understanding between Hampshire Constabulary and the two universities took many months. In turn, this affected the project methodology and ability to submit ethical applications, since it determined what data would be made available. Other impacts included the delay in starting data collection, which meant that the engagement measure and parenting stress measure could not be completed in 'real time', during initial visits. As a result, it did not end up being possible at all. A longer time period for completion would have helped towards gathering some of this data.

Vetting processes for research staff also added to the time. This was made additionally difficult when the research team experienced a change in staffing. Recruitment time plus new rounds of vetting added to delays. Similarly, there were changes of personnel in Hampshire Constabulary, with a change in intervention lead.

As noted, some data access had to be facilitated and/or processed by the intervention lead, even after her move to a new role. Hence, some resources to support that process would have made a significant difference to the intervention lead. It may also have meant that additional data, such as the Engagement Measure, could have been collected.

Finally, there were many concerns about interviewing parents and children. Gaining ethical approval took considerable time, and was achieved just before Christmas 2019. Following that, there were issues with professional gatekeeping, with some social workers appearing to be reluctant to discuss the project with families. Discussions with a regional lead began to move the project forward towards interviews with families taking place in March. However, the 2020 global COVID-19 pandemic meant that this was not possible. We feel strongly about the need to have the voice of parents and children in this project and are very disappointed that these interviews did not take place.

6.4. Study limitations

Key limitations of the study relate to the data that, ultimately, could not be accessed in the course of the project. Most importantly, this relates to the parent and child interviews, data for the economic evaluation, and the engagement and parenting stress measures.

An additional limitation was the lack of clarity about what changes had been made in which regions, as well as the potential ‘contamination’ effect in Southampton. For example, a significant difference in CPP rates was found in all regions, including Southampton. This suggests that the intervention did bring changes even when the FSP was not officially being used. The qualitative interviews brought into question the consistency with which it was being used (or not) in the four regions, highlighting that the idea of FSPs had spread across all regions. Because of these reported inconsistencies in the way in which the FSP was being used by police officers and social workers, this project could not evaluate the intervention as it was meant to be, but rather could only evaluate the version that was being used.

7. Conclusions

This mixed methods study of a new approach to working with families where there has been concern about neglect has provided findings based on both quantitative data on outcome measures and a wealth of rich qualitative data.

The statistical findings suggest that there may be possible reason for optimism, but these are based on a short-term follow-up. Qualitative interviews suggest that there are additional areas that need to be considered. The findings have indicated a number of ways in which the intervention may be developed and/or improved (particularly with respect to training). Ultimately, for such an intervention to be fully implemented and evaluated, sufficient resources are required to facilitate that process.

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9. Appendices

9.1. Template of a family safety plan working agreement

Hampshire County Council

Family Safety Plan Working Agreement

Date of Document…….

This is not a legally binding document, but it sets out the expectations of Children's Services to Safeguard your child/ren. You have the option to seek legal advice regarding this agreement.

Children's Names:	DOB:
Parent/Guardian's Names:	DOB:
Address:	

Hampshire Children's Services/Hampshire Constabulary's* concerns are:

Free type box for SW to complete

Time offered to make the necessary changes/review progress:

Hampshire Children's Services/Hampshire Constabulary's* expectations and the support that will be offered to you are as follows:

SMART and Strengths based

(include what commitment Children's Services and/or other organisations can offer to the family and what support may be offered ie what is included in the CIN/CP plan)

Basic Care – including home conditions *delete as necessary:*

Children will have access to sufficient food to meet their needs; eg 3 meals per day of nutritious value/school dinners – give specifics for this family

Home will be maintained to a consistently safe and hygienic level – give specifics for this family

Gas/Electric will be working within the property. Breakages/required repairs or replacement of appliances will be reported to Landlord.

Specific concerns/support for this family: ie working bathroom, animal faeces, appropriate and clean bed/ding

You will work with XXXXX Agency, XXXXX frequency to achieve XXXXX by XXXX

Ensuring Safety *delete as necessary:*

Children will not be exposed directly or indirectly to domestic abuse – give specifics for this family

Children will be supervised to ensure they remain safe – give specifics for this family

You will not allow your children to have direct or indirect contact with XXXXXXX

Clare's Law and Sarah's Law to be used for all current/future relationships – (Police can offer guidance in respect of Clare's Law and Sarah's Law)

You will ensure that drug paraphernalia is not in the home and that any prescribed substances are locked safely away

Specific concerns/support for this family:

You will work with XXXXX Agency, XXXXX frequency to achieve XXXXX by XXXX

Access to Education

You will ensure your Child/ren will be accessing education at the agreed times during term time – if there is a genuine reason for non attendance you will liaise with the school to advise

Specific concerns/support for this family:

You will work with XXXXX Agency, XXXXX frequency to achieve XXXXX by XXXX

Emotional Wellbeing

Specific concerns/support for this family:

You will work with XXXXX Agency, XXXXX frequency to achieve XXXXX by XXXX

Please Note:

Parents must agree to seek help/advice and support if required by contacting your child's social worker on XXXXXXXXXXX

If CSD is no longer working directly with your family you can seek advice and support from your child's School, Or by calling Hants Direct XXXXXXXXXX

Further action may be considered if these expectations are not adhered to; Children's Services may consider legal advice in respect of your child/ren.

This document will be shared with other professionals working with your family.

These expectations cover the life of the child/ren.

We will agree together on the specifics required for your family and how long this agreement is valid for.

Agreed Review date……

Name	**Signature**	**Role**	**Date**
		Children's Services Team:	
		Parent/Guardian	
		Parent/Guardian	
		Children's Services Team Manager	
		Attending Police Officer*	

**Delete as applicable*

9.2. Guidance notes for police use of family safety plans

Guidance for Operational Teams over the use of the Agreement

Purpose of the contract of expectations

- To ensure clear collaborative working between Children's Services, Police and Families.
- To ensure that families are given clear, measurable expectations, even when there is not to be longstanding involvement and that all agencies working with a family understand what these are.
- Prevention of longstanding neglect/physical harm/sexual harm cases, where there are multiple reassessments by Children's Services. The document is designed to last the lifetime of child, rather than an assessment 'starting afresh' each time.
- The document also allows the Police to be clear about the expectations of the family, so that where it is felt appropriate to prosecute parents, it can be shown that the family have been offered appropriate advice, guidance and support previously.

When to use a contract of expectations

- Within Child Protection Investigations. It is considered that if concerns for a family are significant enough to use this document, then the threshold for Section 47 has been met.
- This does not mean that it needs to be used in every Child Protection Investigation. It is felt likely to be of benefit in cases of neglect, abuse or when there are concerns regarding a family's engagement. However, professional judgement needs to be used.
- As it is a joint document, there needs to be agreement between Children's Services and the Family (and the Police if appropriate) that its use is appropriate. This will be agreed within a strategy discussion. This will be between the Children's Services Team Manager and the Detective Sergeant of the relevant Police Team. If the Police are not involved in the investigation and the use of the document is felt to be needed, the Children's Services Team Manager can

contact the Detective Sergeant in their local CAIT team to discuss and agree both the content of the document and whether there is now a role for the Police.

- It may be that the document needs to be completed during an initial Joint Agency Child Protection Investigation visit, with the content initially agreed between the attending Officer and Social Worker, with guidance taken from the team manager over the phone. There will also be occasions where the document is more appropriately used with a more 'long term' view and can be agreed between the Police, Children's Services and the Family prior to a visit. It would be good practice in these situations to provide the family with a blank copy of the document in advance, so that they have time to consider its meaning.
- The document can be updated and amended during ongoing involvement with a family, to ensure it fully reflects the up to date assessment/concerns.
- The document can then be shared with other agencies working with the family, such as health visitors or school staff. This is particularly of note when a case is to be closed, to ensure that any concerns in the future can be appropriate raised with Children's Services or the Police.

Checklist for professionals when using the document

- Expectations need to be SMART. Specific, Measurable, Achievable, Realistic, Timely. The document loses its worth if parents and professionals don't understand it, or if progress/decline against it can't be clear.
- Parents are able to seek legal advice regarding the document if they wish and may wish to do this prior to signing. In some cases eg PLO/Court Hearing, families may wish to seek legal advice regard the specific contents.
- It is important to consider if parents have learning needs and if they fully understand what is being asked of them and the consequences of the agreement not being adhered to. Consider the use of an advocate if necessary or whether a referral to Adult Services may be required.
- It is also important to confirm that parents have good enough literacy skills to be able to read the document and to consider any support that they need with this.
- It is important to be mindful that if English is not parents' first language, they may require a translator and the document itself may need to be translated.

- The Team Manager needs to sign this document to show that they are in agreement with this. For Police, it will either be signed by the attending officer from a CAIT team, or if the CAIT team is not involved; a Detective Sergeant (if Police involvement is appropriate).
- Please consider the assessment framework when completing this document. Do the expectations cover basic care, emotional warmth, guidance and boundaries, ensuring safety, access to education, social presentation etc and is there clear evidence of the support that the family will be offered to reduce professional concern.
- Parents need to be given a copy for their own reference. Parents must be given appropriate amount of time to consider the document and to seek legal advice if they wish. Clear expectation must be given that the document will be signed with a copy made available for the family.
- Hyperlink to Clare's Law, so that information can be shared with the family regarding the Domestic Abuse disclosure scheme. **https://www.hampshire.police.uk/advice/advice-and-information/daa/domestic-abuse/clares-law/**
- Hyperlink to Sarah's law, so that copies of information about accessing these can be shared with the family. **https://www.gov.uk/guidance/find-out-if-a-person-has-a-record-for-child-sexual-offences**
- This agreements represents a low level supporting intervention. If Police are involved this will be used to support a community resolution. If family do not comply with the agreement, this can be taken to the next level with potential of further actions:
    - Increased involvement from professionals
    - Conditional Cautions
    - Evidence to formally prosecute

9.3. Email to police CAITs regarding the new approach

Dear all,

Attached you will find two documents that I have been working on with Hampshire Child Services and has now been formally agreed regarding interactions with families, this would apply with either single agency Child Services or a joint approach with Police. In general terms we are looking more at Neglect cases but this can be used as a template for other cases too.

The purpose of the document is to provide a greater structure for the families surrounding expectations of them in clear unambiguous terms that they sign to agree what changes need to be made, what engagement is required and also ongoing maintenance of those changes.

This all about the wellbeing of the child/children within the household/family and making the environment more acceptable for them. What underpins all of this a joint approach to improving the quality of life that the child/children have.

This working agreement will not only support and form the conditions for the community resolutions and conditional cautions, it will also allow us should families either not make the required changes and/or there be a decline after withdrawal of services to use the agreements to support further action. This could include where appropriate a criminal prosecution. This is why a formal structure around the requirements needs to be used so the family are very clear what is expected of them at the time not only to either improve, rectify or comply with but also the maintenance of such conditions.

I would encourage you all to print and have a copy of not only the template but the guidance that is being given to the social workers so that you can start to ensure these are being used. This template can now be used to assist with your OOCD conditions and then should be added to the occurrence to provide the basis of the outcome.

At the moment this agreement is being rolled out within Hampshire Child services areas, although this is a good basis for all cases you will be involved with and this

could be used still for non Hampshire CSD cases now. I will be looking to roll this out within the other Child Service areas across the two counties.

Please come back to me should you need anything further.

Kind regards

9.4. Agenda from CPD training day

Child Abuse Investigation Team

CPD

Intervening Before It's Too Late

Monday 3 December 2018

Agenda

09:00	Registration, tea/coffee
09:30	Welcome from Detective Chief Superintendent Stuart Murray
10:00	Gillian Finch, presenting on Adverse Childhood Experiences
11:15	Tea/coffee
11:35	Dr Kevin Smith, presenting on interviewing vulnerable children
12:35	Lunch
13:20	DS Steve Willcocks – BWV interviews
13:50	Detective Inspector Paula James, presenting on neglect
14:10	Break
14:20	Jenni Jones, An Introduction to Psychological Skills Training
15:20	Panel Q&A
15:50	Detective Chief Inspector Fiona Bitters, Head of CAIT

9.5. Content of slides from CPD training day (December 2018)

SLIDE 1: Child Cruelty

SLIDE 2: **Assault / ill-treat / neglect / abandon a child / young person to cause unnecessary suffering / injury**

- date and location
- being a person 16 years or over having responsibility for a child under 14/young person under 16
- Wilfully
- assaulted/ill treated/neglected/abandoned/exposed the child/young person in manner likely to cause unnecessary suffering/injury to health

SLIDE 3: **Lower level Neglect**

Have you heard that expression?

- Is there such a thing?

SLIDE 4: **Changing our mind-set**

- Why?

SLIDE 5: **Ofsted**

- Sept 2017 Ofsted completed a review of cases
- Report detailed links with DA.
- Written agreements – Effective?
- Clear learning came from this review.

SLIDE 6: **What have we done**?

- Through joint working with Hampshire CSD we have produced Family Safety Working agreements and guidance to social workers

[Note: The purpose of the document is to provide a greater structure for the families surrounding expectations of them in clear unambiguous terms that they sign to agree what changes need to be made, what engagement is required and also the requirement for ongoing maintenance of those changes.

Being clear that this isn't just fix this **now** and its ok to revert back.]

SLIDE 7: **Why are we doing this?**

- [Notes:
- This is our first opportunity to be involved within the family and show that we are joint working as agencies and that there are consequences to perpetrators of failing to engage with requirements.
- This all about the wellbeing of the child/children within the household/family and making the environment more acceptable for them.
- What underpins all of this a joint approach to improving the quality of life that the child/children have.
- We want to try and break the cycle.]

SLIDE 8:

This working agreement will not only support and form the conditions for the community resolutions and conditional cautions, it will also allow us should families either not make the required changes and/or there be a decline after withdrawal of services to use the agreements to support further action. This could include where appropriate a criminal prosecution.

[Note: This is why a formal structure around the requirements needs to be used so the family are very clear what is expected of them at the time not only to either improve, rectify or comply with but also the maintenance of such conditions.]

SLIDE 9: **What are our Options?**

- NFA……
- Community Resolution…….
- Conditional Caution……
- Criminal charge……

[Note: mention Outcome 20]

SLIDE 10: **What are the challenges??**

- Understanding what options we have available?
- Joint working and educating partner agencies that Police involvement doesn't always mean – Criminal prosecution and court!
- Ensuring agreements are meaningful, clear and the perpetrators understand what is being asked of them and the consequences if they don't.

SLIDE 11: **What about charging cases of Neglect?**

- No point CPS wont charge
- CPS always say wilful element isn't reached – What does this mean??
- Does/should that impact on what we do??

SLIDE 12: **'Wilful'**

- With the intention of causing harm, deliberately
- Deliberate intentional, intended, done on purpose, premeditated, planned, calculated, purposeful, conscious, knowing.

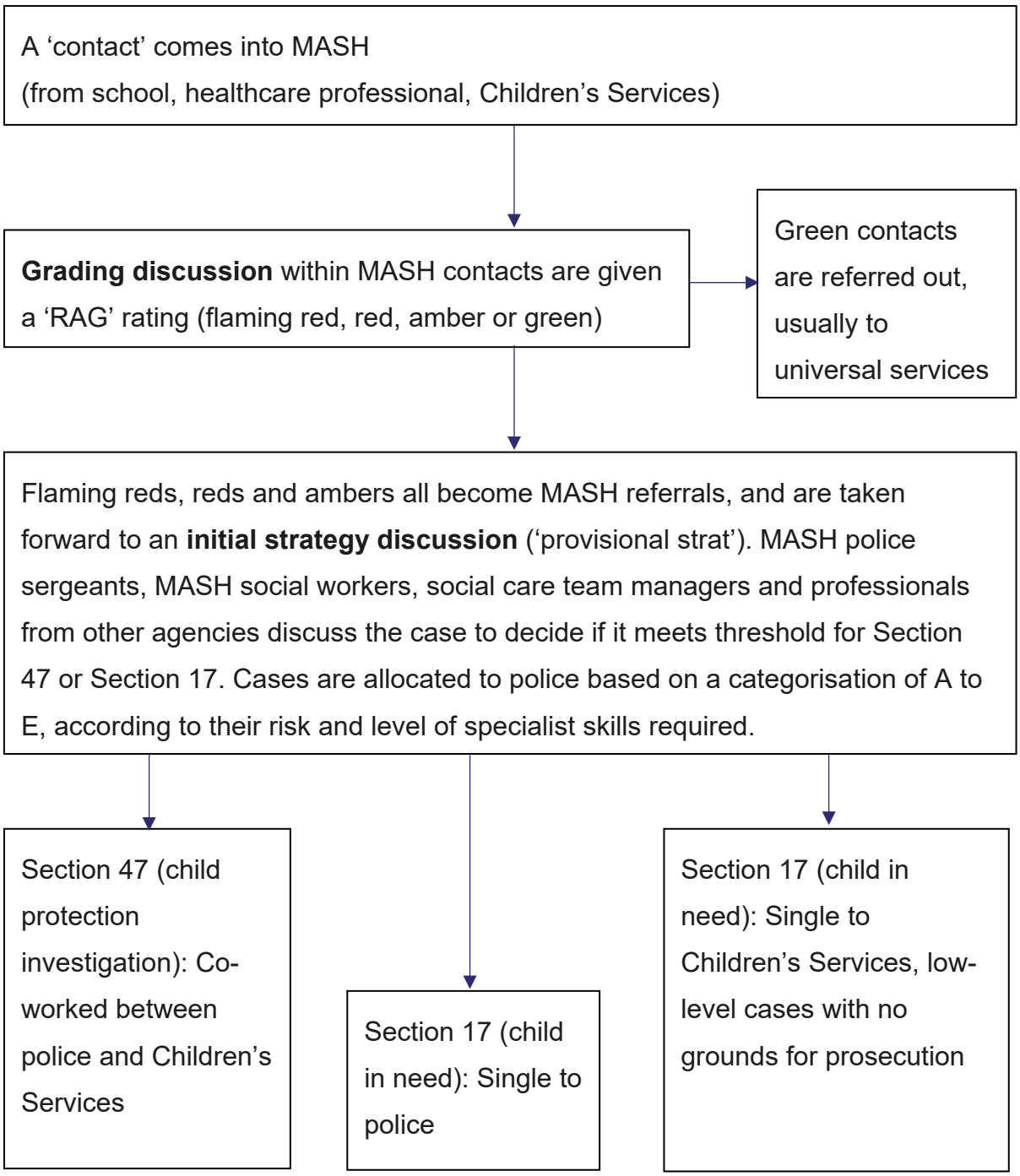
SLIDE 13: **What can we do??**

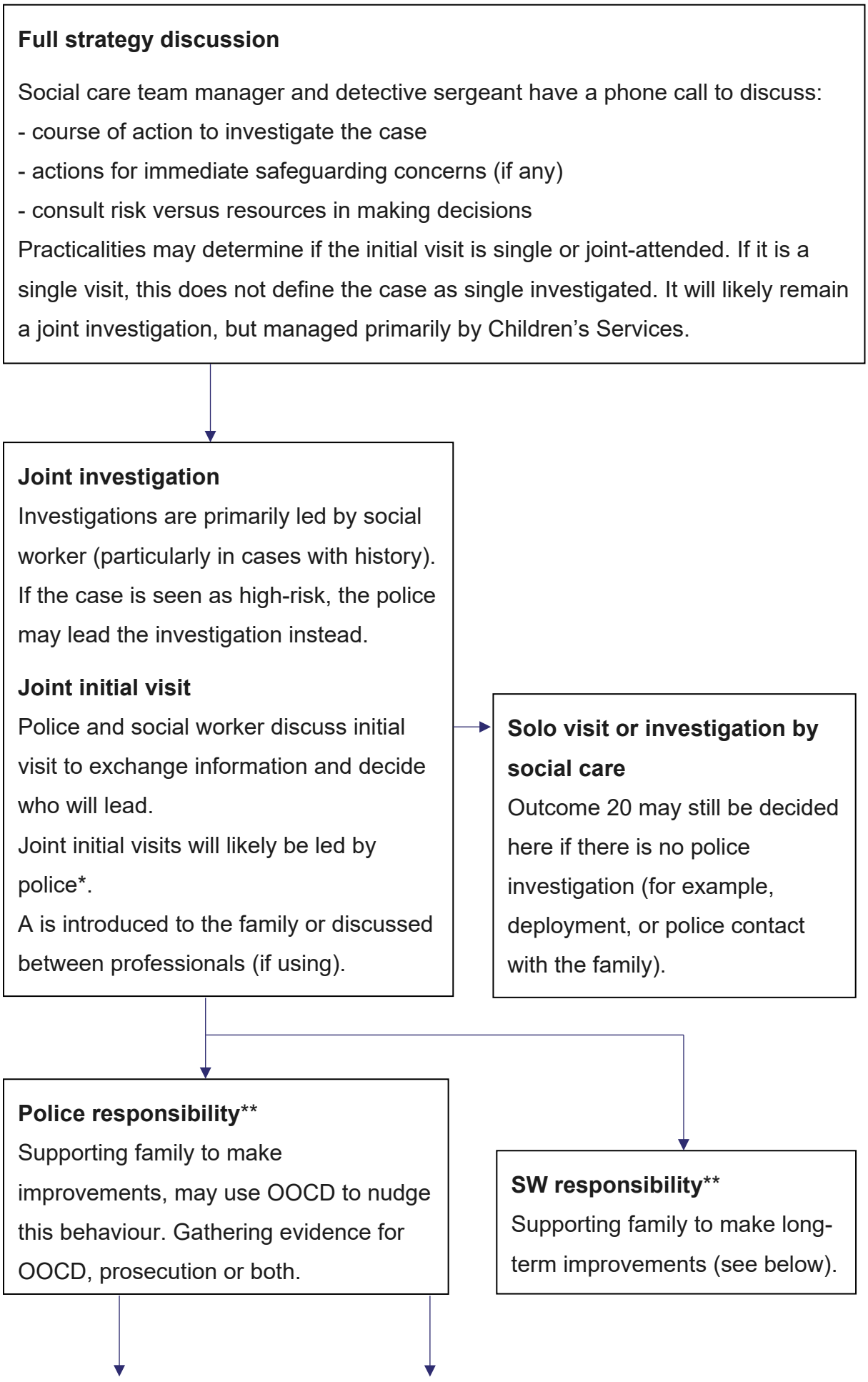
- Utilise the working agreements these will support any case that you have
- Educate Partner agencies
- Present your case to CPS well
- Challenge CPS NFA decisions

SLIDE 14:

- Remember we are investigators our views sometimes conflict with partner agencies……This is ok!!
- Remember it's about doing the right thing, getting the right outcome.

9.6. Process map from MASH referral to possible outcomes




Full strategy discussion
Social care team manager and detective sergeant have a phone call to discuss:
- course of action to investigate the case
- actions for immediate safeguarding concerns (if any)
- consult risk versus resources in making decisions
Practicalities may determine if the initial visit is single or joint-attended. If it is a single visit, this does not define the case as single investigated. It will likely remain a joint investigation, but managed primarily by Children's Services.
Joint investigation
Investigations are primarily led by social worker (particularly in cases with history). If the case is seen as high-risk, the police may lead the investigation instead.
Joint initial visit
Police and social worker discuss initial visit to exchange information and decide who will lead.
Joint initial visits will likely be led by police*.
A is introduced to the family or discussed between professionals (if using).
Solo visit or investigation by social care
Outcome 20 may still be decided here if there is no police investigation (for example, deployment, or police contact with the family).
Police responsibility**
Supporting family to make improvements, may use OOCD to nudge this behaviour. Gathering evidence for OOCD, prosecution or both.
SW responsibility**
Supporting family to make long-term improvements (see below).

No further action
Investigation has taken place (for example, interviews in an attempt to gather evidence). Deemed not at a criminal level or not enough evidence.

Other police outcomes (mostly decided within a few days of visit)
Based on severity of case, decision between community resolution (CR) or conditional caution (CC) is down to detective inspector.
- CR: low-level acknowledgement of offence that acts as a final warning, as it is not in the public interest to take to court***.
- CC: offence is based on assessment of public interest; avoids a charge, although may lead to prosecution if not complied with. Aims to achieve a positive outcome from the parent attending a course. Requires admission from parents. Three-month deadline then taken to court***.
- Prosecution: very rare for neglect cases (due to CPS threshold).

SW responsibility*
Supporting family to make improvements.
FSP: May do either of the following, or both.

Formal FSP
- FSP is written up after initial visit as a formal contract, which the family sign on next visit.
- To evidence the work they have set out for the family to complete (with or without social workers).
- Print copies for family and police.

Handwritten or informal FSP
- Occurs in reaction to safeguarding needs of the child.
- Forms a plan of action for family to improve conditions.
- May be verbal, written on scrap paper or on pre-prepared template.

Monitoring engagement in FSPs

- This is primarily the social worker's responsibility.
- Police may follow up (mostly via social worker) if they have a vested interest in the FSP or other working agreement (for example, if they feel that the FSP may evidence parents' non-compliance in support from services and supporting grounds for wilful neglect, or because FSP conditions link to those in the OOCD).
- Timeframes are monitored by the social worker, and may vary, for example:
  - open timeframe until conditions are met
  - reviewed every six weeks
  - if on CPP, the family are visited every five days
  - no timeframes, as conditions must be complied with indefinitely

* Who leads the joint visits was inconclusive from the interviews. It seemed that police officers would primarily take the lead, although in some circumstances it would be the social worker who does.

** There may be other responsibilities for each professional during the initial visit. Stated here are those that were identified as the majority by each of the professional groups.

*** Police will follow up with children's services to find out if conditions have been met for community resolution and conditional caution.

About the College

We're the professional body for the police service in England and Wales.

Working together with everyone in policing, we share the skills and knowledge officers and staff need to prevent crime and keep people safe.

We set the standards in policing to build and preserve public trust and we help those in policing develop the expertise needed to meet the demands of today and prepare for the challenges of the future.

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