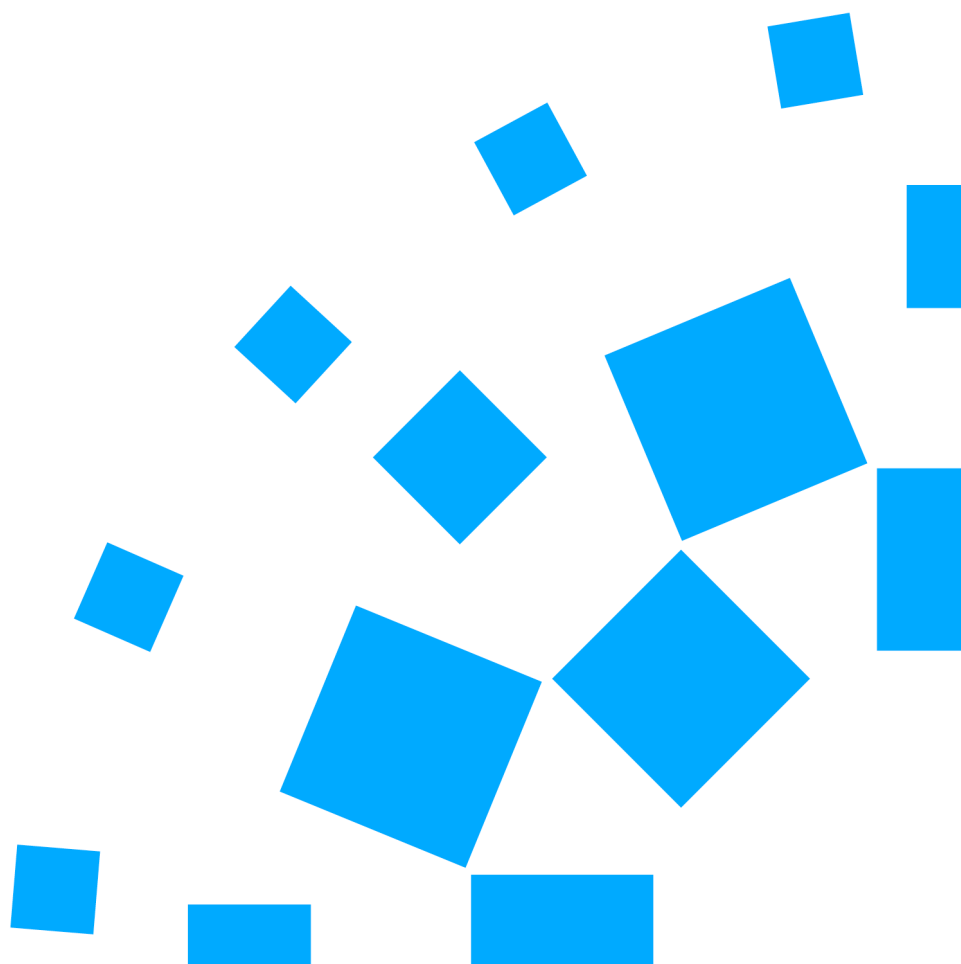


Vulnerability and Violent Crime Programme

Evaluation of the trusted adult workers role and Rock Pool train the trainer educational approach

Full technical report

July 2021



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About



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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 Birmingham. The report presents the views of the authors and does not necessarily reflect the College of Policing's views or policies.

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Executive summary

1.1. Introduction

The impact of adverse childhood experiences (ACEs) can be far-reaching and lead to a variety of negative physical health, psychological and social outcomes. Evidence has suggested that individuals exposed to ACEs may also have an increased risk of experiencing adverse policing and criminal justice outcomes compared to individuals who have experienced no ACEs (Hughes et al., 2017). Preventing adversity in childhood is a complex challenge in its own right. However, there is some evidence to suggest that implementing appropriate interventions during childhood may mitigate some of the negative outcomes (Bellis et al., 2017). One such mitigation strategy is the presence of a 'trusted adult' who supports the child appropriately throughout their adversity and beyond (Bellis et al., 2017). The Office of the Police and Crime Commissioner (OPCC) in Hampshire, in conjunction with the local constabulary and other public sector services, commissioned 'trusted adult workers' (TAWs) to support children who have experienced ACEs. Their initial role was to work with children who could benefit from early intervention (such as those who had experienced only a few ACEs) and support them as mentors, aiming to have an impact on the development of resilience.

To raise awareness and improve education around ACEs, the Hampshire OPCC also commissioned Rock Pool Life community interest company (Rock Pool) to roll out a train the trainer (TTT) programme. Rock Pool was commissioned across all public sector agencies in Hampshire county to deliver trauma-informed training to help ensure a shared language of ACEs and support a shift in culture, ensuring all agencies acted in an ACEs-informed manner. Rock Pool training led to the training of trainers within each organisation. It was the responsibility of the trainers who attended the Rock Pool TTT session to spread the messages they had learnt within their own organisation. During the evaluation period, they were required to deliver six training sessions within their own organisation to share the key messages from what they had learnt from the initial Rock Pool training.

It was thought this twofold approach, improving awareness of ACEs/trauma-informed approaches, and the introduction of TAWs to support children who had

experienced ACES, would lead to public sector agencies in Hampshire becoming more aware and informed in supporting children with ACEs.

The overall aim of this research was to conduct an impact, process and economic evaluation of the TAWs approach in Hampshire, and assess the impact and process of the TTT approach.

Specifically, the research aimed to evaluate the stated intervention aims that TAWs and TTT respectively will:

1. Improve the life outcomes of children working with TAWs.
2. Improve awareness and education surrounding ACEs and a trauma-informed approach within public sector bodies where TTT approaches are employed.

A detailed evaluation plan was put in place to answer these questions. As the evaluation was complex, involving many steps, it has been split into two separate evaluations, namely that of the TAW and TTT approaches.

Overall, the following methods of evaluation were used.

TAWs evaluation

1. Focus groups with a sample of referral agency partners to gain further insight into the referral patterns to TAWs and their perceptions of success for the programme.
2. Semi-structured interviews with the full sample of TAWs to understand the process of managing children with ACEs and perceived success.
3. Prospective cohort study exploring outcomes of children who have worked with the TAWs to assess the impact.
4. Semi-structured interviews with children and families to understand their experiences and opinions of the programme.
5. Questionnaires with children and families to capture any views not captured in the interviews.

TTT evaluation

1. Focus groups with a proportion of those who attended the TTT session and became trainers within their own organisations to understand their role and experiences of training.

2. Questionnaires sent to all trainers to capture any views not represented in the focus group.
3. Questionnaire feedback from participants who attended half-day sessions put on by the Rock Pool-trained trainers. Feedback collected before and after the session, as well as after a longer follow-up period, for those who underwent training before December 2019 to assess the impact of the training in the short and long term.
4. Questionnaires for those who did not attend trainer sessions but work in the relevant organisations to assess wider ACEs awareness following the TTT intervention.

1.2. Key findings

Evaluation element	Findings
Effect	<p>Trusted adult workers</p> <p>The findings suggest that TAWs brought significant improvements for children they are working with. This has been substantiated through several notable case studies captured in interviews. These include improvements in emotional health, connections with others, positive outlooks on everyday life and feeling empowered for the future. There was a statistically significant improvement in the overall Outcomes Star measure (distance travelled or progress) for the children who have been working with the TAWs (improved difference in scores +0.5) and in their family Outcomes Star (+0.65). Additionally, the intervention appeared to work more for those in the younger age group, particularly in those with more ACEs (four to 10).</p> <p>Train the trainer</p> <p>The TTT approach seems to be good at raising awareness of ACEs in public sector organisations. Pre- and post-training surveys of TTT participants demonstrated improved scores relating to awareness of the impact and effects of ACEs, suggesting the training was beneficial.</p>
Mechanism	<p>Trusted adult workers</p> <p>The mechanism for this improvement is likely to be improved resilience and self-esteem among the children. These improvements were captured by changes in emotional health, connections with others, positive outlooks on everyday life and feeling empowered for the future.</p>

	<p>Train the trainer</p> <p>The mechanism for improving awareness was through the delivery of the six sessions by those who underwent the TTT intervention to their local organisations. Most of the trainers delivered these six sessions without difficulty. Dissemination to other members of the public sector who had not undergone training could not be formally captured but, as a proxy, their self-opinion of their knowledge was good even for those who did not attend the sessions at the end of the evaluation period.</p>
Moderator	<p>Trusted adult workers</p> <p>TAWs were originally set up to work in the very early intervention arena (where children should have had a minimal number of ACES). However, in practice the TAWs have been working with many children who already have four or more ACEs, suggesting that, despite the high levels of existing adversity, TAWs could still make a positive difference. The main differences between the local authorities in Hampshire were the use of different referral criteria into the scheme, the background of the recruited TAWs and the methods used to measure distance travelled (different Outcomes Star tools).</p> <p>Train the trainer</p> <p>No Moderator effects were explored for the TTT programme.</p>
Implementation	<p>Trusted adult workers</p> <p>This initiative was not implemented exactly as intended. The intervention was not able to recruit a TAW in the Isle of Wight. Additionally, the intervention aimed to support those with few ACEs, but in practice it was children with four or more ACEs who were mainly referred. Further, the aims and standardisation of the role of TAWs was largely not clear to begin with. But as time went</p>

	<p>on and the staff settled in the role, they began to see beneficial outcomes in the children.</p> <p>Train the trainer</p> <p>Generally, the training delivered by those trained from the intervention was delivered appropriately in all their subsequent settings. However, participants of the subsequent sessions felt there was limited information as to the ‘so what?’ element relating to what practical steps they could take to manage children with ACEs. Despite this, the participants did feel on average they improved their knowledge around the signs, symptoms and effects of ACEs.</p>
Economic cost	<p>Trusted adult workers</p> <p>We were unable to undertake an economic analysis due to limitations in the outcome data available. We did collect the costs of the TAW programme over the length of the evaluation period. During the period of time from January 2019 to March 2020, the following budgets were allocated to each local authority to cover the cost of the TAWs:</p> <ul style="list-style-type: none"> ▪ £88,017.50 to Portsmouth City Council (1.5 full-time equivalent (FTE) TAWs who served 19 children during the study period) ▪ £88,017.50 to Southampton City Council (2.0 FTE TAWs who served 14 children during the study period) ▪ £176,035.00 to Hampshire County Council (4.0 FTE TAWs who served 48 children during the study period) <p>Train the trainer</p> <p>Rock Pool consultancy was paid £67,000 for a number of taught activities over a 10-month period that included the ACEs and TTT package. However, a true reflection of cost would need to also</p>

	include the time spent on training by individuals from each organisation
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1.3. Conclusions and implications

In summary, the findings show positive results regarding the implementation of the TAWs programme, and levels of public sector service referrals. TAWs themselves and the children and families who have worked with them also report positive results. There are however still some barriers that need to be addressed for the project to reach its full potential. The key points are outlined below.

1. There is a tangible improvement in the Outcomes Star scores of children comparing before and after the TAW intervention, as well as improvements in their family Outcomes Star (a measure of distance travelled or progress within certain domains of life). Although the change in the family Outcomes Star measure was not as substantial as the control group, it must be noted that the control group used may not have been suitable due to the case mix, hence causal impact could not be measured. As limited details were provided on the baseline characteristics of the control group it was not possible to say whether they had a greater number of ACEs or fewer compared to the intervention group. Equally, it was not possible to identify whether they had any ACEs or their reasons for referral were due to different sources of vulnerability. This is particularly challenging to interpret as some children in the control underwent more intensive interventions whereas some underwent less intensive ones.
2. The original aim of identifying only children with four or fewer ACEs is no longer being followed as in practice the intervention has been applied to children experiencing more ACEs. This may, however, not be a problem given the improvements seen in the outcomes.
3. Referrers, TAWs and clients have all described striking case studies, highlighting how important the TAW role has been and the improvements they have brought about in children's lives, many of which cannot be quantified. Additionally, TAWs have filled many gaps in current service provision and have hands-on expertise that would not have been delivered otherwise.

4. Barriers to referring to TAWs relate to 1) resource and capacity issues, 2) lack of clarity around referral processes, 3) role of the TAW (to prevent duplication with other services) and 4) timing of their intervention (ie, at what point it is best to employ their skills into a family).

Additionally, it is extremely important to note, given the negative effects of ACEs are experienced much further downstream, resources must be devoted to provide needed support for the children over time.

On the whole, the TTT programme showed many positive outcomes. Trainers were on average happy with the training they received from Rock Pool and consequently were confident and able to deliver onward sessions within their organisations. These sessions were deemed to improve awareness of ACEs and start to stimulate culture change within the organisations.

1. Rock Pool training was largely well received in terms of content by the TTT participants. The content was judged to be good for raising awareness regarding identifying signs, symptoms and effects of ACEs. However, it was not clear in providing guidance on which approaches to use to support children who have actually experienced ACEs (the 'so what?' element). The participants would like to have known more about which interventions are beneficial to children or adults they are managing with ACEs.
2. For individuals who attended the TTT sessions, there was a noticeable improvement in understanding the role of ACEs in their workplace. So the TTT approach can be seen as successful at improving awareness even in the longer term (four to six months; although the sample size for this follow-up was small). However, the scores for improvement were lowest in the responses relating to improving understanding about what to actually do for children with ACEs, which correlates with findings that this element was limited in the training.
3. Those who had attended sessions run by trained trainers were keen to share their learning in their organisation. Although it is not possible to determine whether they were linked, the good knowledge of ACEs demonstrated in the wider questionnaire may be reflective of this dissemination occurring.

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Background

2. What are ACEs?

There is growing evidence, noted in the Home Office Serious Violence Strategy (2018), around the increasing prevalence of children and young people involved in crime as both offenders and victims. One factor possibly contributing to this is that they have experienced a series of adverse childhood experiences (ACEs). A common definition of ACEs used in the UK (and by the police force involved in this evaluation) consists of 10 factors. Five factors relate to direct abuse: physical, sexual or emotional abuse, and physical and emotional neglect. A further five factors relate to markers of household dysfunction: parent who has experienced violence at home, mental illness, substance abuse, incarceration or separation (Bellis et al., 2014a).

2.1. The impact of ACEs

The initial ACEs cohort study conducted in the United States identified that experiencing multiple ACEs is associated with negative long-term health and social outcomes (Felitti et al., 1998). A recent systematic review has identified that cumulative exposure to four or more of these ACEs increased the risk of developing a wide variety of negative mental and physical outcomes, including cardiovascular, metabolic, respiratory disease and cancer (Bellis et al., 2017). In looking at factors affecting policing, it has been estimated that individuals who have experienced ACEs are at a considerably higher risk of incarceration, substance misuse, smoking and alcohol intake (Bellis et al., 2014b). These negative consequences have been replicated in UK settings describing similar levels of associated poor health and social outcomes following exposure to ACEs (Bellis et al., 2016; Bellis et al., 2018). The data taken from household surveys describing the risk increase indicated that almost half of all individuals surveyed in England and Wales had experienced at least one ACE. In Wales 14% had experienced four or more ACEs and 9% had done so in England (Bellis et al., 2014a; Bellis et al., 2018). Given the frequency of exposure, the burden to public organisations, particularly policing, is considerable.

2.2. Possible mitigating factors for ACEs

It is important to note that exposure to ACEs does not necessarily predispose one to making poor life choices as, with appropriate support and intervention, individuals can mitigate their risk. It has been shown recently that building in factors of resilience in a child can result in significant progress in reducing the impact of ACEs on poor health and social outcomes (Science and Technology Committee, 2018).

Specifically, it has been shown the role of a continuously available trusted adult in childhood can be of great benefit in reducing poor outcomes for children who have experienced ACEs (Bellis et al., 2017; Science and Technology Committee, 2018). However, as identified in the recent science and technology parliamentary select committee report (2018), the research evidence relating to the benefits of ACE-related interventions is poor, as few high-quality evaluations have been undertaken. This highlights why there is a definite need to identify interventions that relate to the support of children with ACEs and the evaluation of such interventions.

2.3. How is Hampshire using this knowledge to mitigate ACEs?

In Hampshire county, two strategies were employed to combat the effects of ACEs. They involve (i) the secondary prevention (where the exposure has occurred, but the aim is mitigating the impact) of the negative consequences and (ii) approaches to improve awareness and education around ACEs. Both strategies are led by the Hampshire Office of the Police and Crime Commissioner (OPCC) but are delivered in conjunction with multiple local agencies (including local authorities (LAs), social services, healthcare, education and third sector organisations). It is important to note that these strategies are not solely led by the police force.

To minimise negative consequences of ACEs, trusted adult workers (TAWs) were employed as mentors to encourage the development of resilience among those most at risk. TAWs received training delivered by Rock Pool Life community interest company (Rock Pool – a private organisation that provides training around trauma informed practice).¹ The TAW role was twofold: (i) spread awareness of ACEs

¹ Rock Pool. Rock Pool training. Adverse childhood experiences (ACEs). Available from rockpool.life/adverse-childhood-experiences-aces/ [Accessed 9 March 2019]

through multi-agency settings and (ii) act a trusted adult in the life of a child identified to have ACEs, to help them navigate available services and improve their outcomes (particularly criminal justice outcomes). As some TAWs may come from child support or educational backgrounds, some may have developed skills in trauma-informed care or counselling methods that they may choose to employ during the care of children under their remit.

To raise awareness and education around ACEs, Hampshire OPCC had also commissioned Rock Pool. Rock Pool consultants were commissioned across all public sector agencies to ensure a shared language of ACEs was being used and to shift the culture in each of the agencies to reinforce acting in an ACEs-informed manner. Rock Pool led the training of trainers within each organisation. It was the responsibility of the trainers who attended the Rock Pool train the trainer (TTT) session to spread the messages they had learnt within their own organisation. The recommendation according to the OPCC was that the trainers had to deliver a minimum of six sessions during the evaluation period. However, their approach to doing so in terms of class size and frequency of sessions was up to the individual trainer. In terms of materials for delivery, the format, tools and templates delivered by Rock Pool in their original training session were available for use in their subsequent sessions.

2.4. Funding the project

The project was funded by the Home Office early intervention youth fund (EIYF) and the police transformation fund (PTF). The OPCC in Hampshire commissioned Rock Pool and employed 8.5 full-time equivalent (FTE) TAWs (ultimately this was 7.5 FTE after the exclusion of the Isle of Wight due to challenges in recruiting a ninth TAW) over the course of the 2019/2020 financial year in a variety of different settings.

Multiple key agencies approved the process:

- Chief constable, Hampshire Constabulary
- Community safety partnerships
- Chief officers of Hampshire Probation Trust and Community Rehabilitation Company
- Local children's safeguarding boards (x4)

- Local adult safeguarding boards (x4)
- Local authority directors of public health
- Youth offending team management boards
- The local criminal justice board
- The police and crime commissioner
- Directors of clinical commissioning groups (CCGs)
- Directors of NHS England
- Directors of adult and children's services
- Education and skills providers
- Housing providers
- Providers of mental health services for children and adults

The delivery of the TTT approach delivered by Rock Pool is consistent within the county (Figure 1). However, it is important to note that the delivery of TAWs is different between Southampton, Portsmouth and the remainder of Hampshire. The TAW funding dedicated to the Isle of Wight was repurposed for further Rock Pool training, which falls outside the scope of this evaluation.



Figure 1: Hampshire county, highlighting Southampton, Portsmouth and the Isle of Wight

2.4.1. Trusted adult workers

Allocated budget: £352,070 (January 2019 to May 2020)

A total of 7.5 FTE TAWs were employed across the county (equates to seven individuals working full time with one further individual working 0.5 FTE, eight TAWs in total) for a period of one year (financial year 2019/20). The TAWs intervention was designed by Hampshire Constabulary in conjunction with the OPCC to reduce youth crime rates in the area. As the idea was novel, it had not been modelled on another

intervention elsewhere. The evidence base behind the rationale of funding the project related to the concept that a trusted adult in a child's life improves their outcomes in terms of criminal justice, health and social outcomes, especially for those who have experienced ACEs. In addition to this, the OPCC highlighted that the current service referral pathways for children who could benefit from early intervention was extremely complicated for families and children to navigate without assistance. Therefore, TAWs were also expected to guide children and families through these complex service referral pathways. However, throughout the intervention timeline, different referral pathways into the TAWs were adopted in different parts of the county (see section 2.4.2.2 below).

Working together with the local safeguarding boards and community safety partnerships, the OPCC recruited the TAWs. The TAWs had differing backgrounds. The majority (five) came from a youth offending team background, with others from a policing and social services background.

2.4.1.1. Role of TAWs

The key role of TAWs was to provide early intervention support to children who have ACEs by implementing resilience-building approaches. This in turn should reduce negative consequences experienced by this group, regarding criminal justice, health and social wellbeing. They received referrals from voluntary and statutory organisations who became aware of a child experiencing ACEs. However, the exact definition of improved resilience was not clearly set out in the aim of the programme.

Their role included carrying out assessments to identify the needs of children and significant family members (those who live with the child or play an important role in their care). TAWs also mentored/supported children acting as a positive role model and helped children navigate the maze of services available, while developing a directory of interventions and partner organisations. Their role as the intermediary in the referral pathway was to simplify and consolidate the pathway for children and their families. It was intended that children would be identified and supported at a much earlier stage (when they are likely to have less complex needs) because of TAWs being introduced. Prior to the intervention, often children were only highlighted to services at a much later stage (when the children are experiencing more ACEs and have more complex needs) and in a reactive manner.

Some TAWs (due to recruitment timings, their availability and capacity) received a half-day lecture and group work activities to learn about ACEs and their impact on health and wellbeing. Following this induction, their role was to champion and adopt a trauma-informed/ACEs-aware approach. This included understanding the physiology of trauma, the impact it can have and the use of best practice in trauma-informed approaches.

Although there was differing practice in how children were referred to TAWs by the three LAs (Hampshire county, Portsmouth and Southampton), the children who did get referred were expected to be relatively low level in terms of complexity and have few ACEs. The rationale for this approach to referrals was that such children (with lower levels of complexity) were still in a position for secondary prevention interventions rather than tertiary interventions. However, to be referred to the TAWs scheme it was likely they would have experienced at least one ACE. The referral process did not have a specific threshold of ACEs and varied by LA area, as described in more detail below. Children with any number of ACEs could be referred to the service, but the initial aim was to focus on those children who had experienced relatively few ACEs.

2.4.1.2. Variation in practice per area for referrals to TAWs

Southampton: Two FTE TAWs

TAWs were aligned to the Youth Offending Service within the Targeted and Restorative Service. The roles were branded locally as diversion family engagement workers. The whole Youth Offending Service was subject to remodelling as part of a proposed Extended Localities Model and introduction of an undefined at the time of writing 'Vulnerable Adolescents Service' and a 'Family Partnership Team'. The purpose of this remodelling was to bring together education, welfare, youth offending teams (YOTs), and inclusion and diversion across three sites in Southampton rather than keep these services separate as in a previous model. Two of the three sites in Southampton were covered by TAWs, with the third site in Southampton excluded as no TAW had been funded for this area. Therefore, children were not selected from that particular area for intervention by the TAWs.

There were four referral routes in Southampton:

- Joint decision-making panel (similar to a multi-agency safeguarding hub (MASH)): Participants argue the case for a child to be diverted from the youth justice system. To have their case discussed at the panel, the child has to have admitted the offence (if a first offence), the offence in question cannot be a serious offence and any second offence should have occurred a long time after the first. The National Police Chiefs' Council's offence gravity matrix was used to assess the seriousness of an offence and the appropriateness of an out-of-court disposal, such as the TAW intervention. However, cases were judged on an individual basis.
- In-year fair access panel: This panel discusses children who need to move schools for behaviour reasons.
- Access to resources panel: This panel picks up cases of children where an allocated social worker has finished their input but is cautious to let the case go completely. At this panel they decide on further support for the children if required.
- In addition to the formal panels above, schools and neighbourhood policing teams could make referrals directly to TAWs.

Portsmouth: 1.5 FTE TAWs

In Portsmouth TAWs were selected through a collaborative 'expression of interest' process, via the Children and Young People's Alliance. This process was managed by the LA and Motiv8 (one of the lead providers for children's services in the area). Motiv8 oversaw the work being done by TAWs specifically in Portsmouth.

TAWs in this area also completed the Portsmouth single assessment framework, which includes the Early Help Assessment² for children referred. This assessment collates information including a detailed description of family demographics, risk factors and current status of children, as well as specific shared goals and timelines the child and family aim to achieve.

There was only one method of referral in Portsmouth:

² Portsmouth Safeguarding Children Partnership. (2019) [Assessment tools – Portsmouth Safeguarding Children Partnership](#) [internet]. [Accessed 9 March 2019]

- Children who could benefit from TAW support were identified by the Portsmouth MASH and referred to Motiv8 (the overseeing organisation line-managing the TAWs employed in Portsmouth). Specifically at the MASH, a coordinator would use a threshold document² to identify those at tier two (early intervention services for those at risk of offending). Motiv8 would then carry out a more detailed assessment and determine which support/activities that child needed. The assessment included asking what the child wanted. Following this second stage of triage, Motiv8 would decide if they should be referred to the TAW.

Hampshire LA: Four FTE TAWs in Hampshire

Becoming a TAW was an opportunity for redeployment or secondment in Hampshire. TAWs were identified from among existing Hampshire Youth Offending Team (HYOT) staff. HYOT staff came from a range of disciplines, such as restorative justice officers and youth crime prevention workers. The YOT then recruited to vacant posts created by appointing TAWs, meaning the TAWs service could be mobilised quickly.

Methods of referral in Hampshire were through the Early Help pathway, direct referral, existing children who had completed a YOT intervention and via the police/YOT joint decision-making panel.

2.4.1.2.1. Comparable features between the sites

Across the county (Southampton, Portsmouth and Hampshire) there were differences in the delivery of the TAWs approach, the context in which TAWs work, and the referral process to a TAW. Despite local differences, there were still many similarities in the operation of the TAWs approach across the three LA areas:

- i. the TAWs were expected to have a caseload of between 10-15 cases at any one time
- ii. TAWs were likely to work with their clients for between 9-12 months but very unlikely to work for longer than one year regardless of site
- iii. all children being referred through each of the different boards or methods were likely to be in a position where a secondary prevention intervention (to limit the negative consequences of ACEs) may be employed, and so were not expected to have a multitude of ACEs or had already experienced poor outcomes

Despite the similarities, the differences across the sites may have led to unobserved selection biases when examining outcomes across the sites.

2.4.2. Train the trainer project

Allocated budget: £67,000 – This cost included other Rock Pool-taught activities (July 2019 to May 2020)

Twenty-eight members of staff from a variety of different public sector agencies (Hampshire Constabulary, Hampshire OPCC and each of the three LAs) were selected to undertake TTT sessions. The trainers who have the TTT input undertake a three-day education programme where they learn about the role of ACEs in an individual's life and later consequences. They also learn some coping mechanisms that can be implemented in public sector services. These individuals were selected as they were usually in learning and development roles (eg, police learning and development officer) in their respective agencies. Following on from this, the purpose of the TTT programme was to ensure these 28 individuals went on to deliver a minimum of six sessions a year of a half-day awareness course on ACEs within their agency (further details are provided above). This element of the evaluation started in July 2019 and continued until June 2020, beyond the evaluation timeframe due to their date of commission.

2.5. Overarching theory of change

Evaluations of complex interventions have been criticised for not providing a clear explanation of the mechanisms of change through which the intervention leads to impact (De Silva et al., 2014). A logic model can help to overcome this through, in a simplified way, a hypothesis or theory of change (ToC) about how an intervention works (Moore et al., 2015). Most logic models focus on resources, activities and outcomes that are useful in clarifying goals and communicating how an intervention might work. This section outlines the ToC involved in the evaluation and at the end the logic model is presented.

For the TAWs project, the overarching ToC is that intervening early in the lives of children who have ACEs, by introducing a trusted adult, will build resilience. This in turn will have positive impacts on their health and social wellbeing. In particular, this

will lead to a translatable reduction in criminal justice outcomes for these children and families, ultimately reducing the demand on policing resources.

In addition, to facilitate this process occurring successfully, public sector agencies who have involvement in the referral process or handling of these children need to be well informed as to what an ACEs-informed approach is. This in turn will improve the quality of referrals being sent to the TAWs.

There is an abundance of literature to suggest that the presence of multiple ACEs has a negative impact on the life course of children. This greatly increases their risk of poor criminal justice outcomes such as higher rates of incarceration, substance misuse and violence (Bellis et al., 2017; Felitti et al., 1998; Bellis et al., 2014(b); Bellis et al., 2016). There are few known interventions to mitigate the risk of poor outcomes in children identified to have ACEs. However, one such protective factor mitigating this risk is the introduction of a trusted adult for these at-risk children (Bellis et al., 2017; Science and Technology Committee, 2018). The TAWs project was introduced on this basis. Anecdotally in Hampshire, as is the case in other LA settings, the service routes and referral pathways relating to at-risk children are extremely complicated. Therefore, the introduction of a trusted adult in the TAW role is also intended to ensure that children have the best chance of making it through the complex local systems.

However, to deliver such an intervention successfully there is a need to ensure that policing partners understand the literature regarding ACEs and how they can be introduced in practice. Therefore, there is need for an education and awareness campaign. Rock Pool was selected as it has a track record of success with this particular challenge in Wales and Manchester (thought to reduce school exclusions and have visible beneficial economic improvements to police expenditure relating to youth crime in the area (Eccles, 2019)).

The four headings below outline the key elements of ToC.

1. Implementation – how the intervention is implemented.
2. Mechanisms – the mechanism through which the intervention has its effect and produces change.
3. Outcomes – what change the intervention is trying to bring about.

4. Context – the factors external to the intervention that might affect how the intervention operates.

The evaluation methodology is described in detail in the methods section following this.

2.5.1. Implementation

There were separate implementation strategies depending on the intervention.

TAWs

The TAWs were introduced by each of the three LAs to identify children at early levels of need (low number of ACEs). They then play the role of a trusted adult in their life to provide support and prevent subsequent negative outcomes for that child.

TTT

Rock Pool trained 28 individuals through the TTT intervention. These individuals underwent training within their own organisations where they were required to deliver six sessions of training. The main messages of their subsequent training was to inform their wider workforce of the impact of ACEs, describe a trauma-informed approach and also provide actions for their participants to do once ACEs have been identified.

2.5.2. Mechanisms

Following discussions between the research team and intervention leads, Rock Pool and the other partner agencies involved in the delivery of both interventions, the following mechanisms were identified, through which the interventions should produce the intended change:

TAWs

1. The introduction of a TAW in a child's life should increase their resilience and in turn improve outcomes for that child.
2. The introduction of a TAW will ensure that children are referred to the most appropriate services and are followed up to ensure they attend, which in turn should improve outcomes.

3. TAWs will also provide support for families to identify solutions that may mitigate the impact of ACEs relating to household dysfunction. This should improve outcomes for the child and their family.

TTT

1. Education around ACEs should increase the knowledge and understanding of ACEs for those individuals attending the training.
2. The introduction of trainers should increase the knowledge and understanding of ACEs in the wider public sector workforce (police, social services, LA, education and health bodies, including CCGs and hospital staff).
3. Education should allow for a clearer understanding of the application of an ACE-informed approach in the delivery of multi-agency services.

2.5.3. Outcomes

The outcomes relating to any intervention aiming to improve the lives of children who have experienced ACEs through both direct support (TAWs) and awareness raising (TTT) can be broad. However, they can also be difficult to measure in a short timeframe. Therefore, we have broken down measurable outcomes into short term (within the evaluation period), medium term (up to five years) and long term (beyond five years). Although this evaluation focused on short-term improvements, the introduction of data collection tools to measure the impact of TAWs and TTT have been kept in place for the local OPCC and constabulary to continue measuring longer-term outcomes.

Short-term outcomes (Evaluation period – within nine months)

TAWs

For children and their families who have worked with TAWs:

- Behavioural
 - improved emotional resilience
 - improved levels of self-esteem, confidence and wellbeing
 - improved family resilience (plus reductions in family-related crime such as domestic violence)

- increased distance travelled (defined as an individual's progress relative to his or her own starting point)
- Educational
 - improved school attendance
 - fewer days lost through school exclusion
 - more children/young people in education, employment or training
- Criminal/social
 - reduction in criminal offences (such as antisocial behaviour, violence, incarcerations etc)
 - increased attendance at referral partner interventions
 - reduced missing person episodes
 - fewer child protection enquiries

Medium-term outcomes (nine months to five years)

- Culture change in public sector organisations to provide an integration of an ACEs-informed approach in the delivery of key services.
- Reduction of entrants in the youth offending system.
- Reduction in policing demand by children/young people.
- Refinement of the selection process for TAWs.
- Improved health of children in the area based on public health outcome framework.
- Improved school attendance across all schools.
- Reduction in missing person episodes.
- Reduction of 'children in need' and 'looked-after children'.
- Improved partnership working between referral agencies.
- Benefits shown across each of the six 'troubled families' strand outcomes. The six strands relate to a variety of measures relating to health and wellbeing markers captured across public sector services, which were originally captured mandatorily as part of the Troubled Families programme, which no longer exists in Hampshire.

Long-term outcomes (five years and beyond)

- Reduction in youth crime rates.
- Improvements in happiness and resilience of children/young people.
- Improvement in youth health.
- Reduction in the number of 'looked after children' in social services.

These outcomes are presented below in a logic model describing a summary of the interventions taking place across Hampshire relating to ACEs.

TTT

- Staff who have undertaken Rock Pool TTT will have improved awareness of ACEs, their implications and understanding of becoming ACE informed.
- Those who have undertaken TTT should have developed confidence in delivering this material within their organisation.
- Understanding of ACEs by public sector staff who support referral pathways for at-risk children will improve.
- Cultural change of public sector organisations by becoming more ACEs informed.

2.5.4. Context

Within this project there were several key contextual factors that might influence the success of this intervention.

1. New job role and impact: Whether the change of job role to becoming a TAW had been appropriate and were they comfortable in this role?
2. Time pressures: The TAWs were expected to maintain a workload of 10-15 cases. Would this remain the case and was this caseload appropriate?
3. Quality and impact of the education and awareness training: Did staff feel sufficiently upskilled?
4. Did TAWs have the correct background skills? Would this approach work sufficiently well for those solely from a policing background, for example police community support officers, or did it require a multi-agency background?
5. Quality of referrals and differences in referrals across the region: The region already had multiple referral pathways. Did this create issues for the TAWs?

Figure 2: Logic model describing the interventions implemented across Hampshire county TAWs

Aims	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> ■ Principles <ul style="list-style-type: none"> - Adverse childhood experiences (ACEs) have a negative impact on the health and social wellbeing of children as they become adults. - There is limited evidence to suggest what can be done for children or adults who have experienced ACEs to improve outcomes. However, it has been shown in several settings that the introduction of a trusted adult can improve the resilience of children, which in turn can improve outcomes in later life. ■ Aims <ul style="list-style-type: none"> - To effectively intervene in the lives of families/children who are at risk of negative criminal justice system outcomes by introducing a trusted adult who will guide them through available services and deliver interventions. 	<ul style="list-style-type: none"> ■ Trusted adult workers (TAWs) <ul style="list-style-type: none"> - 7.5 full-time equivalent TAWs employed across the county, differing by area. Their role is to work with children affected by ACEs, to mentor and support them, help them and their families navigate through the challenging referral pathways of interventions in Hampshire, deliver interventions themselves and build resilience in the children they are looking after, by working with children and families. 	<ul style="list-style-type: none"> ■ Caseload of 10-15 children with families per TAW. ■ Identify through regular interaction the ACEs that these children have experienced on a template. ■ Complete needs assessments of these children and families. ■ Develop a directory of services. ■ Build relationships with partner agencies. ■ Build resilience with the children they are working with and measure this using validated tools. ■ Identify gaps in support for children and families they are working with. ■ Quarterly reports on the progress of the above children and families. 	<ul style="list-style-type: none"> ■ Short-term outcomes (within the evaluation time frame of less than one year) <ul style="list-style-type: none"> - Increased emotional resilience, self-esteem, confidence and self-wellbeing of children who have worked with TAWs. - Less offending by these children and their families. - Increased school attendance and reduced exclusion of these children. - Improved 'distance travelled', ie, progress relative to starting point. ■ Medium-term outcomes (within the next one to two years) <ul style="list-style-type: none"> - Improved partnership working. - Reduction of entrants into youth offending system with reduced demand on policing. - Development of directory services for children who have experienced ACEs. ■ Long-term outcomes (within the next five years) <ul style="list-style-type: none"> - Reduced youth crime rates and police demand. - Fewer 'looked-after children'. - Better youth health.

Figure 3: Logic model describing the interventions implemented across Hampshire county TTT

Aims	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> ■ Principles <ul style="list-style-type: none"> - Adverse childhood experiences (ACEs) have a negative impact on the health and social wellbeing of children as they become adults. - There is a lack of shared language and understanding of ACEs across the public sector and referrals are not 'early enough'. ■ Aims <ul style="list-style-type: none"> - To increase understanding of ACEs and ACEs-informed practice in the public sector. 	<ul style="list-style-type: none"> ■ Education and awareness <ul style="list-style-type: none"> - Rock Pool training has been commissioned to teach the basics of ACEs, how they can be identified, outcomes and possible strategies for children who have experienced ACEs. To encourage a sustainable approach, a further subset of individuals will be trained as trainers who can then continue to deliver these education packages in a variety of different settings (train the trainer (TTT)). 	<ul style="list-style-type: none"> ■ 28 individuals, including two TAWs, to go on the TTT course. ■ For those on the TTT course, deliver six sessions per year to others within their organisation. 	<ul style="list-style-type: none"> ■ Short-term outcomes (within the evaluation time frame of less than one year) <ul style="list-style-type: none"> - Improved awareness of ACEs in multi-agency staff. ■ Medium-term outcomes (within the next one to two years) <ul style="list-style-type: none"> - Culture change in public sector. - ACEs-informed practice.

Methods

3. Research aims

The overall aim of this research was to conduct an impact, process and economic evaluation of the TAWs approach in Hampshire and an impact and process evaluation of the TTT approach.

Specifically, the research aimed to evaluate the stated intervention aims that TAWs and TTT respectively will:

1. Improve the life outcomes of children working with TAWs.
2. Improve awareness and education surrounding ACEs and a trauma-informed approach within Hampshire county public sector bodies where TTT participants are employed.

3.1. Research design

To achieve the aims of the evaluation, two separate evaluations of the TAWs and TTT approaches have been undertaken, using the following approaches:

1. TAWs evaluation

- a. Focus groups with a sample of referral agency partners to gain insight into the referral patterns to TAWs with perceived success of the intervention from the referral boards.
- b. Semi-structured interviews with the full sample of TAWs to understand the process of managing children with ACEs and perceived success.
- c. Prospective cohort study exploring outcomes of children who have worked with the TAWs to assess the impact.
- d. Semi-structured interviews with children and families to understand their opinions on the intervention.
- e. Questionnaires with children and families to capture any views not captured in the interviews.

2. TTT evaluation

- a. Focus groups with a proportion of those who attended the TTT sessions and became trainers within their own organisations to understand their role and experiences of training.
- b. Questionnaires sent to all trainers to capture any views not represented in the focus group.
- c. Questionnaire feedback from participants who attended half-day sessions put on by the Rock Pool-trained trainers. Feedback collected before and after the session, as well as later on for those who underwent training before December 2019 to assess the impact in the short and long term of the training.
- d. Questionnaires for those who did not attend trainer sessions but work in the relevant organisations to assess the dissemination of the approach.

A multi-method approach was taken to allow for triangulation of findings, particularly in the case of small sample sizes or a limited number of responses. Due to the variety of methods used, there were certain overlapping approaches in qualitative and quantitative participant recruitment, design and analysis. Therefore, this section has been set out by the type of methods being used: 1) semi-structured interview, 2) focus group, 3) questionnaire and 4) before-after analysis, with the TAW and TTT evaluations discussed within each methodological approach.

Ethics approval was sought and obtained from the University of Birmingham ethics board prior to commencement of data collection. Both written and/or verbal consent was required from all participants to take part in the relevant elements of the evaluation.

3.1.1. Semi-structured interviews

Semi-structured interviews were used in two settings: 1) interviews with TAWs and 2) interviews with children and families.

3.1.1.1. Context and sampling

All TAWs were invited to take part in the face-to-face interviews and, where not possible, via a telephone interview. During the study period, we conducted interviews with seven TAWs (six face-to-face and one telephone interview). Unfortunately, one

TAW went on long-term sickness leave in 2019 and so could not take part in the evaluation. Due to the varying levels of experience and background, and children looked after, it was important to achieve a 100% response rate with the remaining TAWs interviews, which was achieved. The interviews took place in a variety of settings when conducted face to face, including Hampshire OPCC offices or where the TAW was based.

In the latter part of 2019, invitations went out to children and families via their TAWs to take part in interviews with the research team to document their experience. We were aiming for a wide range of families and aimed for 10-15 interviews to take place. The sampling method was a convenience sample based on response. We appreciate this may lead to a selection bias, however due to limited time this was a pragmatic approach. Unfortunately, due to the December 2019 general election, as per guidance on the pre-election period from the College of Policing and Home Office, we had to cancel many of our interviews. Though we had hoped to reschedule these in January and February 2020, we could only complete three interviews by the end of the evaluation period.

3.1.1.2. Data collection

Data was collected using semi-structured interviews. A topic guide was produced for both sets of interviews.³

The topic guides were iterative in nature and the researcher conducting the interviews as part of our team had appropriate experience of interviewing vulnerable family members (where relevant). The interviews lasted up to one hour and were recorded either by portable audio recording devices or using telephone software that allows for recording.

3.1.2. Focus groups

Focus groups were used in two settings in the study: 1) a sample of referral agency partners and 2) those who attended the TTT sessions. To further understand the process by which children and families were referred to the TAWs, we conducted

³ Topic guides can be found in the Appendices (Supplementary 1, 2 and 3).

two focus groups consisting of referrers from across the three LA areas (Hampshire county, Southampton and Portsmouth).

3.1.2.1. Context and sampling

For the referral group element of the evaluation, we conducted two focus groups. Individuals who are responsible for referring to TAWs were identified early in the evaluation. We sent out invitations to participate in the focus groups from the OPCC. We tried to obtain a purposive sample (a type of sampling approach to obtain a variety of representative views) whereby we identified individuals from a variety of backgrounds to provide a wide spectrum of views. This included getting views from those referring from social services, LA, youth offending teams and healthcare services. We obtained views from those referring in Hampshire and Portsmouth, however we could not recruit any individuals from Southampton. Generally, there were no issues with engagement with individuals in Southampton. However, distance to travel at the interview site (OPCC office) may have proven a challenge, although other options closer to Southampton were suggested.

For the TTT evaluation, we sent out an invitation from the OPCC to try to get as many trainers as possible involved in two focus groups. Due to last-minute cancellations on the planned date of the focus group, however, this became one large focus group conducted at Hampshire OPCC.

3.1.2.2. Data collection

The focus groups were conducted by two researchers in our team also using semi-structured topic guides. Dependent on the emerging themes from the groups, this topic guide was iterative in nature. The topic guides for both focus groups are presented in the Appendices (Supplementary 4 and 5).

These focus groups were recorded using portable audio recording devices and were approximately one hour in length each.

3.1.3. Analysis methods for focus groups and interviews

The interviews and focus groups were transcribed by a third-party transcriber, after which the audio recordings were deleted. Any mention of specific names or identifiable details were redacted during transcription. The data has been evaluated

using a thematic analysis approach (Richie and Spencer, 1994). This occurs in five steps:

- familiarisation with the raw data
- identifying a thematic framework
- indexing the transcripts according to the ideas presented
- charting the data with the assistance of NVivo software
- mapping and interpreting the data

The thematic analysis has been conducted by the lead author and the themes agreed on by the team.

3.2. Questionnaires

As part of both evaluations, questionnaires were employed throughout with the following groups of participants:

- children and families who worked with TAWs
- TTT professionals themselves
- participants who attended half-day sessions put on by the taught professionals as part of the TTT approach⁴
- those who did not attend trainer sessions but do work in public sector organisations where the TTT professionals were delivering their sessions

The questionnaires acted as an addition to the qualitative interviews and focus groups, allowing collection of further information from those who took part in interviews. This included scoping for generalisability and to gather information regarding the impact of the intervention.

3.2.1. Questionnaire design and sampling

The questionnaires were designed by the project lead. They were assessed for suitability by the project working group and also tested with the intervention leads for

⁴ Feedback collected before and after the session, as well as for follow-up feedback for those who underwent training before December 2019.

readability and ease of use. LA leads also advised on the questionnaire ultimately delivered to children and their families.

Recruitment for the questionnaires depended on the type of participant being approached. The questionnaire sent to children and their families was administered via their TAW (which we are aware may introduce bias, though the approach was taken to increase response rates). The questionnaire sent to the trainers had been distributed via the intervention leads at Hampshire OPCC. The questionnaires sent to those attending the trainers' sessions and those who did not attend the sessions were managed by the trainers themselves. Lastly, for the follow-up feedback questionnaires, the evaluation team had sent the requests for these follow-up questionnaires directly to the participants who attended the previous sessions and consented to being subsequently contacted.

For some of the questionnaires it was not feasible to calculate the maximal response rate (for example, when examining the dissemination of information across organisations, we could not capture information on the staffing levels within each organisation). The questions were all delivered using electronic formats. Participants could remain anonymised as they were assigned a participant number that followed them through the study.

3.2.2. Questionnaire content

The questionnaires had differing aims depending on the participant. The questionnaires sent to the parents/carers of children who worked with TAWs aimed to explore their experiences of working with the TAW. The questionnaires that went to TTT participants aimed to explore their views of Rock Pool-provided training, their personal knowledge of ACEs/trauma-informed practice and their experiences of delivering subsequent teaching. The questionnaires sent to participants of the TTT sessions were designed to explore their understanding of the material taught at differing time points (pre-session, post-session and longer follow-up post-session) and any possible applications of the information in practice. Lastly, for the questionnaire sent to individuals who did not attend the training, their knowledge of training material was used as a proxy of dissemination within an organisation.

3.2.3. Statistical analysis

Categorical baseline data was described using frequencies with proportions. Likert scale data (tested and shown to be non-parametric in nature) is presented using both proportions and graphs.

3.3. Prospective cohort study

A prospective cohort study was conducted where children entering the TAWs programme were followed up from point of entry to the point they left the cohort. Their Outcomes Stars were recorded before and at the end of the study to assess any differences. These were then compared to a control group derived from LA data of other children who have undergone similar interventions (some local examples include emotional literacy support assistants (ELSAs), young carers, Child and Adolescent Mental Health Services (CAMHS), family support service key workers and Catch22 (a service for those affected by drugs and alcohol). This means the case and control groups may not be directly comparable. This is because it was not possible to determine from the anonymised control data the nature of the intervention and level of support received by the child, though we understand some of these approaches are more intensive than others.

3.3.1. Study design and population

This study is a prospective, open cohort study. We have enrolled children into it who meet the criteria to work with a TAW. As TAWs started at different time points depending on their geographical location, we allowed for the study design to be open, meaning children could enter (index date) and exit (exit date) the study at different time points (quarterly time points in the year). Exit could occur either by completing the programme or early exit by the child.

After collecting data between January 2019 and the end of the financial year (31 March 2020), we accumulated longitudinal records on 81 children. This data was collected by TAWs on an Excel sheet. The quarterly returns were sent to the OPCC and then to the evaluators. We then aimed to compare data from these children to other children using comparison data from Hampshire LA electronic recording systems (SafetyNet). This provided data for children from similarly deprived

populations who have undergone interventions because of family troubles or childhood adversities.

3.3.2. Baseline data, covariates and outcome data

We captured a large variety of data on children at varying time points in the study.

The demographic data we agreed to capture at baseline includes information on:

- age
- gender
- ethnicity
- disability
- LA of residence (Hampshire County Council, Portsmouth City Council, Southampton City Council or Isle Of Wight)

Data we agreed to capture iteratively included:

- number of ACEs and type (we agreed it was important not to screen for ACEs, so this data was recorded over time as the TAWs learnt more about the children they worked with and learnt what ACEs they had experienced)

Data we collected at the start and end of the TAW programme:

- the age-specific child and youth resilience measure⁵
- the Rosenberg self-esteem scale⁶

Data we collected at quarterly time points throughout the TAW programme:⁷

- Outcomes Star domains (it is important to note that Southampton, Portsmouth and Hampshire each use a different version of the Outcomes Star framework. Please see Supplementary 8 in the Appendices, which lists the details of the Outcomes Stars used in each LA). The Outcomes Star is a measure of distance travelled, which essentially means whether the child is progressing in certain

⁵ Jefferies P, McGarrigle L and Ungar M. (2019). [The CYRM-R: A Rasch-Validated Revision of the Child and Youth Resilience Measure](#). Journal of Evidence-Based Social Work, 16, pp 70–92.

⁶ Fetzer Institute. (2013) 'Self report measures for love and compassion research: Self-esteem'. Pers. Individ. Dif., 35, pp 213–240.

⁷ Ministry of Housing, Communities & Local Government. (2017). [Troubled Families Programme annual report published](#) [internet]. [Accessed 10 January 2019]

areas of their life. Due to the use of different Outcomes Stars, it is very difficult to provide comparison between the sites. Despite the variation in Outcomes Star frameworks used, they tended to include information relating to the following domains:

- making a difference
- hopes and dreams
- wellbeing
- education and work
- communication
- choices and behaviour
- Six strands framework: taken from the Southampton strands approach, which has been adapted from the mandatorily recorded data used in the pre-existing Troubled Families programme. This data is routinely collected on children undergoing state-led interventions in Hampshire county.

The six strands framework contains information across the following domains and was collected in addition to the variables outlined above.

STRAND 1

Parents or children involved in crime or antisocial behaviour

- Number of interactions with the police per quarter where child is suspected of committing an offence or being involved in antisocial behaviour (ASB)
- Number of interactions with the police per quarter where parents or carers of the child are suspected of committing an offence or being involved in ASB

STRAND 2

Children who have not been attending school regularly

- Number of children persistently absent from school with attendance below 90% per quarter
- Number of children chronically absent from school with attendance below 50% per quarter
- Permanent exclusions per quarter
- Fixed-term exclusions of three or more days per quarter

- Missing from education per quarter
- Child with social, emotional and behavioural difficulties registered in an alternative education provision per quarter

STRAND 3

Children who need help

- Pre-school children who don't thrive
- Separate missing episodes per quarter
- Identified as needing early help per quarter
- Assessed as a child in need per quarter
- Subject to an enquiry under section 47 and/or subject to a child protection plan per quarter
- Number of children identified as having special educational needs per quarter
- Children identified as at risk of exploitation per quarter

STRAND 4

Adults out of work or at risk of financial exclusion or young people at risk of worklessness

- People 16 years or older identified as being at risk of becoming not in education, employment or training per quarter
- Children under 16 years at risk of becoming not in education, employment or training per quarter
- Number of families with rent arrears per quarter
- Number of families at risk of eviction per quarter
- Number of families whose family finances/debts are affecting ability to provide basic care for adults and children per quarter
- Families that do not have appropriate support to manage debt

STRAND 5

Affected by domestic abuse (DA)

- Families experiencing DA per quarter
- Families accessing support from DA victim services per quarter
- Families accessing support from DA perpetrators services per quarter
- Number of times a child is a victim of physical abuse per quarter
- Number of times a child is a victim of sexual abuse per quarter
- Number of times a child has perpetrated violence against their parent or carer per quarter

STRAND 6

Parents and children with a range of health problems

- Parent or carer has a substance misuse issue
- Child has a substance misuse issue
- Parent or carer has a mental health issue
- Child has a mental health issue

3.3.3. Cohort study

The exposed (treatment) group consists of the subset of 81 children who have undergone the TAW approach. These children are compared to children who have not undergone this approach (control group). However, they may have had other types of support. Data for the control group sample was taken from the Hampshire SafetyNet data.⁸ In total this amounted to 188 controls taken retrospectively from the year 2019.

⁸ SafetyNet is a county-wide system drawing on administrative data sources collecting information on each of the strand domains above

3.3.4. Statistical analysis

We conducted a before/after analysis (using t-tests) and checked for statistical significance of outcomes. Significance was set at $p < 0.05$. STATA version 15.1 MP/4 software⁹ was used to conduct all analysis.

3.4. Economic analysis

In addition to seeing if the programme works (or on what sub-group it works), we have made efforts to find out whether the programme is economically viable. Unfortunately, due to limited outcome data that is suitable, we have been unable to calculate an economic cost-effectiveness calculation for either the TAWs or TTT approach.

⁹ StataCorp, 2017

Findings

4. TAWs evaluation

4.1. Focus groups with a sample of referral agency partners

Four themes emerged from the referrer focus groups data, and are discussed below. Firstly, 'The referral process' outlines the typical process of referring to TAWs, along with drawing on the shortcomings of ACEs-oriented referrals and referrers' ideas for improvement. The second theme, 'TAWs processes', depicts some of the key ways in which TAWs work, highlighting the contrast between the workings of this professional group and others. Theme three, 'Benefits and outcomes', focuses on the positive impact of the TAW intervention as observed by referrers, stressing that TAWs are a worthy investment. Finally, 'Barriers and challenges' depicts key barriers to both TAWs and referrers working effectively.

4.1.1. The referral process

4.1.1.1. The current process

Professionals discussed TAWs' remit when considering a referral to the TAWs. Some referrers described a match in terms of 'instinctively know[ing] that's the sort of work that...someone needs' (Referrers 01). Others described TAW referral criteria as unclear, with some referrers having not seen the criteria until the day of the focus group, by which point they would have been working with the TAWs for up to six months. One reason why criteria was clear to some may be because 'it's quite tick-box' (Referrers 02) to refer children. It was explained that, to set up the service, a pragmatic approach had to be adopted to operationalise the TAW service, which was somewhat limited in capacity:

'The reality is we've got four people and it finishes in March [2020], and we needed to provide a service over that period. So, yeah, it is a bit tick-boxy. We definitely thought about it when we went to the ACEs toolkit training and how they were saying, "Don't do that because that's not a really great way of reflecting other people's trauma" [...] but in terms of having to set up

referral criteria and having boundaries, we sort of needed to [...] start somewhere.’ (Referrers 02)

Groups also described how there were different referral routes in different localities. Some localities operated their referrals via a form with the potential of wider discussion. Others had lead professionals who primarily worked with children but then might take their case through the Early Help pathway (described in section 2.4.2.2) and suggest TAW input. Some professionals also discussed supplementing the referral form with a ‘loose screening of ACEs for the family’ (Referrers 02), which was then followed by ‘gathering more information to then put that forward for management to have a look over to say whether they felt also that it was like an appropriate referral to accept’. (Referrers 02).

4.1.1.2. Limitations of ACEs-oriented referrals

Both groups acknowledged that referrals were based on a child’s number of ACEs, with four the minimum number required to trigger a referral for TAW input (higher than the original aim of the programme). However, one professional commented that ‘if, perhaps, they were meeting three, you might ... look at whether there’s a fourth because that feels...right’ (Referrer 02). One group strongly emphasised this ACEs-oriented system as restricting, although some children ‘tick every single one of those [referral criteria boxes]’ (Referrers 01). One focus group attendee with a background in education discussed that this defined criteria would risk some children being missed for intervention (the ACE score may be overly restrictive as children with fewer ACEs may still have high levels of need). Another professional in the focus group recognised that, in some cases, school attendance could be a more accurate marker of need rather than relying on the ACEs scores alone:

P[rofessional]: ‘The ones that we were working with for the inclusion, they were [...] would be what I’d call the lost students, because they don’t exhibit this challenging behaviour, and they will just sit and cry 12 hours a day. They were the lost ones.

F[acilitator]: So, for you, the value in it was having the criteria around school attendance, because I think it was below 70% and a couple of other things...

P: Yes.

F: Whereas, if it was-

P: Well, it was 0%.

F: So, yeah, so if it's just on ACEs, then that [...] they might become the lost ones again.' (Referrers 02)

A lack of consideration in the referral framework for resilience factors was voiced by both groups, given 'that you could have one ACE and be more negatively impacted than somebody that might have eight' (Referrers 02). One group also discussed referrals overlooking a family's openness to change as a problem. They suggested that if families are 'within the trauma crisis situation' they are also 'not ready for the intervention that we can provide' (Referrers 02).

4.1.1.3. Improvements to referral process

Suggestions for improvements to the referral process included tightening referral criteria, which should be 'tailored to the capacity' of TAWs to avoid them becoming oversubscribed and a 'diluted service' (Referrers 01). A professional in one focus group stated that, by having broad referral criteria whereby many children would benefit from their input, the current limited number of TAWs meant support was not always available, leading to disappointment for some potential recipients:

'All the referrals that we're getting for young people [...] all need some level of support, but they can't all get TAW support. You know, when you're in a fortunate position where you might have other projects and stuff that you can signpost or refer young people to, depending on criteria, that's great [...] but actually getting it a little bit more refined at the start would alleviate [...] disappointment, I suppose, in that sense, or the time or the gaps between actually people coming in and actually getting support.'

(Referrers 02)

Both groups agreed the referral process should go beyond the referral form and include a case discussion whereby referrers can justify their reason for referral with other professionals and have 'a bit more of scrutiny collectively' (Referrers 02). From this, TAWs could then review their capacity, jointly discuss any referrals that need prioritising and appropriately allocate caseloads.

Using 'life chances' (Referrers 01) as a marker of need rather than ACEs was suggested by one professional. They described this as a catch-all approach by including all children who have had their potential compromised and are not equipped with the resilience to lessen the impact:

'I mean, you could look at life chances, couldn't you, turn it on its head, and think this child's life chances are being blighted because [...] and then that would catch everything, wouldn't it? [...] So, this child's life chances are being blighted because they have not been going to school, they've been very anxious and crying. Before that, they moved school 10 times, and they don't have the resilience to mitigate against the damage that that's caused or, you know, so you could make an actual qualitative case, rather than it being a scientific "how many points do you score"' (Referrers 01)

This distinction between a focus on the 'score' an individual reaches on a risk assessment tool and a more qualitative, rounded assessment of their strengths and needs reflects a wider debate regarding risk assessment tools used within offending and clinical services (Grove and Meehl, 1996; Hart, 1998). There has been a move in recent decades from the use of more 'actuarial' tools, which use identified predictor variables to produce tools where risk can be scored against known probabilities, to a structured professional judgement (SPJ) approach. This draws on both judgements by professionals (which alone can be unreliable and biased) and actuarial tools (which alone can limit the focus to a small number of, often static, factors to the exclusion of relevant dynamic factors). SPJ is characterised by the development of instruments that provide direction based on research evidence but allow flexibility and discretion in their application, which should be an ongoing and responsive process (Douglas, Cox and Webster, 1999).

4.1.2. TAWs processes

4.1.2.1. A family-centred/person-centred approach

Both groups felt an important aspect of TAWs' work was their ability to work with families and children in a bespoke way, underpinned by the TAWs' qualities of being 'adaptable and flexible' (Referrers 02) to provide an individualised approach:

‘This [...] TAW managed to work with her really intensively, even to the point where she’s also doing some maths work with her [...] and also did some stuff around the bereavement. I mean, it was a very bespoke intervention. Luckily for me, that TAW had experience with [like with bereavement] and, eh, some of the more therapeutic stuff, as well as the educational stuff [laughing], and as well as working with the family in a therapeutic and quite restorative way as well. So, she had loads of experience and managed to bespoke the support that she needed to be able to [help her feel confident in finishing her school year more successfully].’ (Referrers 01)

One group also discussed the importance of TAWs working with the whole family, and that, via this systemic approach, they could address ‘entrenched problems with the family’ (Referrers 01) that prevent the child developing and thriving. Again, the TAWs’ flexible way of engaging with families was specified as an important aspect of achieving this deeper understanding of difficulties within families.

4.1.2.2. TAWs have time

Further to flexibility, TAWs having the time to spend extensively with children and families was acknowledged as important. One professional commented that the TAW’s service was ‘not bogged down by assessments and reports and is freed up to have that face-to-face time’ (Referrers 01) and the TAW was the one making an actual difference to children’s outcomes. This same group discussed how TAWs having more time allowed for gentle persistence to engage with hard-to-reach families, who would normally get lost in the system following disengagement:

‘Because we are so limited on where we can go [refer to], and the outcomes [of say] just a family engagement worker who will be doing a couple of visits, parents don’t engage, so they give up.’

‘With the TAW [...] they are able to put in so much more time with the family, and they have had much better results.’
(Referrers 01)

4.1.2.3. A different way of working

In contrast to professionals' comments on strict referral criteria risking children accessing TAW support, professionals also described how the actual approach TAWs adopt can address a multitude of problems – described as a 'nice balance' that could cover children 'who wouldn't meet criteria anywhere else' along with addressing 'challenging behaviour' that is often identified for intervention (Referrers 01).

Both groups discussed the importance of TAWs offering early intervention. This meant professionals could offer an intervention to families that was ACEs and trauma-informed, addressed challenging behaviour and helped children to avoid adverse outcomes:

'The families have really bought into that and, actually, you can [...] get some real change with those young children [...] and teenagers. So, you don't [...] sometimes you wouldn't have seen that before. There wasn't much, other than social care, to offer. So, this is getting that early prevention in before things are escalating.' (Referrers 02)

This group also commented on how the ACEs framework had provided an alternative perspective for understanding challenging behaviour. For the police participants in particular, a new-found focus on ACEs was felt to have added a further dimension to how they approached people and may lead to adapting their recording processes as a result:

'It made us actually look at ACEs [properly] – it focused your attention on that a bit more and, from a police point of view, we've looked at perhaps changing our form [police-specific form – no further context as to the setting] slightly, so we've got [an] area on there that does highlight what the ACES are. Because police officers go in and, you know, they [...] sort of deal with someone and they write it up, but [...] they're, you know, focused on what they're doing [...] but we're looking at changing the form [in reference to the form above] so then [...] that means that we're looking at it [...] Although we were looking, always

looking at them [...] I think it sort of focuses your mind a bit [on it], and it's recorded that we've acknowledged that those factors are in play.' (Referrers 02)

4.1.3. Benefits and outcomes

4.1.3.1. Making a difference for children

Empowering both the child and wider family to make positive changes was identified by participants as a notable outcome from TAW input. One professional commented on how a whole-family approach was key to families making lasting changes for the better:

'Being able to go in and like sort of empower the whole family, as a whole, and not just working with the young people, who [it] might sit with for a little bit, but actually, once that intervention finishes, who's going to be instilling that message with them still? Being able to do that with the whole family is so valuable.'

(Referrers 01)

Well observed in one group was the difference TAWs contributed to children's school outcomes, particularly in improving attendance for 'school-refusers' (Referrers 01). One professional, a TAW themselves, described how working with the school collaboratively led to the school starting to think of how to accommodate the child's needs, and that the 'school have structured his timetable in a way that allows him to feel more comfortable at school' (Referrers 01). Interestingly, professionals in this group discussed how different LA areas seemingly had different focused outcomes for TAW intervention. One referrer described a significant onus on school outcomes while another professional said ACEs-oriented outcomes and 'getting the right services in place' (Referrers 01) was more of a focus for the TAWs in their area.

4.1.3.2. Bridging gaps

Bridging the gap between families and professionals was another outcome identified by professionals, in that TAWs were felt by participants to be 'an advocate for us [the professionals] and for the family' (Referrers 01). Similarly, this synergy was identified to exist between professionals too, potentially due to TAWs working in a multidisciplinary team, meaning professional paths were more likely to cross:

‘I feel like one of the changes is [...] improving links between the Youth Offending Team and Early Help. We’re starting to do more joined-up stuff, aren’t we, like running some groups together and sort of talking a bit more, so communication has got a bit better, I think, between the two agencies, and insight into what both are doing.’ (Referrers 02)

Though not strictly related to TAWs, one referrer mentioned how the ACE Toolkit programme (a 10-week programme for parents to improve their understanding of ACEs, funded by the LA and delivered by Rock Pool) was now a viable, attractive option to refer to if TAWs were at full capacity. This meant professionals who worked in triage had multiple potential pathways to refer children and families to:

‘What we’re trying to do now is look at, well, we can’t do [...] can’t refer into TAW, can we refer into the ACE Toolkit, which is a programme that these guys are running alongside Early Help, and parenting courses and [...] So, we’re sort of trying to bridge that gap a little bit, so I think that’s been really helpful.’
(Referrers 02)

4.1.3.3. A value-for-money service

One group in particular discussed the economic value of TAWs, and that in the long term they felt the TAW role would be worth the money and could actually save LAs money:

‘It’s definitely worth investing for the long-term future. I mean, even though it costs more money because it’s obviously a more intensive service, in the long term, it saves a lot of money, doesn’t it?

‘...investment – that’s what we’d want to argue for, the investment now to save on x number of prosecutions, x number of going through the family court proceedings...’

‘...worth it, for the future. I think that’s what we’ve traditionally lacked, isn’t it, that long-term vision because people are just looking at their budgets for the next one or two years, and [we]

spend more energy thinking about why that person's not eligible for the service than why we can help them. Whereas, they need that intensive investment now to prevent all the damage down the line with that, you know, ripple effect.' (Referrers 01)

Both groups agreed on the value TAWs had brought to LA services, clarifying that 'everyone's bought into it' (Referrers 01). Other professionals expressed their sadness that 'these guys are going to go really at the end of March' (Referrers 02) once the funding for the intervention had ceased.

4.1.4. Barriers and challenges

4.1.4.1. Difficulty in defining a TAW

Uncertainty about what a TAW was, their remit and overlap with other professionals was expressed by both groups. They noted that more information was warranted, such as in the form of an information pack, to then fully explain to parents and initiate engagement:

Interviewer: 'Are people clear about the work that a trusted adult worker would do with a young person and family?'

Interviewee: 'I think that that could be [...] improved because, from my point of view, I'm trying to get parents to buy into that, because I'm not really speaking to the young person, I'm speaking to the parent...'

Interviewer: 'Yeah.'

Interviewee: 'But they're saying to me, "Well, what do they do?"

So, I'm having to sort of give this bit of information, which I'm thinking, well, I hope that's right [laughing], because we [...] we've not had, you know, sort of like an information pack to actually sort of help us be able to get the parents on board to start with. So [...] we're just having to sort of really go with what we think and what we've heard from other conversations that we've had.' (Referrers 02)

In one of the groups, one professional explained she didn't think the TAW role had been officially introduced in her local area. Another clarified that she 'was not aware

until I was invited to come to this that there was a TAW' (Referrers 01), indicating that the rolling-out process had not been done particularly systematically.

4.1.4.2. Too few TAWs

Provision and capacity of TAWs was explained as a challenge by referrers. One group identified the risk of 'dilut[ing] the service' (Referrers 01) whereby TAWs become overprescribed and therefore lose their value due to a high caseload inhibiting the quality work they could undertake:

'If the caseloads increase, you haven't got the capacity, and when you're there, you're thinking, "Oh, I've got to go in a minute because I've got to go to the next one", so it devalues everything that you're doing with that family.' (Referrers 01)

Both groups discussed alternative pathways to TAWs in the eventuality of TAWs reaching full capacity. While one group saw this leading to adverse outcomes for the child because of no other suitable service provision, the other group discussed the Youth Crime Prevention (YCP) service as a viable option as, although the TAW role is broader, 'the Youth Crime Prevention would pick that kind of thing up' (Referrers 02). One professional in this group also discussed their team's forward thinking once the TAW service ends, in wanting to retain the strong expertise and emphasis on early intervention built up from the TAW role:

'So, there is conversations around what do we do next, at the [end of] March – we don't want to lose the expertise that we've got, and we need to think about where it sits within YOP [Youth Offenders Programme] and what that service would look like, sort of broadening it out, and probably it sits sort of YCP level because that [is] our early intervention, that's our prevention service, and they have a similar role, in terms of a very wide remit of sort of broadness.' (Referrers 02)

4.1.5. Summary

The views of the referral bodies can be grouped into four key themes.

- The referral process: Due to limitations in the available number of TAWs per area, referral processes varied. Where a referral process was centred around the

number of ACEs, this was felt by participants to be limiting. It was clear that the current referral process was felt to be too narrow, however broadening it would stretch capacity. Participants suggested that increasing scrutiny and multidisciplinary decision-making could mitigate this tension and help to identify the most suitable children.

- TAWs processes: It was seen by participants from referral bodies that a unique and useful element of the TAWs approach was their ability to work in an adaptable and flexible manner and work with the whole family, not just the child who was referred to them. TAWs were funded to have dedicated time with children and families, and were not tied down with paperwork and processes. The referral bodies reported this different way of working was beneficial to children.
- Benefits and outcomes: Participants felt the service made a difference to the children involved, with numerous positive stories emerging around the way TAWs have improved the lives of children and their families. Additionally, TAWs were seen as bridging the gap among different professionals in the multidisciplinary environment, particularly in a cost-effective manner.
- Barriers and challenges: Despite the reported success, barriers were still identified concerning 1) definition of their role and 2) lack of available resources in terms of the number of TAWs.

4.2. Semi-structured interviews with the TAWs

Five themes emerged from the data, and are discussed below. The first theme, 'TAWs processes', outlines the many ways in which TAWs work with children, their families, and other professionals. The second theme, 'Positive outcomes' exemplifies the impact of these processes, ranging from everyday functioning to longer-term prospects, along with the challenge of how to accurately quantify these outcomes for evaluation. The third theme, 'Challenges with referrals', depicts the glitches in the TAW referral system, along with identifying some potential improvements. The fourth theme, 'Barriers within the system' identifies key issues that were felt to prevent TAWs from fulfilling their role, ranging from training issues to blocks in the wider working culture. Lastly, 'Barriers within the home' outlines instances where issues within the family led to TAWs experiencing challenges in undertaking their work.

4.2.1. TAWs processes

4.2.1.1. Communication and relationship building

Many TAWs explained how a critical aspect of building a relationship with children and families was through accepting their situation and not forcing a service on them they may not want. They felt this may have contrasted with the family's experience of other services:

'Being able to hold people as they are and be like, "okay, your situation isn't how I want to live my life but it's how you're living yours, so let's make it the best you possibly can" rather than perhaps with other services, where we're trying to shoehorn them into what we think is right.' (TAW 01)

A 'whole-family approach' (TAW 04) was discussed as an important aspect of the TAWs intervention, as this allowed TAWs to have a role in multiple areas of the child's life:

'I think it is just that more integrative kind of work [...] and being able to kind of [...] hit every aspect of what's going on for them.'
(TAW 03)

TAWs also discussed how maintaining boundaries was an important aspect of their communication with families, particularly with their own time and setting out when they were contactable, even if that meant 'families are really annoyed' (TAW 01) if they couldn't get hold of the TAW. One TAW described that informing parents of their schedule was one way of explaining their availability:

'So, it's just being really clear that I'm not available this afternoon or I'm going – I'm training or I'm on holiday or just I've got other meetings today and just not answering the phone straight away.' (TAW 02)

4.2.1.2. Time is key

Having the time to work with the family was discussed as an essential aspect to how TAWs work. This leads to making a difference in children's outcomes, compared to how they might have worked with children in their previous or alternative roles:

‘I think a lot of it is time [...] being able to allocate two visits a week, not one [...] being able to tell them, right from the get-go, like I’m going to be here for a bit [...] whereas, with my other families, I work with them for a maximum of six weeks.’

(TAW 03)

TAWs identified that time gave the opportunity for a child’s trust to develop. This was described as particularly important in the context of trauma-focused work:

‘Obviously, the trauma [...] when I applied for it, I did think how [...] is it going to happen, like how are we going to go about addressing like this because it’s obviously a year, which is a long time to support a young person, but it could take six months to build the trust with the young person to be able to get them to even speak to you.’ (TAW 04)

Time was also described as allowing TAWs to gently re-engage with families, following a period of low engagement. This was also depicted as an advantage of the TAW role compared to other family workers:

‘There’s families that dip in and out of their [...] engagement [...] So, I suppose that positive in that is that we can always re-engage them... because we’ve got the time and the space to do that, where of course other services, you know, don’t.’ (TAW 01)

4.2.1.3. Positive activities

Focusing on children’s achievements and positive qualities was described by TAWs as an important part of their role as ‘these kids are only ever hearing the negatives’ (TAW 02). Ensuring that sessions involved positive activities was identified as a way of engaging with the children and identifying constructive ways of them spending their own free time:

‘If we can do positive activities with them now, they can hopefully continue that and do that with friends [...] even if it’s walking round the park, it’s still positive activity and it’s better than just sitting in the house.’ (TAW 05)

One TAW mentioned how she felt it was important to draw on a child's talent, and bring this into their sessions. This exemplified TAWs' appreciation for the child's positive interests and ensuring a child-focused approach:

'She's been doing some art stuff and, yeah, because she was passionate about that, so I encouraged that as well and said, you know, use that! If you enjoy it [...] get more artistic on us!'
(TAW 06)

4.2.1.4. Specific interventions and approaches

Some TAWs discussed the importance of a trauma-informed approach when working with children and families. They felt this contrasted with other professionals' approaches, and was an important aspect of why TAWs could effectively work with families:

'The background or the training in trauma-informed approaches has got to be key, and I guess that's what sets us apart [...] from our colleagues.' (TAW 06)

Motivational interviewing¹⁰ (MI) (Rollnick et al., 2008) was also described as a useful approach in empowering families. One TAW described how her use of MI with a mother helped 'get her to the point where she'd built that confidence' (TAW 01). Helping children work out different behavioural choices was also highlighted as particularly useful in a classroom setting. By letting them work it out for themselves, the child will likely feel empowered and repeat that positive behaviour in future:

'So, it's trying to do a bit around kind of how to manage their behaviour [...] when you're in that classroom setting, and instead of shouting out, what could you do instead? But it's trying to empower that young person to find the answer, rather

¹⁰ A counselling approach used to engage clients, clarify their strengths and aspirations, evoke their own motivations for change and promote autonomy in decision making. Rollnick S, Miller WR and Butler C. (2008). 'Motivational interviewing in health care: helping patients change behavior'. New York: The Guilford Press.

than me just tell them [...] what I think they should be doing, because if I tell them that that's what they should be doing, they probably wouldn't do it; whereas [...] I plant the seed and they try and figure out the answer, they're probably more likely to try not to shout out [...] So, it's trying to think of little different techniques, but getting that young person to buy into it and think of it themselves, to actually empower them to go, "I've made that decision," rather than just being told.' (TAW 05)

By way of specific interventions, TAWs spoke of a range of skills they would impart to children. Psychoeducation and 'understand[ing] more about their feelings and thoughts' (TAW 06) was specified as a way to normalise a child's reaction to situations. Teaching coping techniques was described as a way TAWs would assist children in managing problems, particularly 'anger issues ... at school or at home' (TAW 05). Gradually reintroducing the child back to school after a period of disengagement was another identified intervention. This was reported as having promising outcomes by way of school attendance:

'He hadn't been to school for like three or four months [...] we slowly built up sort of time spent in school [...] and now [...] he's attended the school every day, full time, for the last two months.' (TAW 04)

4.2.1.5. TAWs' traits and skills

The majority of TAWs identified being a consistent and reliable professional as an important trait. Consistency involved a TAW being the family's lead professional, which gave insight into how families develop trust with their TAW:

'Having one person to help [...] someone sort of consistently, for the family, but also for those children to build up that sense of "Oh. this is a person [...] this isn't just one of those people who comes round three times and then gives up or sees me every 21 days because they have to."' (TAW 03)

Part of reliability was described as being transparent with families, by way of explaining if they were going to be late for meetings as opposed to 'just not showing

up or something like that' (TAW 06). Honouring commitments was expected both ways, which seemingly had good outcomes by way of appointment attendance:

'I think it's quite nice to be able to sort of say, "Look, this is going to happen every week at 11 o'clock, we're going to meet" and they tend – 90% of the time, 99% of the time, they're there.'

(TAW 07)

All interviewees discussed the importance of being open-minded and having a non-judgemental approach. Some TAWs explained how being trauma-informed supported this, along with accepting that families were 'valid in their responses' (TAW 02). Indeed, appreciating the child's perspective was described as a way of understanding their interpretation of situations:

'I think being really open-minded and non-judgemental [...] is a really good thing to have [laughing] because you see everything! When you work with the young, you see and hear things that you would not know that are happening in the world.' (TAW 07)

Being a good listener was also identified as an important skill for TAWs, particularly given that '80% of that one-to-one is just sitting there listening to what they [...] have going on' (TAW 05). One TAW described listening as a key feature families had noticed in the service TAWs provided, again possibly contrasting with their previous experiences of how other services interacted with them:

'Listening – I mean, that is key. How many times people say that they're listening to people and they're not [...] And I think that's one of the differences the families have realised, because I do listen to them [...] to hear what it is that they've got to say and what's going on.' (TAW 06)

4.2.1.6. Collaborative working

Many TAWs noted that co-working with other professionals was essential for a family's care package. Given a family's needs could be so varied, referring to a wide range of services was felt to be integral in providing a holistic approach:

'So, for example, one of them, I had somebody from the Department of Work and Pensions who was like seconded with

supporting families, so she came and did some work over finances with her. So, it's just [...] it is picking up on those needs and just seeing what we can find for them.' (TAW 02)

Liaising and 'staying up to date' (TAW 02) with other services was also discussed as important, meaning workload could become intense due to the responsibility to 'keep that network and keep everybody informed [...] making sure everyone knows what everyone else is doing.' (TAW 06)

4.2.2. Positive outcomes

4.2.2.1. Emotional health

TAWs identified improved self-esteem in the children they work with. Seeing their confidence develop was described as 'a really positive thing about being a TAW' (TAW 07) and was an aspect in particular they felt improved 'every time you see them' (TAW 07). TAWs explained how these children felt they were 'often written off as like "the bad one"' (TAW 02), possibly from making 'wrong choices' (TAW 02). They felt addressing their fragile self-esteem was an important aspect of the work, and provided children with 'a bit of power back'. (TAW 03).

Two TAWs spoke about the lack of positive engagement as a risk factor for mental health problems. Given that 'some of these children go to school, come home, sit at home, and don't go out and do things', they felt they may struggle with motivation, leading to a downward spiral to depression. Therefore, the importance of early intervention for preventing mental health problems was seen as an integral part of the work:

'[The] earlier that you sort of intervene, the more sort of chance you've got to get in there with changing behaviours and things ... in terms of pathways that are... developed through the brain, and that a lot of that goes in in that early adolescence. So, yeah, so I think there is a good... good point to get in.' (TAW 06)

Emotional support for the wider family, particularly for parents, was also discussed, in that a TAW was there 'if things are going really wrong [...] someone to talk to and talk it through with' (TAW 01). Further, TAWs explained that given the length of time

they could spend with families, there was scope to address underlying issues, potentially meaning families could move out of the system:

‘When you like see the social workers and things, they’re just [...] they can’t have the time with the families that they need [...] they’re going round and round in circles – like they’ll go in, they’ll do well, they’ll have the plan, and they close, and then they come back, and it’s because the root cause isn’t being dealt with. Personally, I feel like it should be [...] there shouldn’t be time constraints on things. But I get also that you could work with some of these families for years and all you’re doing is being a support network for them. But it actually is that more valuable than not having that support, because I kind of think, well, if they trust you, and there’s the option to work with them, then why wouldn’t you, if it’s making some kind of headway and if they are using you in a good way?’ (TAW 02)

4.2.2.2. Improved connections

Many TAWs commented on the positive influence a child’s relationship with a TAW could have on their relationships with other professionals. Specifically, children experiencing the benefits of inputs from TAWs were felt to then have faith in other services to help them:

‘In terms of long term, [the] ability to trust maybe professionals, and also getting them to a point where they can engage in services.’ (TAW 06)

Similarly, addressing entrenched mistrust families might have in state services was also described as a benefit from TAW input, meaning families may be more open to help in future:

‘When they’ve all had bad experiences of social workers in the past, that kind of idea of, “Oh well, we worked with [NAME] and she was alright, so let’s give someone else a go.”’ (TAW 01)

One TAW discussed how activities they do with children could be a ‘good bonding exercise’ (TAW 05) for families, which could be continued following TAW input.

4.2.2.3. Everyday life

As mentioned, a child's improved school attendance was frequently cited as a positive outcome of TAW input, whether attending lessons or going to school at all. Accepting that progress may be gradual and incremental was depicted by one TAW, who recognised that any improvement was still significant and important:

'They weren't attending school or they were having fights at school, and now – I mean, one of them is only in school one hour a day, but he wasn't going in at all, so [...] it's taken a year but I'll take it!' (TAW 03)

Assisting with practical tasks was identified as another way TAWs helped families, with this ranging from helping parents 'pay their gas bill so they're not going to get their gas cut off' to organising seeing a doctor because a child's 'asthma was really playing up' (TAW 01). One TAW mentioned that what might seem as trivial or straightforward tasks to most, could be complicated for a family who does not have access to basic modern means:

'I had to Google how to apply for a national insurance number yesterday [...] but, again, this is a family who couldn't do that themselves because Virgin or Sky or whoever had cut off their thing for not paying, so they couldn't Google it [...] Some of the things that we take for granted, that feel so simple, just [...] and it's just an obstacle too many for the families that we work with and the level of need.' (TAW 03)

4.2.2.4. Feeling empowered for the future

Families and children feeling empowered in making their own positive decisions was described as 'the long-term outcome' (TAW 01) of TAW work, so families could continue their progress beyond TAW input. TAWs spoke about the importance of equipping children with the skills 'to find solutions' (TAW 03) and how this process was essential in preventing children from facing adverse outcomes:

'So, I think the role is very much that [...] empowerment [...] you don't have to go in and be like, "Right, this is how this works!" It is just [...] I don't even know how to word it [...] it's just that

sense that I know that, without me, and it could have been anyone, but without someone in my place, he would probably have been expelled from school.’ (TAW 03)

Two TAWs spoke about their work with children in preparing them for therapeutic input. The trauma-recovery model was identified as a useful approach in terms of ensuring children are in the right place for therapy:

‘Making sure the base is nice and secure [...] so that when I’ve finished in March, they can go on and they can be successful in having some counselling or whatever that might look like.’
(TAW 01)

For many families, TAW input had a defined endpoint, and so preparing for transitions to work with other services or have no input was defined as an important aspect. One TAW spoke about acknowledging parents’ ‘problematic attachment to adults’ (TAW 01), therefore ensuring endings were positive is ‘probably as much [...] [of] the importance of the work as everything else, really, as difficult as it will be’ (TAW 01).

4.2.2.5. The family’s voice

TAWs discussed positioning the family and child at the core of their own approach when engaging with other professionals as important in ensuring the family’s voice was heard. Tied in with empowerment, one TAW described the family ‘being valued and being important and it being their ownership of what’s going on for them, rather than other people sort of determining their fate kind of thing’ (TAW 06). This TAW also described the importance of her challenging other professionals’ stereotyped views of a child, to avoid unhelpful labels and stigma:

‘Professionals, people can label families with certain names, and perhaps [...] there are other ways of reframing what is going on for that family and it not being labelled as [...] something, do you know what I mean? Like I hear people saying, “Oh, he’s a manipulative kid,” and I’m like, “He’s a manipulative kid?!” [...] He’s getting his needs met the only way that he knows how. He’s got learnt behaviours for that. How can you label a child [laughing] in that way?!” (TAW 06)

Working via a flexible approach to meet the varied needs of the family was described as a positive aspect of the role. By being 'not prescriptive' (TAW 01) and, again, having the time to explore problems, families and children were provided with a bespoke service to 'ensure they have all the skills they need to kind of thrive in life' (TAW 03). This flexibility was described as a defining feature of the TAW role, yet in some ways made evaluating their impact a challenge given some processes and outcomes are hard to observe and measure. Additionally differences in their roles across the various LAs further added to the complexity in evaluating the outcomes they had affected.

4.2.2.6. The difficulty of measuring outcomes

Some TAWs expressed uncertainty in understanding what difference they were making, which was in part due to the flexibility of their role:

I: 'So, do you think that being so flexible, or not having a kind of defined role as what a trusted adult worker is, do you think that's a good thing or a bad thing?'

P: 'Oh, I don't know! For me personally, as a worker, not ideal because I'm never really sure if I'm...am I doing what I'm supposed to be doing? Am I just being a family – not "just being", but am I solely being a family support worker, therefore why is this role any different?' (TAW 01)

They also discussed how, although they could see children's everyday progress, accurately measuring this in the long term would be a challenge. One TAW reflected on her experience in working in preventative work, and how this presented similar challenges in evaluating their work:

'But I guess a lot of it is kind of what happens in the future, and we won't necessarily know if we've helped or not – and it's the same in my other role in prevention: we're sort of preventing something that may or may not ever have happened anyway.'

(TAW 01)

4.2.3. Challenges with referrals

One TAW discussed how, even though the child was 'the main referred point' (TAW 06), often issues weaved within the family meant the focus of work was broader than originally specified in the referral:

'You'd go with the referred child and then realise actually, after a bit of time spending with the family, that the child that's not referred is the one that's [...] very anxious, got difficulty with eating, not sleeping, and the child that you've been referred is actually bouncing along quite nicely.' (TAW 06)

TAWs discussed the potential limitations of using ACEs as a marker of need. Families' resilience factors were also proposed as worthy of consideration at the point of referral, as it was explained that the number of ACEs alone is not necessarily a true determinant of a family's need:

'I think they excluded families straight away based on the fact that they were putting a number on how many adverse childhood experiences you had because, you know, you could have one and be really traumatised, or have 10 and be okay. So, I think there needed to be some balance to offset that in like what resilience factors are there as well.' (TAW 06)

Identifying where the family is in the cycle of change was discussed as a way of improving the referral process. TAWs described how progress with families could be delayed when families were not in the right place for work, along with the potential impact this had on their relationship with the family:

'I think where the families are in their cycle of change [...] Like I say, we don't know that, and I've got a family that I worked with at – when I first met them [...] I thought they are well up for this, and mum's proper in the action stage of the cycle in change and we're really going to make some difference. Actually, she really, really wasn't, and I wouldn't have known that until I got to know her and started to kind of push for some of those questions and got the backlash from her.' (TAW 01)

4.2.4. Barriers within the system

4.2.4.1. Training needs

TAWs identified gaps in their training, which varied from some TAWs not having any specific TAW training at all to others attending the three-day Rock Pool training. One TAW identified how, quite quickly, they were seen as the ‘trauma expert in [the] office’ (TAW 04) yet had received limited training about trauma approaches, meaning they had to depend on ‘CAMHS workers [...] to sort of understand it a bit more’ (TAW 04). Another TAW also commented on how training with younger children would have more effectively prepared her for the role, as ‘it’s very different to what I’m used to’ (TAW 01).

4.2.4.2. A lack of time

Despite TAWs discussing the novel benefit of time in their role, a lack of time was identified as a barrier to them fully progressing with families. One TAW discussed the importance of understanding the time it takes to get families in a place to commence work, and questioned whether it was right to even start if work cannot be completed:

‘We have to do so much work to get to a point, and now, if my families are now ready to look at that work, and I’ve only got until March, I think we have to look at the [...] how ethical it is to raise a lot of those questions, knowing that I’ve only got a couple of weeks left to work with you and I can’t support you through that.’
(TAW 01)

4.2.4.3. Complications with co-working

Some TAWs discussed how an overlap between their responsibilities and those of family support workers could add difficulty in terms of understanding the focus of both roles. They described how they ‘can kind of be dragged into doing a bit of both’ (TAW 02), meaning maintaining boundaries and explaining their remit – that they ‘were there for the emotional side of things’ (TAW 01) – was important for both their workload and families’ expectations.

One TAW discussed their exclusion from the wider professional circle supporting families. They noted how a lack of involvement in meetings may have meant

professionals did not gain the benefit of a TAW's role, or a fully joined-up service for the family:

'Sometimes, you don't get invited to like meetings and things, and I think it's really important that TAWs get invited to like Children's Services meetings if there's social workers involved, purely for the fact that we get a better insight, and we're quite a big part to play [...] especially if you're working long term with young people [...] because, again, we're that [...] we are quite a big influencer for those young people.' (TAW 05)

4.2.4.4. Increasing budget

Many TAWs discussed the impact of a restricted budget on both the activities they could do with children and the amount of time they could spend with them due to the number of TAWs employed. While one TAW recognised a low budget was not strictly a 'TAW thing' (TAW 07), they explained how important resources were for getting children to engage in the work:

'Some of them are happy to just sit and have a cup of tea and chat, but others, you have to sort of pull [...] pull it out of them, and [...] doing a positive activity seems to help because they're sort of doing something fun and something that they may not have tried before, and then they're more open to speaking and they get a little bit more comfortable and [...] So, I think, like money-wise, financially, there's always that [...] oh, that activity is quite expensive.' (TAW 07)

More money meaning more workers was also discussed. One TAW identified that 'we don't have enough workers to meet the need of the families in need' (TAW 03) and how increasing provision would mean 'spend[ing] an extra couple of sessions with each one because we [...] wouldn't be kind of oversubscribed' (TAW 03).

4.2.4.5. The culture of support

TAWs discussed a challenge at the management level, in that they did not feel managers fully understand the role of a TAW. It was suggested that managers

expected TAWs to follow the same processes and in the same timeframes as other similar roles, which was felt to cause misunderstandings:

‘I think, in terms of barriers, managers understanding the role [...] there is that very much of “Well, what is this job and why do you get longer with these people than them people, and how are you going to fit this in?” And I think, because of the system we are in, in terms of a [...] sort of like a council set-up, I guess, on the expectations of what a family engagement worker looks like, they have to get their head around this is not, “Give them 10 cases and, in six weeks, those 10 cases are gone and” [...] This is a bit different.’ (TAW 03)

This TAW also spoke of the wider culture, at the council level, which was not felt to be fully oriented towards a supportive service, but rather one of blame. She felt this could be improved by a TAW’s solution-focused and empowering approach:

‘Again, I work with a lot of schools who say, “She’s just not coping – I can’t believe they’ve given her that child” [...] and I’m thinking “what...?” I think we’re very much in a culture of kind of blame and looking for difficulties, and then not necessarily having solutions for them. So, I think the trusted adult worker might be a solution to some of these, in an indirect way. So, again, I did not speak to this Year 11 and say, “You mustn’t have fights in the street, that’s not okay – you need to stop having fights in the street.” I went in and said, “What’s going on for you – what’s happening?” and he said, “Oh, I get so frustrated! They call me this, they call me that, and I don’t know what to do, and I’ve tried telling the teachers!” “Okay, let’s talk to your teachers...” And kind of going in and really finding out what’s going on. And now, I’m hearing that he’s talking to the teachers without even contacting me – that’s all I wanted, like that’s exactly what it is. So, I think the role is very much that [...] empowerment.’ (TAW 03)

4.2.4.6. Difficulty defining a TAW

As mentioned previously, a TAW can adapt to the needs of each family, which was largely seen as an advantage to the role. It was reported that the 'jack-of-all-trades form of support' (TAW 03) could however also present complications in terms of TAWs understanding the remit of their role and remaining focused:

'I just don't know if what I'm supporting them with is what I should be supporting them with [...] I don't know if, sometimes, I'm getting side-tracked in [...] in like what the family are seeing as their highest need at that moment. I feel like I get pulled into that a little bit, in terms of, if he's not going to school, okay, let's come up with a new sort of plan to sort of get him back into school, but actually, that's not my role.' (TAW 04)

TAWs also discussed that children could be confused about what a TAW was and having to adjust to 'this new person come[ing] in that's sort of doing the same things but just being really nice to you' (TAW 01) particularly if they were 'so used to family support workers and social workers and YOP workers' (TAW 01).

One TAW spoke about a parent's confusion of what the TAW role was, expecting them to assist with financial problems which then led to 'difficulty engag[ing] them with the process' (TAW 04) once they realised a TAW was not specialist support. Another explained the importance of 'the clearer we can be, the better' (TAW 03), but that being family-led meant an adaptive support system to 'ensure they [young people] have all the skills they need to kind of thrive in life' (TAW 03).

4.2.5. Barriers within the home

4.2.5.1. Timing is important

As discussed, families being in the right place for change was felt to be essential for the work to be undertaken and be successful. For some families, pragmatic issues such as 'they're going to be evicted' (TAW 01) would take priority and momentarily refocus the TAW's work, meaning more complex trauma-based work would be sidelined. One TAW spoke of how adaptive their approach needed to be when managing the various ways families functioned and reacted to adverse situations:

‘So, if the family has a crisis point, one family will contact me immediately and keep contacting me, when another family will just bury their head in the sand [half-laughing] and not contact any professionals. So, I guess, to some extent, there are all these things that are a bit separate just because they’re different people and different families.’ (TAW 03)

4.2.5.2. Parents need to be invested

TAWs spoke of the importance of parents being engaged with and invested in the work, both in recognising their part to play and making time for TAW sessions. One TAW spoke about how parents shifting responsibility could mean they were not yet ready to undertake the work and make a change, meaning they stayed within the system:

‘We can put in all the time with him, but it’s not going to change it because it needs to come from home and she’s [the mother’s] reluctant because she doesn’t think she needs to change. So [...] it’s like you’re not going to get anywhere with the TAW role because they’re just not in that space.’ (TAW 02)

Parents’ working hours were also described as a potential barrier, which, although it ‘is a positive that they’re working [...] because it’s a role model to that young person’ (TAW 05), it could mean TAWs miss the opportunity to update parents (and carers) on the work.

4.2.6. Summary

The views of the TAWs can be grouped into five key themes:

- TAWs processes: Many TAWs identified that a critical aspect of building their relationship with children and their families was accepting their situation and not forcing a service on them. This approach was contrasted with the way other services approached supporting families. The additional time the TAWs had with each family in their case load was seen as key for success. Additionally, positive reinforcement behaviours and the opportunity to conduct specific interventions, which can draw on the TAW’s unique skillset when conducted in collaboration with the child, were seen as important success factors.

- Positive outcomes: The TAWs reported substantial improvements in children's emotional health, connections with others, positive outlooks on everyday life and feeling empowered for the future. TAWs also felt they provided the option to repurpose the child's status in their family and gave them a voice. It was clear to the TAWs that in this type of role, it is often not clear how to measure these sorts of outcomes. But interviewees were clear there had been benefits for children and families.
- Challenges with referrals: TAWs identified that ACEs may not be an appropriate marker of need, and a good referral may need to consider where the family is as a whole and where they are on the cycle of change, for example how ready they are for the intervention.
- Barriers within the system: TAWs identified training gaps. They felt that even though they did have more time than other service providers, they still didn't have enough to finish the work they started with these families. Additionally, they felt there were challenges in maintaining their unique role because they overlapped with other professionals who often worked concurrently with the families. TAWs also identified the limitations in available budget for them to undertake the activities they needed to, as well as a lack of support from senior managers.
- Barriers within the home: There were clear messages from the TAWs that parental engagement and external events within the home could affect the efficacy of the programme so the timing of the engagement was important.

4.3. Prospective cohort study exploring outcomes of children who have worked with TAWs

4.3.1. Descriptive statistics

The intervention data consists of 81 children who worked with TAWs. By April 2020, 43 cases (53%) were closed and the remaining 38 (47%) were still open. The majority of the children who worked with TAWs were male (70%), 29% were female and 1% were non-binary. The average age of the child was 12.4 years, ranging from 4 to 18 years of age. 98% of children were identified as White British and 89% as with no disability. 48 cases (60%) came from Hampshire, 19 (23%) from Portsmouth and 14 (17%) from Southampton.

The number and type of ACEs:

On average, each child met five ACEs (from the list of 10¹¹). Table 1 (below) illustrates how many ACEs were met by all the children the TAWs worked with.

Number of ACEs met	Number of children	Percentage
0	1	1.2%
1	2	2.5%
2	3	3.7%
3	10	12.4%
4	17	21.0%
5	18	22.2%
6	14	17.3%
7	9	11.1%
8	2	2.5%
9	4	4.9%
10	1	1.2%
Total	81	100%

Table 1: Number of ACEs met

4.3.2. Before and after analysis

Across all three areas, data on the Outcomes Stars (measures of progress or distance travelled) were collected for each child in the intervention. As noted above, different LAs across Hampshire used different versions of the measure (please refer to Supplementary 8 in the Appendices for a description of the domains included in each version).

Each category within the Outcomes Star was given a grade from one to 10, 10 indicating fewer problems. Each quarter it was updated so we could track any progress made. To compare all three areas, we used an average of each Outcomes

¹¹ The ten ACEs include five factors related to direct abuse: physical, sexual or emotional abuse, and physical and emotional neglect. A further five factors relate to markers of household dysfunction: parent who has experienced violence at home, mental illness, substance abuse, incarceration or separation (Bellis et al., 2014a).

Star in the first quarter the TAWs worked with the family/children and compared it with their closing quarter. Where a case had not been closed, we used their last available quarterly update.

Data was not available for all families. In 17 cases (21%) there was not enough data for the analysis (usually because there was only one quarter available so we could not track any progress. There are a number of reasons why this could have happened, including TAWs losing contact with families due to a lack of engagement or because families were only worked with for one quarter). As such, the analysis below is based on 64 cases (79%) that had enough data collected on their progress throughout the intervention.

Some TAWs in the Hampshire LA collected the 'Family Outcomes Stars' (a composite measure of how the whole household is doing, including the parents/carers and their parenting style). These measured the following: physical health, your wellbeing, meeting emotional needs, keeping your children safe, social networks, education and learning, boundaries and behaviour, family routine, home and money, and progress to work. Each category within the 'Family Outcomes Star' was given a grade from one to 10, 10 indicating fewer problems. Each quarter it was updated so we could track any progress made. We have this data for 29 families and report the progress below.

4.3.3. Outcomes Star – child

At the start of the intervention (first quarter) the average Outcomes Star across the children was 4.1. Table 2, below, reports the statistical difference¹² between the average Outcomes Star between the first and last quarters for the overall intervention and by each area separately:

¹² Two sample mean comparison (paired) t-test

Outcomes Star – child									
	First quarter			Closing quarter			Difference	Test Statistic (T)	Significance (p)
Area	Mean	SD	N	Mean	SD	N			
All areas	4.1	1.42	64	4.6	1.73	64	0.5	-4.26	0.0001*
Hampshire	3.6	0.70	34	3.8	0.65	34	0.2	-1.75	0.09
Southampton	6.3	1.35	14	7.5	1.04	14	1.2	-4.29	0.001*
Portsmouth	3.5	0.49	16	3.8	0.68	16	0.3	-2.20	0.04*

Table 2: Outcomes Star (child), average Outcomes Star reported per child, first and closing quarter of the intervention, per area

* indicates the statistical significance (at least at 5% level)

Across all areas there was a statistically significant increase in average outcome between the first and closing quarters. However, results were different across the regions. In Hampshire there was an increase of 0.2 in the Outcomes Star but it was not statistically significant at a 5% level (but was significant at 10%). Southampton had the largest increase of 1.2, which was statistically significant, and Portsmouth had an increase of 0.3, which was statistically significant. These findings suggest that the TAWs intervention was associated with an improved Outcomes Star score. However, as there was no control group we cannot conclude the findings are causal.

Next we report the differences between the average Outcomes Star between the first and last quarters for female and male children separately:

Outcomes Star – child, by gender									
	First quarter			Closing quarter			Difference	t	p
Gender	Mean	SD	N	Mean	SD	N			
Female	4.12	1.41	16	4.87	1.89	16	0.75	-3.09	0.008*
Male	4.16	1.44	48	4.52	1.68	48	0.36	-3.10	0.003*

Table 3: Outcomes Star (child), average Outcomes Star reported per child, first quarter and closing quarter of the intervention, by gender

* indicates the statistical significance (at least 5% level)

Female and male children receiving the TAW intervention had similar Outcomes Stars reported in the first quarter. But female children had, on average, higher Outcomes Stars when compared to male children in the closing quarter. The difference between the two quarters was 0.75 for females and 0.36 for males and both were statistically significant. This suggests that the TAWs intervention appears to be associated with a larger increase in the improvement of Outcomes Star scores for females when compared to males. However, due to the small sample size of the female cohort, we have not conducted further analysis to assess whether these findings are statistically different between the cohorts.

Next we categorise cases by child's age:

- Young – if children are aged 5 to 12
- Teens – if children are aged 13 to 18

Then we report the statistical difference between the Outcomes Stars at the first and closing quarters in Table 4 below:

Outcomes Star – child, by age group									
	First quarter			Closing quarter			Difference	t	p
Age	Mean	SD	N	Mean	SD	N			
Young	4.02	1.22	23	4.60	1.57	23	0.58	-3.92	0.001*
Teens	4.22	1.53	41	4.62	1.84	41	0.40	-2.69	0.01*

Table 4: Outcomes Star (child), average Outcomes Star reported per child, first quarter and the closing quarter of the intervention, by age group

* indicates the statistical significance (at least 5% level)

The average Outcomes Star for younger children was 4.02 at the first quarter and 4.60 at the last quarter. The difference of 0.58 was statistically significant. The average Outcomes Star for teens was 4.22 at the first quarter and 4.62 at the last quarter and the difference of 0.4 was statistically significant. This suggests that the TAWs intervention was associated with a larger increase in the improvement of Outcomes Star scores for young children when compared to teens. However, there was a significant improvement for both age groups at the closing quarter. Similarly to the sex-specific analysis above, we could not assess whether the service was statistically significantly more impactful for younger children.

We then categorise cases based on how many ACEs they have experienced:

- 'Below average' – if they experienced 0-3 ACEs
- 'Average' – if they experienced 4-6 ACEs
- 'Above average' – if they experienced 7 or more ACEs

Then we report the statistical difference between the Outcomes Stars at the first and closing quarters in Table 5 below:

Outcomes Star – child, by number of ACEs experienced									
	First quarter			Closing quarter			Difference	t	p
No. of criteria met	Mean	SD	N	Mean	SD	N			
Below average	3.72	1.31	12	4.04	1.64	12	0.32	-1.61	0.14
Average	4.14	1.48	39	4.53	1.55	39	0.39	-2.89	0.01*
Above average	4.57	1.33	13	5.40	2.16	13	0.83	-2.79	0.02*

Table 5: Outcomes Score (child), average Outcomes Star reported per child, first quarter and the closing quarter of the intervention, by number of ACEs experienced

* indicates the statistical significance (at least 5% level)

Across all three categories, the difference in the quarterly Outcomes Star for a child was positive. The difference of 0.39 was statistically significant for the group with an average number of ACEs and the difference of 0.83 was statistically significant for the above average group. From this type of analysis, it is not clear why the distance travelled was most substantial in the most complex group. It is possible that this group had the most distance to travel and potentially the most easily achievable improvements to life outcomes during the intervention period. However, in this analysis we could not identify whether this was the case.

4.3.4. Outcomes Star – family

Some TAWs in Hampshire collected a 'Family Outcomes Star'. Here we report the statistical differences between the Outcomes Stars for families at the first and closing quarters in Table 6 below:

Outcomes Star – family									
	First quarter			Closing quarter			Difference	t	p
Area	Mean	SD	N	Mean	SD	N			
Total (all from Hampshire)	6.56	1.39	29	7.21	1.21	29	0.65	-3.96	0.001*

Table 6: Outcomes Star (family), average Outcomes Star reported per family, first quarter and the closing quarter of the intervention

* indicates the statistical significance (at least 5% level)

The average Outcomes Star for a family was 6.56 at the first quarter and 7.21 at the closing quarter. The difference of 0.65 is statistically significant. Given that the TAWs intervention was designed to target the child or young person and not necessarily their family, this may explain why the Child Outcomes Star scores are lower (indicating more problems).

4.3.5. Family Outcomes Star and control group analysis

We received data from Hampshire county LA to use as a control sample for this analysis. After cleaning the data, we merged all known variables across both groups to form a final dataset, which consisted of 188 control sample observations and 33 treatment sample observations. Data for controls was provided from 2019, where the majority of families were identified via the Early Help Hub process, while a few were historically directly referred to local coordinators from professionals working with the family under universal services such as schools or health. In both cases the family would need to meet the ‘supporting families programme’ criteria, which was having problems in three or more of the following headlines areas: education; crime and ASB; children who need help; employment and financial exclusion; domestic violence and abuse (including violence against women and girls); and health. Families would have then received a lead professional/early help coordinator who should have provided whole-family interventions based on the individual needs and concerns for the family, as identified at the Early Help Hub. The most common interventions for those families in the control group were ELSAs, young carers,

CAMHS and family support service key workers. The data provided did not, however, give the specifics for each child in our sample.

Using the six strands, we identified information collected by TAWs if each child in the treatment group suffered from problems with crime, education, needing help, employment and financial issues, domestic abuse and health. This information was also available for our control sample. The total number of problems identified was higher for the treatment group (from six strands information). The average number of problems was 3.2 for the treatment group and 2.6 for the control group and the difference of 0.6 was statistically significant ($t = -3.82$, $p = 0.002$). It is important to note that the control group contained no information on ACEs. This means when matching children, we could not take into consideration any like-for-like differences in the adversity they were facing at intervention entry that may influence their eventual outcomes.

Further, it is important to note that this control group were children who also went through alternate interventions ('business as usual') rather than no intervention at all. Therefore, comparing the outcomes of this group and the treatment group we could not capture the average treatment effect as both groups were exposed to some form of intervention. Also it is important to highlight in the control group we only had information on Family Outcomes Star measures and not on the Child Outcomes Star measures, limiting our ability to compare the findings between the intervention and control group. More detail is required on the baseline characteristics and complexity of children's problems prior to their entry into the intervention.

Additionally, the sample size was very small. The treatment group only consisted of 33 observations, and we could not successfully match both groups on their main characteristics of age, gender, deprivation index and problems experienced through the six strands information.

However, we have outcomes for children on Family Star Outcomes, which are: physical health; your wellbeing; meeting emotional needs; keeping your children safe; social network; education and learning; boundaries and behaviour; family routine; home and money; and progress to work. Family Outcomes Stars were collected initially (first quarter) and then six months later for the control group and for the closing quarter for the treatment group (the length of follow-up would depend on

how long the TAW was working with the family – this may be more than six months for some children).

Table 7 below illustrates differences between the averages of the initial and closing quarters Outcomes Stars and the difference of Outcomes Stars between that time.

Family Outcomes Star – Hampshire									
	Treatment group			Control group			Difference	t	p
	Mean	SD	N	Mean	SD	N			
First quarter	6.44	1.40	33	6.43	1.56	188	-0.01	-0.036	0.97
Closing quarter	7.19	1.18	33	7.58	1.42	188	0.39	1.49	0.14
Difference	0.75	1.21	33	1.15	1.32	188	0.40	1.81	0.07

Table 7: Family Outcomes Star – first quarter average, closing quarter average and the difference between first and closing quarters.

* indicates the statistical significance (at least at 5% level)

Both groups had a very similar starting average for the Family Outcomes Star but at the closing quarter the increase was larger for the control group. None of the differences were statistically significant. There may be numerous reasons for this, including the complexity of the children and families selected for either the TAWs intervention or the control group. The TAWs intervention was designed to target the child or young person and not necessarily their family. Therefore, it might be expected that any improvements would be in the child-specific Outcomes Star rather than the Family Outcomes Star. The control group was selected from a cohort that would have been selected for family intervention, so may have received more interventions specifically targeted at family change, rather than specifically targeted at the child.

4.3.6. Summary

- In total, during the study period 81 children worked with TAWs, with 38 still continuing with the intervention at the point of evaluation. On average, a high proportion of children had more than four ACEs when beginning the intervention. It is important to highlight that the different LA areas used differing referral pathways and mechanisms to measure distance travelled and progress made.
- Outcomes Star children: There was a statistically significant improvement ($p=0.0001$) in the average Outcomes Star score (+0.5) for children supported by the TAWs. When breaking down by gender, both males and females noted improvements, although this was higher in females. Additionally, the intervention appeared to have a bigger impact for those in the younger age group and particularly in those with more ACEs (4-10).
- Outcomes Star family: There was a significant increase (+0.65) in the average Family Outcomes Star score after the intervention.
- When compared to controls: cases in Hampshire were compared to controls using six strands data with both groups showing an improvement in Family Outcomes Star. The Outcomes Star increase was higher in the control group, however it is likely that this control group may not have been suitable. Both the treatment and control group underwent interventions. In the control group some of the interventions focused on family-wide improvements rather than child-specific improvements such as in the TAW programme. This may be one reason why the control group appeared to have a better Family Outcomes Star score. Additionally, the complexity of the caseloads could not be assessed using this approach. After reviewing the number of ACEs, it is clear that the TAWs children had a higher-than-expected number of ACEs, which may have meant they were more complex cases to manage than the controls. The data employed did not record how many (if any) ACEs the control group had experienced.

4.4. Semi-structured interviews with children and families

We conducted a small number of interviews of parents/carers (three in total) to ascertain their views on the TAWs intervention. Five themes were constructed from the family interview data, which are described below: (1) 'Reasons for referral'

outlines the range of problems experienced by the child and their family that initiated a TAW referral. (2) 'Processes' explains parents' interpretation of the ways in which TAWs work to encourage progress and change for children. (3) 'Positive outcomes' outlines some of the perceived benefits of TAW input, including positive change for the family as well as the referred child. (4) 'Barriers' identifies perceived challenges to TAWs working effectively, including funding restrictions and families themselves rejecting the support provided. Lastly, (5) 'Parents' future perspectives depicts both a positive outlook and great appreciation of the TAW role, while also encompassing parents' unease at the thought of TAW support being withdrawn.

4.4.1. Reasons for referral

Parents interviewed discussed how their child's anger and aggressive behaviour were central to their TAW referral. As one mother explained, her son's behaviour, which had warranted input from the police, triggered his referral:

'So [...] the difficulties I had with [NAME] were that his behaviour was becoming quite aggressive [...] and it led to me having to phone the police on a couple of occasions where he [...] had deliberately damaged property, and I actually, for the first time felt quite threatened by his behaviour, and, because I've got a younger son, I was concerned about his safety being in that environment. So, I think, due to the police being involved, that's what kick-started the work with [NAME].' (Family 03)

Difficulties engaging at school and out-of-school programmes were also explained as reasons for referral. This included both truanting from lessons and becoming agitated and aggressive when present in class:

'It got to the point he [...] he just wouldn't go to anything. He wouldn't speak to anyone. He [...] if he went, he would kick off and he would walk out, and 10 minutes, he was home. He was quite violent. There was, you know, lots of [...] lots of [...] very negative behaviour and, you know [...] He wasn't going to anything.' (Family 01)

When asked about the difficulties her family were experiencing, this mother joked that explaining these alone would take the entire interview, due to the entrenched,

historical problems within her family. This included her son's 'mental health problems and behavioural problems'. (Family 01)

4.4.2. Processes

4.4.2.1. Accepting and adapting

TAWs taking the time to listen and ensure the family's voice was heard was identified as a key process for promoting engagement. One mother explained how the relationship with their TAW was bolstered by them appreciating the family 'as people, not just statistics' (Family 01). This mother also spoke of how a TAW taking the time to 'find out the reason and get to the bottom of' (Family 01) why the family struggled in certain aspects, they felt, made all the difference in outcomes.

A TAW's willingness and ability to adapt to suit the child's and family's needs was highlighted as particularly important. One mother discussed how her son's weight problem was recognised by the TAW, who adapted activities to ensure she could still engage with him:

'So, they now, because food is his motivator because that's his thing [...] [they] came, [we came], as a professional team, came to [...] okay, he'll go out to eat and he'll open up, you know, across a table [...] eating, so he has a Subway now, a healthy Subway, and basically she tells him what he can have [laughing] in his Subway, and what drink he can have, and no crisps and cookie with it, and that's [...] that's the pattern they're in at the moment.' (Family 03)

Another parent discussed how their TAW had worked with the school to share the importance of a child-focused approach, resulting in a bespoke plan 'that's adjusted [...] and [NAME] being the centre of it' (Family 01) leading to improved school engagement.

4.4.2.2. Building trust

Parents discussed how their own trust and that of the children took time to develop with their TAW. Yet this was reached through the TAWs' perseverance to work with the families, even if they were met with engagement challenges:

‘So, the first few [weeks] were quite hard for her [...] he wasn’t, you know, very good with her, but she persevered, bless her [...] and now, I think they’ve got quite a nice [...] relationship [...] So, obviously, you know, trust comes over time, doesn’t it? Again, I was a bit concerned how long she would be involved, and maybe, if he didn’t engage, maybe they would just cut it off, but [...] she was like, “No, I’m here till I need to be.”’ (Family 03)

Another mother commented how, despite not having huge insight into the sessions between her son and the TAW, she could see that they had established a secure trust between them, given that ‘he is very open and honest with her’ (Family 02).

4.4.2.3. Approaches and interventions

Although parents did not know TAWs’ specific approaches with their children, relationship-based work was identified as a key aspect. One mother explained how dialogue with her child’s TAW enabled her to share her concerns regarding her son, which partially shaped the work:

‘He’s quite socially isolated, he was bullied because of his weight, so all those issues I’ve witnessed as a mother, I’ve told her about, and so she’s working her way through all of that to address it with him.’ (Family 03)

4.4.3. Positive outcomes

4.4.3.1. Better relationships

As a result of the TAW intervention, parents identified positive developments in their child’s anger and aggression, which one mother commented also improved the home environment:

‘It’s a nicer place to be when we’re all home now. It [...] his attitude and [...] Obviously, he’s a 13-year-old boy so he’s got [...] he’s going to have an attitude, but [...] the anger, that’s really decreased [...] which is nice. So, yeah, it has made the family home [...] [a nicer place] to be.’ (Family 02)

Another parent commented on her son 'opening up' (Family 03) with his TAW as a sure marker of progress, demonstrating improved communication skills. Another parent described this as a positive outcome of the TAW work, and deemed it hugely significant given her son's previous experiences of being let down by adults:

'He [had/has] trust issues [...] because he's been let down quite a lot by adults that he loves and adults that he trusted and people that are meant to look out [for him] hugely, so to have someone involved in his family that he [...] you know, that he trusts – he can be himself around. He is himself around [NAME] as much as he is with me. Whereas, with some people, he'll kind of put his head in his hands and there'll be no engagement. You know, he [...] [he's built] [...] there's enough trust there for [NAME], for [NAME] to have that sort of trust and [...] and that is a good thing.' (Family 01)

Parents also identified engaging with peers and increased participation in social activities as an important outcome. One parent discussed how, despite her son being 'very self-conscious about his body weight and mixing with others' (Family 03), he'd voluntarily signed up to a four-week holiday programme, which she said 'he would never have signed up for' (Family 03) prior to the TAW work.

4.4.3.2. Improvements for the family

One mother spoke of her developing trust in professionals, deemed a particularly important outcome given her turbulent history with previous support services. This parent explained that, because of the TAW work, her own mental health was addressed, possibly due to increased trust and engagement in services that could support her:

'I think that [she has helped] with certain authorities has been a bit of a biggie for me because I don't really trust them and, from a young child, I've had quite a negative experience with most of them. So, it's helped to really kind of build trust.' (Family 01)

This parent also commented on how her mental health needs now being addressed meant she was more able to fulfil her role as a parent. Both her TAW offering practical help – 'let's get you to the appointments, let's get medication sorted out' –

and ‘having someone to talk to’ were seen as pivotal support mechanisms for her ‘to be a better parent’ (Family 01).

4.4.3.3. Thinking about the future

All parents discussed their child’s improved school engagement as a result of TAW input, which one parent depicted as going from ‘0% engagement to [...] between 80% and 90% engagement within a year’ (Family 01). Another parent discussed how her son’s classroom behaviour had drastically improved, in that ‘he’s not getting himself into as much trouble as [...] as he was.’ (Family 02).

Given these in-school improvements, children may be able to better position themselves for their future. One mother discussed how her son’s improved school performance will mean ‘he at least comes out with the entry levels’ (Family 01). This was described as a marked improvement on his previous prospects. Another mother described their TAW’s active role in her son’s contemplation about careers:

‘He’s just changed his mind about what he wants to do in college, so he’s now thinking he might want to join the Navy [...] [NAME]’s told me that maybe on their next session she’ll take him down to the careers office or down to the dockyard where we live in [NAME] and, you know, look around and give him some ideas about that, so that will be really good.’ (Family 03)

4.4.4. Barriers

4.4.4.1. Resistance to support

The interviewees identified a number of family-related barriers to TAWs working effectively with children and their families. One mother spoke of her mistrust in services and ‘huge fear’ (Family 01) of the LA, which may be a common challenge met by TAWs when they initially begin engaging with hard-to-reach families:

‘I find with a lot of social workers and things like that [...] they look down their noses at your life and your family home or the way, you know, the way you are or the way you’ve conducted yourself, or they judge you on what they read on pieces of paper, which sometimes can be very misleading [if/and] people don’t always factually put things down, and it’s a very brief

explanation of a much bigger picture, because, with any situation that's going on, usually there's a reason for that.'

(Family 01)

Another mother spoke of how her son's initial apathy towards the intervention was overcome by the TAW's persistence to engage with the child. Yet this was also restricted somewhat by his insistence on only being seen in school hours because 'when school's finished, that's his own time' (Family 03).

4.4.4.2. Budget-related barriers

Funding was also identified as a barrier to TAWs being able to work long term with families. One mother discussed how 'there isn't enough people to work with my type of family [...] that have certain needs' (Family 01), depicting her frustration that effective, much-needed support will be cut short due to resources when 'it should be about people' (Family 01).

4.4.5. Parents' future perspectives

While parents expressed their gratitude for TAWs' input and making 'an improvement to my son's life' (Family 02), one mother showed great concern as to how she would cope after the TAW support ends. Already fearing how she would cope independently, this mother predicted that her own engagement in services would decline, despite this being completely unintended:

'I'm already panicking, thinking, "oh my god, how am I going to go to this on my own or how am I going to do that on my own?" and [...] It [...] I'll go into the mode of I just won't go or I don't know what to do. I mean, obviously, it's not going to be premeditated or intentional, but that can be my mindset a lot of the time because I struggle to do that bit on my own.'

(Family 01)

4.4.6. Summary

The views of the children and families interviewed are grouped into five key themes:

- Reasons for referral: A variety of problems led to the referral. These included behavioural challenges, mental ill health and difficulties at school.

- **Processes:** The clients said the TAWs worked carefully with them to build trust in an adaptable manner using a variety of approaches and interventions, which was important for their child and family's needs.
- **Positive outcomes:** The families described a huge variety of positive outcomes as a result of working with the TAW. These included 1) better relationships, 2) improvements for the family and 3) positive outlooks and thinking about the future.
- **Barriers:** One challenge identified by parents working with TAWs was their mistrust in the system and fear of the LA. Additionally, there were barriers to engagement with children when the intervention was delivered outside of school hours.
- **Parents' future perspectives:** Parents highlighted distress at the thought of the TAW finishing their time with their child and were unclear about a future without them due to the improvements they have brought into their children's lives.

4.5. Questionnaires with children and families

In total we received a small number of responses (six in total) to a questionnaire for parents asking about their child's experience of the TAWs intervention (all respondents were female). This consisted of a mixture of closed and open questions. The participants were looking after five male children and one female, one of whom was deemed to have a disability. All respondents and their children were White British. Caution should therefore be applied when drawing conclusions from these results.

Prior to working with the TAWs, the households had a variety of challenges, including mental ill health and domestic violence, with all six of the respondents reporting these exposures in the household.

All respondents were happy to work with the TAW and thought they would be useful for their child. They had all worked with their TAW for at least seven months and their children were seen by the TAW at least every fortnight. All respondents believed their TAW had a good rapport and all believed they had a positive impact on their child's life, as the following quotes attest:

‘It provided her with a safe adult who understood her needs and enabled her to explore how she could change her thoughts and feelings, boosting her self-esteem and confidence in working toward not becoming a victim of DV [domestic violence] herself.’

‘Calm and kind, didn’t judge us and tell us off ever. Sat and listened to him and that’s why they had a good relationship. Took a long time for him to trust her but she never gave up.’

All bar one of the six parents felt positive thinking about their child’s future. One added:

‘I feel saddened that this has come to an end. A service like this is invaluable to vulnerable children.’

All of the respondents said they believe other families like theirs would benefit from working with a TAW.

‘This is a much-needed service. I desperately needed this service for my older grandson, who is at risk of becoming a perpetrator and is in need of a male mentor separate from family to give him the much-needed one-to-one role model to empower him not to become a perpetrator.’

All bar one of the respondents found no issues working with the TAW. The only respondent who had reservations highlighted it was just because it was a struggle to find the right time in the week to fit them in.

When requesting feedback on what else could improve the service, this question was met with thanks and a plea to continue the programme.

‘The project desperately needs to continue. Working with these vulnerable young people is a long-term commitment and these children have faced many people leaving them. Unfortunately due to the virus the last few meetings were unable to go ahead. I have seen a positive change in my granddaughter but am concerned that this needs a lot more work. I don’t know if group work for some children may benefit. Definitely more mentors are desperately needed.’

4.5.1. Summary

- We received few responses from parents to this questionnaire so the findings should be treated with caution.
- Of the respondents, all were very happy to work with a TAW and had worked for a period of seven months or longer. There were clear messages of success with the process as many parents thanked the service and were sad their time with the TAW was coming to an end.
- There was a strong desire for this project to continue running and ensure it remains as flexible as possible.

5. TTT evaluation

5.1. Focus groups with a sample of those who attended the TTT and became trainers within their own organisations

Three themes were developed from the Rock Pool trainers' focus group. The first, 'Experiences of Rock Pool training', depicts the professionals' views of the three-day course, the outcomes of the training and suggestions for improvement, which relate to both the structure of the training and its content. 'Delivering training' focuses on professionals' experiences of delivering the Rock Pool workshops (to individuals in their own organisations), including the successes they observed and potential ways to improve the course's recruitment, structure and delivery. Lastly, 'Culture change' outlines some of the positive impacts of both training courses at the wider level and the effect of a more general development in ACEs awareness.

5.1.1. Experiences of Rock Pool training

5.1.1.1. Views on training

In terms of content, professionals (in this text referring to those trained by Rock Pool to become trainers within their own organisation) commented on the training being content-heavy, both in terms of being 'repetitive' at times, and in volume – 'there's a lot of content to put into half a day's worth of training' (trainers were being trained to deliver the information in a half-day training input in their own organisations) but that this was 'all good stuff'. One professional explained their expectation of thinking that

three days of training ‘to be taught how to deliver half a day’s worth of content would be overkill’. However, they counterbalanced this by noting that having the three days was necessary to fully understand the content and have the opportunity to reflect on his learning. Importantly, interviewees reflected on the training’s relevance, which they were positive about. They described a ‘really good balance between “chalk and talk” activities’ that allowed people to ‘link it into the real world’, although they commented on the natural process of ‘pick[ing] up your own flow’ once they started to deliver it themselves.

5.1.1.2. Positives and outcomes

As mentioned, respondents were generally in favour of the three-day structure, which was ‘self-contained, lots of information’ and ‘very well presented’.

Professionals commented on how a glitch at one of their training sessions meant a confusion in content, but this was well managed by the facilitators:

‘Thinking back, there was [...] I think it was the first day, a lot of confusion on the [...] the content that was provided. So, the scripts didn’t tally up with the PowerPoint presentation [...] and the deliverers did great in kind of accommodating that.’

In terms of preparedness for independent delivery, one professional commented on how they felt ‘prepared to run the training’ following the Rock Pool training. Another acknowledged the training had enabled her to ‘get to a place where we can deliver it without having to hold onto [...] other people’s, eh, sharings’. That said, one person commented that ‘support above and beyond the delivery’ aspect would’ve been appreciated. It was suggested an additional half day could’ve been useful in facilitating this, although it was recognised this extra time would be an ‘awful lot to commit to’ for all involved.

Further, interviewees commented that the spread of empowered and knowledgeable professionals ‘in a whole bunch of different contexts [being] those champions within their own organisations’ was ‘really powerful’, which was a product of the ‘content [...] and purpose’ of this training being ‘the right stuff’. The quick spread of the training through departments and services, once people caught word of it, was also discussed. One professional from the police described how they were ‘committed to training all of our members of staff’, including key partners. This illustrates the

potential reach of the training once a few key professionals are equipped to deliver the programme.

5.1.1.3. Improvements

In terms of room for improvement, professionals commented on the need for further follow-ups. There was general consensus that a further follow-up would have been helpful to address professionals' needs. It was recognised a follow-up session was arranged, but this was said to be related to practicalities, as opposed to being a space for professionals to reflect on their experiences of presenting, which could help reinforce their learning:

'If the support or a training of trainers had a kind of follow-up, eh, check-in, whether it's with us as a group to be able to kind of debrief and talk through how that's going.'

'I mean, for me, that would be [...] changing from just sharing the information to actually living the information because we would be then acting in a trauma-informed practice type of way.'

Professionals also commented on the applicability of the training for the recipients. They felt that recipients understood what they could do with the training and could apply their learning and make a difference. They added that more emphasis on resilience and recovery, in addition to awareness of ACEs, would have added a more practical aspect to the training:

'There was an awful lot around awareness of ACEs, which clearly is what it was about, but of course that naturally raises the question of: so what does that mean for us and what can we do about it? And, actually, I feel that that was probably [...] too small of a focus.'

'So, thinking about who I'd want to present this to [...] and thinking about how to make it [...] accessible without becoming overwhelming in terms of the depth of content, to make it practicable and useable for them, and I think that links back to the question of [...] almost the "So what?" after the [...] "Here are the things that we wanted you to be aware of" [...] I think a

lot of the people that I have in mind to deliver this to want that “And what should I do?” more than this current content gives them.’

5.1.2. Delivering training

5.1.2.1. Successes

Professionals highlighted one key outcome from delivering the training: increased ACE awareness. They felt this was the main purpose of the Rock Pool training. One professional described how, for her, the training had highlighted a considerable gap in other professionals’ understanding of ACEs and childhood trauma, even for those who undergo extensive training:

‘I think it’s really raised, for me, that awareness of [...] how little people do know. Certainly, my Children’s Services social work colleagues, that it’s not something that’s embedded [...] in their training, and when people are kind of asking questions and you think, “Oh wow, you don’t know about this...” – it shows just how important it is.’

Attendees also discussed how the training enhanced professional connections. They highlighted this as particularly significant given the multitude of organisations the training reached, and therefore could connect:

‘I think, especially where we are being brought into this as a [...] kind of pan-area group, the more we can interact and support, not only in this training, but that is [...] going to lead to further connections. It already has, in some places.’

‘It’s leading to that [...] connectedness between groups and professions, which I think is really important and a kind of by-product of working in this way.’

Those trained on the TTT course discussed positive feedback they’d received when they went on to deliver training, which generally was ‘really positive’. One professional commented on some feedback she’d received after delivering a session. The recipient described it as ‘the best lecture they’ve ever had’ and her

new-found awareness had sparked her to be ‘mindful of how she communicates with anybody and everybody’.

5.1.2.2. Recruitment to Rock Pool

Professionals discussed LA approaches to advertising and recruiting attendees from local services to the Rock Pool training. One interviewee described it as a ‘scattergun approach’ whereby the end result was ‘one person from this team, one person from that team’. It was reported this approach made it more difficult for professionals to embed their learning once back in their own teams because ‘they’re just one individual from one team’ meaning there won’t be ‘that opportunity to develop the conversation’. Instead, a more ‘systematic approach’ was suggested as potentially more effective, as this would lead to a ‘whole trickle-down’ of training throughout an organisation.

In terms of which professional groups training should be delivered to, one professional said she felt it was best pitched to workers who have a basic level understanding of ACEs and trauma, ‘but are still dealing [...] with trauma in their everyday, day-to-day jobs’, as ‘people who already have quite a lot of experience probably know quite a lot of it already’. That said, other professionals discussed the importance of the training reaching the managerial level, to ensure that the organisational culture supports professionals embedding their learning:

‘But I think that is the issue, like [NAME] said, it’s a scattergun at the moment, and it sounds like most people that are coming are kind of frontline workforce, whereas, actually, maybe what we need to be targeting in these early days are the service managers and the team managers, because if we haven’t got them on board and they don’t understand, it’s not going to go much further.’

5.1.2.3. Prioritising professionals’ wellbeing

Given the emotional, high-impact, content of the Rock Pool training, professionals described the need for further effort to inform in-service recipients that the training could be potentially triggering of their own trainees’ previous traumatic experiences, which had been voiced in the feedback they’d received. While some professionals

have emailed recipients after the session to debrief, others discussed how they have a slide in the presentation informing the group where they can access support from within the organisation:

‘We’ve certainly had emails afterwards that have said [...] either “That’s really helped and that’s been really, really positive” and others that have kind of said, “Actually, yeah, that really touched a nerve”. So, what we’ve started to do [...] is to then send an email afterwards and say, “Don’t forget, we know this can be triggering, and if you need to speak to someone, you can speak to me, you can speak to your manager...”’

‘From our organisation, which is the police, we have a stack-load of support mechanisms already in place [...] that first [slide] where you’re unpacking it and you’re doing the disclaimer at the beginning, that you actually make that really organisationally [...] relevant, so that you’ve got the slides and you’ve got the links to our wellbeing, our wellbeing toolkit, and our employee assistance programme and all those kind of things.’

It was specifically stressed that monitoring recipients’ wellbeing could not and should not be fully handled by the trainers (those trained by Rock Pool), as their role is to ‘deliver the content [...] not [...] to take over’. Given the breadth of professionals from different teams in the room, ‘ensuring that those safeguarding [...] points are in’ would be impossible because trainers (those trained by Rock Pool) ‘can’t possibly know 25 different routes’. Instead, the idea of recruiting teams systematically was mentioned as a way of ensuring that professionals would be accessing the training with support around them:

‘Doing it in a systematic way means that you’ve got a support network – you’ve got somebody who understands why this might have opened something up for you and that they may have been through that journey too.’

5.1.2.4. Barriers to application

With regards implementation, professionals discussed how a one-off training session would be unlikely to make lasting change, and that further sessions were warranted for new-found knowledge to be embedded:

‘Okay, I’ve got knowledge. I will hold on to that knowledge as much as [...] [it] sticks with me. But unless I’ve got somebody facilitating my learning, facilitating applying it, and having that second conversation about “So what?” [...] and doing that over time [...] I mean, I think so many organisations have this as a [...] You know, one-hit-wonder training doesn’t work. It sparks a start, but unless it’s supported – and that then depends on the context that you’re doing it into and your capacity to go back and do that.’

Therefore, those trained by Rock Pool talked enthusiastically about an alternative model to the training, which would facilitate the space for further content and revisit recipients for further sessions:

P[rofessional]: ‘I think it’s a potential need. I think it would be a good thing. So, for example, if you did-’

F[acilitator]: ‘Resilience?’

P: ‘Yeah. Here, group one, we’re talking trauma awareness; on this date...’

F: ‘Mm, come to the next one, yeah...’

P: ‘...three months later, six months later, we’re coming back to talk to you again – oh, I’d love that model.’

It was said that this structure would allow for a deeper understanding of ACEs than what the existing half-day session provides.

5.1.2.5. Barriers to delivery

Professionals discussed how providing six training sessions in their organisations could be time-consuming, given the preparatory work, physically delivering the sessions and any follow-up contact with recipients afterwards. In this context, any

potential further feedback sessions were seen as an additional burden that would only add to their already high workload:

F: 'Because this takes up so much time [...] to set it up, to get people to turn up, to print everything off and all of those different things, then actually it becomes something different if we're doing it again. If we're having a feedback session and our colleagues come in and say, "Well, it hasn't worked because of this, this and this..." we've almost got to do something about it...? [...] which then becomes something else, perhaps more so than me, as a [minion] worker, would necessarily have the time to be able to do in my organisation at the moment, but that's not to say it's not a brilliant idea.'

P: 'You see, I agree. It is that element of [...] how much time do I actually have for this?'

Some minor technical glitches were also discussed, in that some Rock Pool trainers' USBs didn't work, and that switching from PowerPoint to YouTube to show a video made the presentation clunky. Instead, it was suggested that having the videos embedded in the slides would result in a more seamless presentation.

5.1.3. Culture change

5.1.3.1. Increased ACEs awareness

Professionals referred to a recent shift regarding an increased awareness of ACEs, both locally and nationally, which served as an important backdrop for organisations to facilitate change:

'When we started this journey, nationally, we weren't talking around this subject, the way we are now nationally, and locally, talking around this subject, and we've oddly become really, really more informed generally anyway, and we probably want more of it and so do our audience.'

5.1.3.2. Small and large changes

Changes were identified at both a broad level and as a product of smaller, individual actions. One professional referred to tangible progress being made by public services signing an agreement to become more trauma-informed via committing to research-based practice. By way of small but still significant changes, individuals reported incorporating their increased awareness into their interactions, described as just as important as larger, systemic change:

F: 'When we get back to those people in the room that are wondering what they can do next [...] it's one small thing, isn't it?'

P: 'Yeah.'

F: 'It's just the "pass it on and be kinder and be nicer and talk differently and ask questions differently". So, there are [...] for me, there are some real tangibles, I think, that you can take away from that learning and that awareness-raising to make a difference to every single individual because, if every single individual starts to think differently, then, you know, it's that thing [...] culture eats systems for breakfast, isn't it? It's that thing that says the culture will change, despite what's happening in your senior leadership team.'

5.1.3.3. Increased professional support

Professionals told of how they had been contacted by managers about the increased awareness regarding vicarious trauma and had been asked if they could guide institutions to embed a more comprehensive support system for staff.

'Their managers have then contacted us to say, "You've started something in the staff room – what does this mean?" [...] And then, interestingly [...] I have been contacted by a lot of [NAME] schools to say [...] "We've heard this thing, vicarious trauma, what's that? I think we might need some support with that," and haven't, you know, necessarily known where to access that support. So, I think, like you've said, that word has really spread

and it has opened up those helpful discussions, so to know that staff perhaps aren't being supported and aren't feeling supported, but I guess it's got to start somewhere.'

5.1.4. Summary

The views of the TTT participants could be grouped into three key themes: 1) Experiences of Rock Pool training, 2) Local delivery of training and 3) Culture change.

- Experiences of Rock Pool training: On the whole TTT participants commented positively on their expectations of the training. There were many positives, including well-presented material and leaving trainees feeling ready to act as trainers. The focus on potential improvements rested around the limited information about the 'so what?' element once a child has been identified to have ACEs.
- Local delivery of training: Numerous positive outcomes were identified, which included improving awareness and praise for the overall TTT model. Additionally, there was great support for the benefits this training brought for professionals in terms of their own wellbeing. However, there were some barriers to application (considering whether one-off sessions were sufficient) and delivery (often time-consuming for those with an already high workload).
- Culture change: The trainers (trained by Rock Pool) identified a shift in terms of increased awareness of ACEs locally and nationally, which facilitated change in their local organisation. In particular they noted positive changes in becoming trauma informed and also increased professional support in their organisations.

5.2. Questionnaires sent to all trainers

In total 28 individuals were trained by Rock Pool. We received responses from 13 individuals. Twelve of the respondents were female, nine aged above 36 years and there was a mixture of organisations where they worked (four from LAs, six from police/YOTs/OPCC and three from voluntary organisations).¹³

¹³ Further details can be found in Supplementary table 6 in the Appendices.

Following the delivery of the Rock Pool training we anticipated the TTT participants were likely to have an improved or greater knowledge of ACEs to go on to deliver their own sessions. Table 8 summarises their answers to ACEs-related questionnaires, asked to participants in their own workshops.¹⁴ Interestingly, despite an in-depth training programme, TTT participants still scored low in confidence in terms of their understanding of ACEs and a trauma-informed approach. Particularly this is highlighted when TTT participants are asked if they are confident in supporting children with ACEs. The fact that five of the 13 respondents report that they are not is problematic if they are required to advise others on managing this.

¹⁴ The full data can be found in Supplementary table 7 in the Appendices.

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I understand what ACEs are		3			10
I understand what the impact of ACEs may be to an adult who has experienced them during childhood		3			10
I understand the role stress and trauma plays on the brain		2	1	1	9
I understand what a trauma-informed approach is	3			2	8
I understand what resilience is			2	2	9
I understand how resilience can be built		1	1	3	8
I am confident in knowing how to support a child who has experienced ACEs	1	4	1	3	4

Table 8: Responses to questionnaire for those who have undergone the TTT approach; understanding and confidence questions

Next we explored the TTT participants' experiences with their Rock Pool-delivered training. The results are summarised in Table 9. On the whole, TTT participants were happy with how the Rock Pool training went, felt it was of use within their organisation and the opinions held that it should be delivered to more people who are willing to become trainers.

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I believe the TTT sessions delivered by Rock Pool were well delivered	1	1		3	8
I believe the material covered from the Rock Pool training is of use to my organisation	1	1	1	1	9
I believe this training should continue to be delivered to more people who are willing to become trainers			3		10
I believe the TTT approach works in my organisation			4	1	8

Table 9: Responses to questionnaire for those who have undergone the TTT approach; views from TTT participants about their training

We explored some of the reasons why TTT participants selected the options they had and identified some key barriers to the success of the training, some of which related to delivery:

‘The Rock Pool sessions were problematic as they were extremely and surprisingly disorganised and the TTT materials did not correspond to the training course materials. The issues were partly addressed at the time as the trainers went some way to match the TTT materials with the handouts. This took hours of time in the training room and outside, which was hugely frustrating and a little disrespectful of delegates’ time.’

Despite the delivery problems, TTT participants saw the value in the training.

‘I strongly agree that the training should be rolled out but not in the current form. This course was highly unorganised, the materials were not fit for purpose and at the training the materials were inaccurate, wrong and difficult to understand. For example, the course slides, which they were training us to use, were not the slides which we had as a handout. Also, the course instructions did not match the slides. The instructions did not support us as learners to understand what we were responsible for delivering. I run a training programme and we were able to adapt the training in line with the learning outcomes to ensure that the experience for the delegates was positive, relevant and meaningful.’

Despite this challenge, many still managed to deliver their sessions, with at least 12 of the respondents either having delivered all six or had any outstanding sessions organised. The data was collected in the months prior to the end of the evaluation.

Other barriers beyond the challenges in teaching or in terms of delivering six sessions did occur. These came from other pressures internally within their own organisations, with at least four respondents either agreeing or strongly agreeing to having experienced some organisational barriers in the delivery in their sessions.

Challenges appeared to be because of a lack of buy-in from senior leadership, which didn't help delivering six sessions.

‘While my managers see the value in the course and have supported [me] in my delivery, I still feel that there is a lack of real engagement from senior leadership from our organisation and those pushing the training. I don't think this is through lack of desire but more around priorities. We have also been busy with recruitment of new staff, which has taken priority over most other things, including this training.’

Additionally, TTT participants experienced challenges from frontline staff attending training about the relevance to them.

‘Resistance from students [this comment related to custody staff who attended a session put on by a TTT professional] in how it’s relevant to their roles, how they can realistically implement a TIA [trauma-informed approach] given the time and resources constraints and limitations of their role responsibilities in relation [to] dealing with trauma...’

Despite the challenges, TTT participants were confident that the sessions were of use, would lead to organisational change and should continue (Table 10).

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I believe individuals who have attended my sessions have found them to be of use				7	6
I believe the delivery of these sessions will lead to organisational culture change relating to ACEs and a trauma-informed approach			4	6	3
I believe that we should continue to deliver more training sessions to those who have not yet received it in my organisation			1	1	11

Table 10: Responses to questionnaire for those who have undergone the TTT approach; views from TTT participants about the training they delivered

Views around the impact of the half-day sessions on changing culture in their organisation were varied, ranging from the view that organisations were working towards being trauma informed, to suggesting little buy-in at all.

‘Yes we are working towards being trauma informed.’

‘Culture change comes from regular management support and implementation. I don’t feel this training has enough buy-in of the longer-term support to really see that culture change.’

‘People are motivated and enthused by the training. At the moment, however, we are not getting whole organisations at the training. Just representatives from organisations. To change an organisational approach, we need everyone to attend.’

‘The LA has made a commitment to deliver to all staff and it is being fed into other change work in the LA around the year of the child.’

5.2.1. Summary points

- Despite the three-day training input, TTT participants still had varying levels of knowledge surrounding ACEs and trauma-informed practice. This is concerning as they were subsequently responsible for the delivery of future training in their own organisations.
- Several barriers existed relating to 1) delivery of Rock Pool sessions, 2) application of material to their local sector and 3) internal organisational barriers.
- Despite the challenges above, TTT participants were confident the scheme was still of use and, if the barriers were mitigated, was likely to be a successful approach that is the first steppingstone (albeit not the solution) to an organisational culture change.

5.3. Questionnaire feedback from participants who attended half-day sessions put on by the TTT professionals

We received responses to feedback questionnaires from a range of individuals who attended training sessions put on by trainers in their respective public sector

agencies. Some responses had to be excluded because of missing information. In total we electronically transcribed results from 191 of the pre-session questionnaires, 153 of the post-session questionnaires and nine of the follow-up responses by January 2020. The participants were given the pre-session questionnaire shortly before the session, the post-session questionnaire shortly afterwards and then the follow-up questionnaire several months after their session.

Note: some people who filled in the pre-session questionnaire did not complete the post-session questionnaire. Individuals were not linked to maintain anonymity.

The overall baseline characteristics of respondents who attended the training sessions and completed the pre-session questionnaire can be seen in Supplementary table 8 in the Appendices. The group were mostly female (76.4%) and more than half came from education or LA backgrounds.

It was encouraging to see that the session met the anticipated aims of many of the participants. Additionally, there was a clear willingness to inform others as to the information learnt in the sessions. Table 10 reports the difference in mean scores before and afterwards. There were statistically significant improvements across all of the elements measured by changes in the mean score from the received sample¹⁵. The most noticeable changes when examining the data was the general shift from 'neutral' or 'not confident' responses prior to the training to the 'more confident' answers following training. For example, the understanding of what ACEs are moved up by two points on average on the five-point scale from the pre-session to post-session responses. Supplementary tables 9 (pre-session) and 10 (post-session) in the Appendices provide the full summaries of responses in the pre-session and post-session questionnaires.

¹⁵ We performed the appropriate statistical test, namely the t-test, where the null hypothesis of zero difference of means between can be rejected at the appropriate cut-off value (which depends on the sample size) and which then determines if the difference is statistically significant.

Variables	Difference mean (pre) – mean (post)	t
I understand what ACEs are	1.84	-17.9*
I understand what the impact of ACEs may be to an adult who has experienced them during childhood	1.78	-17.7*
I understand the role stress and trauma plays on the brain	1.29	-14.2*
I understand what a trauma-informed approach is	2.08	-22.4*
I understand what resilience is	0.96	-10.9*
I understand how resilience can be built	1.18	-12.4*
I am confident in knowing how to support a child who has experienced ACEs	1.62	-15.3*

Table 10: T-tests demonstrating the differences in results pre- and post-session responses. *Results statistically significant at $p < 0.01$

We followed up a small number (nine) of individuals (in some cases up to six months after their original Rock Pool training session) to see whether the knowledge of the training was retained and if there were any positive applications of the knowledge in practice. Given the small numbers, the findings need to be interpreted with caution.

Although the average scores were not as high as the immediate post-session questionnaire, there was still a clear retention of knowledge in comparison to the baseline understanding and knowledge. Additionally, it was positive to see that individuals had informed others about the training, and it was useful beyond their

trainees. The full details can be seen in Supplementary table 11 in the Appendices. Table 11 shows the difference from pre-session to follow-up across some of the survey questions. We note that for this small sample, some of the answers showed statistically significant changes.

Variables	Difference mean (pre) – mean (follow-up)	t
I understand what ACEs are	2.03	-15.7*
I understand what the impact of ACEs may be to an adult who has experienced them during childhood	1.83	-11.0*
I understand the role stress and trauma plays on the brain	1.3	-5.9*
I understand what a trauma-informed approach is	1.74	-8.9*
I understand what resilience is	0.95	-4.0*
I understand how resilience can be built	1.06	-3.9*
I am confident in knowing how to support a child who has experienced ACEs	1.52	-5.7*

Table 11: T-tests demonstrating the differences in results pre-session and follow-up session responses. *=Results statistically significant at $p < 0.01$

5.3.1. Summary points

- On average, prior to the teaching session, there were low levels of knowledge surrounding ACEs, resilience and confidence in delivering a trauma-informed approach
- Following the session, there was an increase in knowledge around ACEs, captured through the survey, showing statistically significant improvements. A small follow-up sample showed that this understanding was retained for a longer period. However, given the small sample size, this finding should be treated with caution.
- Additionally, it was encouraging to see participants were disseminating information beyond their session peers.

5.3.2. Questionnaire for those who did not attend trainer sessions but work in the relevant organisations

A questionnaire was distributed to staff in organisations where someone attended a TTT input from Rock Pool. The questionnaire link was provided to the TTTs and we asked for them to send the information out as a blanket email to their organisation members. In total we received 92 responses. There was a relatively even sex split in responses, however most of the respondents were from the police or YOT (76.1%).¹⁶

The findings show that, though none of these respondents had attended the training sessions, 89% had heard of ACEs before and the same percentage were aware that training was being rolled out in their own organisation. Table 12¹⁷ displays the results of the survey indicating their knowledge of ACEs, resilience and a trauma-informed approach, suggesting, on average, a greater than 'neutral' understanding of these factors.

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I understand what ACEs are	7	8	26	31	19
I understand what the impact of ACEs may be to an adult who has experienced them during childhood	5	8	19	38	21
I understand the role stress and trauma plays on the brain	3	9	17	38	24

¹⁶ Baseline characteristics can be seen in Supplementary table 12.

¹⁷ The full data can be seen in Supplementary table 13.

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I understand what a trauma-informed approach is	16	22	25	19	9
I understand what resilience is	3	2	19	47	18
I understand how resilience can be built	5	13	23	38	11
I am confident in knowing how to support a child who has experienced ACEs	19	20	32	15	4
I believe my organisation are trauma-informed in their approach	4	13	37	26	10

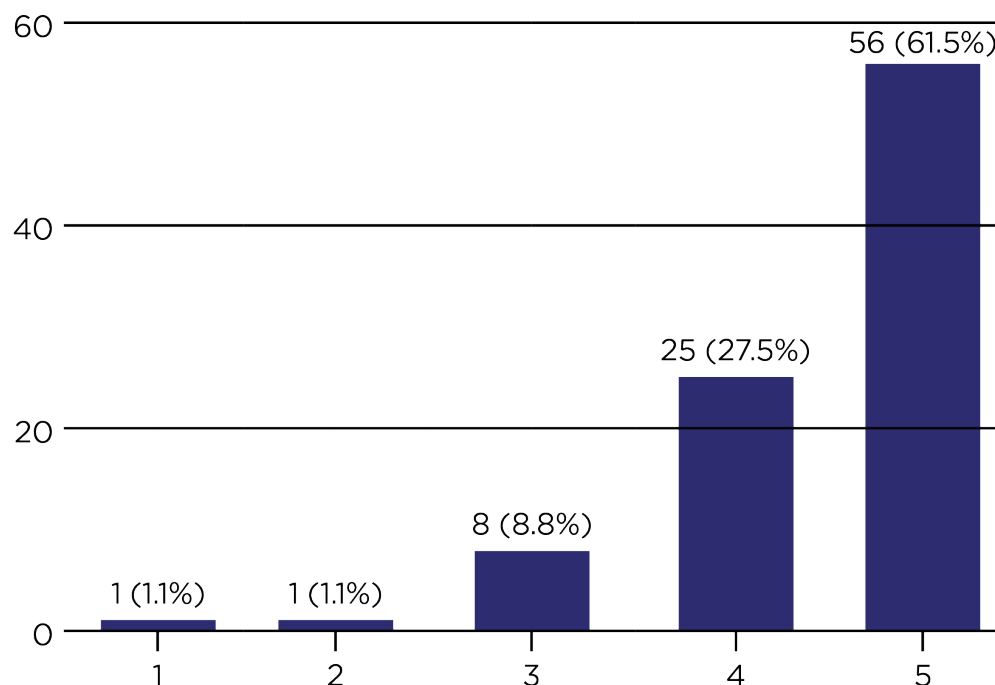
Table 12: Questionnaire results for those who have not undergone the TTT approach but work in organisations where individuals have done so; understanding of ACEs, resilience and trauma-informed practice

Additionally, over 60% of respondents strongly believed that ACEs training should be rolled out more widely across all elements of their organisation (Figure 2).

Figure 4: Usefulness of training to all within their organisations

I believe training covering ACEs and a trauma-informed approach may be useful to everyone in my organisation

91 responses

**Key**

1 = strongly disagree

2 = disagree

3 = neither agree or disagree

4 = agree

5 = strongly agree

5.3.3. Summary points

- Despite these participants not attending the TTT sessions, there was a high awareness of ACEs among them.
- Although knowledge of ACEs was not as high as seen in those who had undergone training, baseline knowledge was greater than 'neutral' and suggested a relatively reasonable knowledge of ACEs and trauma-informed practice across the organisations.

- We do not know whether this knowledge was present prior to the TTT sessions, however it is possible that there has been organisational dissemination of information relating to ACEs. We do find that a majority of respondents believe that trauma-informed training is useful for all those in their respective organisations.

Discussion

6. Summary of key findings

6.1. TAWs evaluation

In summary, the findings show positive results regarding the TAWs programme in terms of public sector service referrals, for the TAWs themselves and also most importantly for the children and families who have worked with them. While these are positive findings, there are still some barriers that need to be addressed if the project continues to receive funding. Additionally, it is important to note, as the negative effects of ACEs are much further downstream, resources must be devoted to continuing this work over time.

1. There is a significant improvement in the Outcomes Star scores of children after the TAW intervention, as well as improvements in their Family Outcomes Star, compared to the score at the start. When compared with a control group, the Family Outcomes Star scores for TAW participants did not show such a substantial improvement. It must be noted, however, that due to limited information about the control group we cannot be confident that they are suitably comparable. In particular, we do not know the number, type and complexity of ACEs in the control group. Some of the control group may have been subject to interventions that are designed for the family rather than the child, so we might expect to see greater family improvements in that sample.
2. The original aim to identify only children with four or fewer ACEs was not used. In practice the intervention was applied to children experiencing more ACEs. This may not be a problem given improvements seen in the outcomes. Although the referral partners had intended to refer children with few ACEs (less than four) it could have been that, once the TAWs started working with the family, they identified more ACEs than the original referral.
3. Referrers, TAWs and clients have all described striking case studies highlighting how important the role of the TAW had been and the improvements they had brought about in children's lives. Additionally, TAWs had reportedly filled gaps in current service provision and had hands-on expertise that would not have been delivered otherwise.

4. Barriers to referring to TAWs, perceived by the TAWs and referral partners, related to 1) resource and capacity issues, 2) lack of clarity around referral processes (whether ACEs is the correct measure), 3) role of the TAW (to avoid duplication with other services) and 4) timing of their intervention (ie, at what point is it best to employ their skills into a family).

6.2. TTT evaluation

Overall, the TTT programme showed many positive outcomes. Overall, trainers were largely happy with the training they received from Rock Pool, and then were confident enough to deliver forward sessions within their organisations. These local half-day sessions were deemed to improve awareness of ACEs and start to stimulate culture change within the organisations.

1. Rock Pool training was largely well received. The content was seen as good for awareness raising. However, participants suggested more information would have been useful to demonstrate practical approaches to support children who have actually experienced ACEs (the 'so what?' element).
2. For individuals who attended the TTT sessions, there was a noticeable improvement in understanding the role of ACEs in their workplace, suggesting the TTT approach could be successful at improving awareness (awareness was retained over the longer term, four-to-six months, among a small sample of respondents). However, the lowest scores for improvement were seen in responses relating to improving understanding about what to actually do for children with ACEs. This correlates with findings that this element was limited in the initial three-day courses and focus group respondents suggesting the need for sessions where they could share experiences and reflections of the TAW role in practice.
3. TTT recipients and their participants were keen to disseminate their newly learnt information. This was potentially reflected in the good knowledge relating to ACEs shown in the dissemination questionnaire.

7. Conclusion and recommendations

7.1. TAWs evaluation

A challenge of evaluating an intervention that aims to improve the lives of children who experience adversity is the breadth of improvements these interventions seek to achieve, and the ability to follow them up for long enough to see impacts in later adolescence and adulthood. Unfortunately, this is not possible as part of this evaluation. However, even though in the initial stages, it does appear the role of TAWs is largely positive.

Improvements have so far been identified through case snapshots captured in the interviews with referral partners, as well as demonstrable improvements before and afterwards in the distance travelled (Outcomes Star) by exposed children.

Professionals from various referral agencies also made the case about the important role TAWs play in the arena of early help and ACEs.

These factors support investment in the scheme to continue through to a longer-term evaluation. Some recommendations for improvement if attempting to replicate this service are outlined below.

1. Ensure the roles and aims of the TAWs are clearly defined with measurable outcomes.
2. Ensure standardised referral processes in each locality and, where possible, limit overlap with existing services.
3. Ensure the referral process matches the capacity of TAWs so as not to overburden their services.
4. Consider the best timing to employ the TAW into the family's life.
5. Conduct further research to examine the outcomes using a larger sample size and over a longer time period. In particular, there is a need to increase the sample size to test hypotheses.
6. Provide a suitable control group, with information on the ACEs for individuals in that group to perform a causal analysis and collect more granular data on outcomes to compute benefits for an economic evaluation.

7.2. TTT evaluation

It is important to improve awareness of ACEs, which is an emerging issue across all public sector services. Using local trainers taught by a central organisation is not a new approach, and has been used in other settings. It provides an opportunity to quickly disseminate information in a bespoke and tailored way across organisations. Overall, the TTT approach seemed to provide improvements in the knowledge and awareness of ACEs. However, it struggled with delivering practicable information as to the next steps for their services identifying children at risk. Therefore, some recommendations are made as part of this evaluation.

1. The TTT role seemed to be undertaken well by those who were already in learning and teaching positions in public sector organisations. Their roles often provided the platform to successfully deliver the sessions to disseminate the information.
2. Despite positive views about the training delivered by Rock Pool consultancy, there were some negative opinions about the missing elements of the curriculum, particularly in relation to practicable advice about what to actually do for children who experience ACEs to mitigate their future risk. This remains a challenge that needs to be addressed in future awareness-raising activities.

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Appendices

Supplementary 1: Topic guide for interviews with TAWs

Topic guide for TAWs:

My name is <<<INSERT NAME>>, and I am here to ask you about your experience of being a TAW.

Key topics to be covered

1. Can you tell me about why you applied to be a TAW?
2. What was your experience before starting?
 - a. Prompts: What role were you doing? What experience did you have working with children?
3. Can you tell me about your experiences of working as a TAW?
 - a. Prompts: Positive/negative experiences? How many children you manage? What is the spread of need in the children that you work with? How do their families perceive your role?
4. Do you think the role of TAWs is useful?
 - a. Prompts: Do you feel like you are making a difference? What do you think the role should be in the future?
5. Are there are any barriers to success in this role?
 - a. Prompts: Financial? Resources? Time?
6. Are there are pieces of good practice you have seen or conducted when it comes to managing these children and families you would like to share?
7. What skills do you think are required to be a TAW?
 - a. Prompts: what sort of person should be a TAW? What sort of experience should they have?
8. Anything else you would like to add about your experiences of working as a TAW?

Thanks, and close

Supplementary 2: Topic guide for interviews with children

Topic guide for interviews with children:

You are here today with your parent/carer/key worker.

My name is (Interviewer) and I am here to ask you about how things have been in your family. I am interested in your experiences and I would like to find out about what you think about the help and support that you and your family has had from your trusted adult worker:

Icebreaker questions:

1. How old are you?
2. Who do you live with at the moment
 - a. How many brothers and sisters do you have?
 - b. Do you get on well with them?
 - c. Do you have any pets?
 - d. If so, what are their names?
3. Which school do you go to?
 - a. What class are you in?
 - b. What is your favourite bit about school?
 - c. Do you have a best friend?
 - d. What is their name?
4. What kind of things do you do at home?
 - a. Play in the garden
 - b. Play on the computer
 - c. Watch TV

Are there any books or other resources that could be used to start the following discussion?

5. Can you tell me about a time when things were not going well at home?
6. Who helped you and family with that difficult time? (TAWs...)
7. How did they help you?

8. What did you think about the help you got from people trying to help you?
9. What was useful about it?
10. What was not so useful?
11. What things have changed since that difficult time?
12. Would you like to tell me anything else about how you and your family have been helped?

Thanks and close

Supplementary 3: Topic guide for interviews with parents/carers

Topic guide for interviews with parent/carers:

My name is <<<INSERT NAME>>>, and I am here to ask you about how things have been in your family. I am interested in your experiences and I would like to find out about what you think about the help and support that your child and your family has had from your trusted adult worker:

Key topics to be covered

1. Before you were provided with a TAW please can you tell me about your family and any difficulties you were facing?
2. Can you explain how your family were allocated a TAW?
3. What was your opinion of being assigned a TAW?
4. Can you tell me about the sessions that have been conducted with your TAW?
5. Do you believe the TAWs have been useful?
6. If they were or were not useful, why?
7. How is the family's relationship with the TAW?
8. What differences have the TAW brought to the family?
9. Once you have finished working with the TAW, how do you perceive the future to be?
10. Would you like to tell me anything else about how you and your family have been helped?

Thanks and close

Supplementary 4: Topic guide for focus groups with referral panels

Topic guide for referral panel:

My name is <<<INSERT NAME>>>, and I am here to ask you about your experience of referring to Trusted adult workers (TAWs)

Key topics to be covered

1. I would like to hear your opinions on Trusted adult workers and the importance of this role?
 - a. Prompts: What do you know about what they do? Do you think it is a useful/not useful role and why? Do you think they have the correct aims/objectives? Has this changed the process that you were undertaking prior to the introduction of TAWs?
2. I would like to understand further about the process undertaken to select children that would be referred to TAWs?
 - a. Prompts: How does a child get from the attention of a public sector service to a TAW?
3. Please explain what happens to children who were not referred to TAWs?
 - a. Prompts: Do you continue to monitor these children? Could they ever become eligible for an intervention with a TAW? Why is the decision made for them not to be with a TAW?
4. What influences the decisions about the above?
5. Anything else you believe is important for us to know?

Thanks and close

Supplementary 5: Topic guide for focus groups with trainers

Topic guide for trainers:

My name is <<<INSERT NAME>>>, and I am here to ask you about your experience of undertaking Rock Pool training

Key topics to be covered

1. I would like to hear your opinions on how you felt the Rock Pool training was for you?
 - a. Prompts: In terms of benefits for you? Challenges you faced? What was useful/not useful? How was the delivery?
2. How have you applied the lessons learnt in the training to you day job?
 - a. Prompts: How are things different after going on the course?
3. Has the training led to any culture change in the workplace that you are based in?
 - a. Prompts: can you give examples? Any reason why it may not have if it didn't? How could it achieve this?
4. Have you been able to deliver any follow-on sessions and how did you find these?
 - a. Prompts: What went well and what didn't? Recruitment of attendees? Engagement of attendees? Any verbal feedback? Delivery?
5. Were there any barriers to delivery?

Thanks, and close

Supplementary 6: Baseline characteristics for those who are trainers

Number of participants	13
Age group	
26-35	3
36-45	4
46-55	6
Sex	
Male	1
Female	12
Disability	
No	13
Ethnicity	
White English/Welsh/Scottish/Northern Irish/British	13
Organisation	
Local authority	4
Police/YOTs/OPCC	6
Voluntary	3

Supplementary 7: Questionnaire results for those who have undergone the train the trainer approach

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I understand what ACEs are		3			10
I understand what the impact of ACEs may be to an adult who has experienced them during childhood		3			10
I understand the role stress and trauma plays on the brain		2	1	1	9
I understand what a trauma-informed approach is	3			2	8
I understand what resilience is			2	2	9
I understand how resilience can be built		1	1	3	8
I am confident in knowing how to support a child who has experienced ACEs	1	4	1	3	4
I believe the train the trainer sessions delivered by Rock Pool were well delivered	1	1		3	8

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I believe the material covered from the Rock Pool training is of use to my organisation	1	1	1	1	9
I believe this training should continue to be delivered to more people who are willing to become trainers			3		10
I believe that the train the trainer approach works in my organisation			4	1	8
I am confident in delivering the training sessions			1	2	10
I have experienced no organisational barriers in the delivery of my training sessions	3	1	1	4	4
I believe individuals who have attended my sessions have found them to be of use				7	6
I believe the delivery of these sessions will lead to organisational culture change relating to ACEs and a trauma-informed approach			4	6	3

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I believe that we should continue to deliver more training sessions to those who have not yet received it in my organisation			1	1	11

Supplementary 8: Baseline characteristics of participants who completed the pre-session questionnaire

Number of participants	191
Age group	
18-25	23 (12.0%)
26-35	37 (19.4%)
36-45	41 (21.5%)
46-55	54 (28.3%)
56-65	26 (13.6%)
66+	8 (4.2%)
Not declared	2 (1.1%)
Sex	
Female	146 (76.4%)
Male	45 (23.6%)
Disability status	
Don't know	1 (0.5%)
No	178 (93.2%)
Yes	9 (4.7%)
Not declared	3 (1.6%)
Ethnicity	
Any other mixed	3 (1.6%)
Any other ethnic	2 (1.1%)
Bangladeshi	1 (0.5%)
Black Caribbean	1 (0.5%)
Indian	3 (1.6%)
White UK	174 (91.1%)
White and Asian	2 (1.1%)
White and Black African	2 (1.1%)
Not declared	3 (1.6%)
Organisation	
Education	45 (23.6%)
Healthcare	6 (3.1%)

Legal	9 (4.7%)
Local authority	61 (31.9%)
OPCC	15 (7.9%)
Police	5 (2.6%)
Probation	5 (2.6%)
Third sector	30 (15.7%)
Youth offending services	15 (7.9%)

Supplementary 9: Pre-session questionnaire summary of responses

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
Have you heard of ACEs before?	59	34	7								
I understand what ACEs are			9	17	14	30	21	8	2.9	3	1.2
I understand what the impact of ACEs may be to an adult who has experienced them during childhood			8	15	18	28	24	7	2.9	3	1.2
I understand the role stress and trauma plays on the brain			8	3	20	29	30	9	3.24	3	1.0

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I understand what a trauma-informed approach is			8	16	35	28	10	3	2.5	2	1.0
I understand what resilience is			8	1	13	29	35	15	3.6	4	0.9
I understand how resilience can be built			8	5	18	37	26	6	3.1	3	0.9
I am confident in knowing how to support a child who has experienced ACEs			10	20	32	20	14	3	2.4	2	1.1

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I believe my organisation are trauma-informed in their approach			14	9	23	36	15	4	2.8	3	1.0
I am looking forward to the session today			9	1	13	2	29	46	4.3	5	0.8

Supplementary 10: Post-session questionnaire summary of responses

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I understand what ACEs are				1	1	1	22	76	4.7	5	0.6
I understand what the impact of ACEs may be to an adult who has experienced them during childhood					1	1	26	71	4.7	5	0.6
I understand the role stress and trauma plays on the brain					1	3	37	59	4.5	5	0.6

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I understand what a trauma-informed approach is					2	4	33	61	4.5	5	0.7
I understand what resilience is					2	3	38	58	4.5	5	0.7
I understand how resilience can be built			13		3	6	42	37	4.3	4	0.7
I am confident in knowing how to support a child who has experienced ACEs			10		5	12	50	23	4.0	4	0.8

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I have found the session useful today			11	1	1	3	17	67	4.7	5	0.7
Did the session meet your anticipated aims?	86	2	12								
The session will improve my ability to conduct my day job when working with children and adults			12	1	2	9	31	44	4.3	5	0.9
I believe the trainer did a			11	1		2	17	69			

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
good job of delivering the information											
I am likely to inform others in my organisation about the content of the training			16	2		5	23	54	4.5	5	0.8

Supplementary 11: Delayed post-session questionnaire summary of responses

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I understand what ACEs are							11	89	4.9	5	0.3
I understand what the impact of ACEs may be to an adult who has experienced them during childhood							33	67	4.7	5	0.5
I understand the role stress and trauma plays on the brain						11	33	56	4.4	5	0.7
I understand what a trauma-informed approach is						11	78	11	4.0	4	0.5

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I understand what resilience is			11			11	33	44	4.4	5	0.7
I understand how resilience can be built						33	33	33	4.0	4	0.9
I am confident in knowing how to support a child who has experienced ACEs						44	33	22	3.8	4	0.8
I have been able to implement my new understanding of ACEs into practice						33	44	22	3.9	4	0.8

Question	Yes (%)	No (%)	Missing (%)	1 (Strongly disagree) (%)	2 (Disagree) (%)	3 (Neutral) (%)	4 (Agree) (%)	5 (Strongly agree) (%)	Mean	Median	SD
I am confident in delivering a trauma-informed approach						44	33	22	3.8	4	0.8
I have informed others in my organisation about ACEs or a trauma-informed approach following my training	67	33									
I believe the training we received was useful for people in my organisation						11	22	67	4.6	5	0.7

Supplementary 12: Baseline characteristics for those who have not undergone the train the trainer approach but work in organisations where individuals have done so

Number of participants	92
Age group	
18-25	4 (4.3%)
26-35	13 (14.1%)
36-45	31 (33.7%)
46-55	28 (30.4%)
56-65	11 (12.0%)
66+	5 (5.4%)
Sex	
Male	51 (55.4%)
Female	41 (44.6%)
Disability	
No	84 (92.3%)
Prefer not to say	3 (3.3%)
Yes	4 (4.4%)
Ethnicity	
White British	83 (90.2%)
Any other White background	4 (4.4%)
Mixed background	3 (3.3%)
Any other mixed background	2 (2.2%)
Organisation	
Local authority	16 (17.4%)
Police/YOTs	70 (76.1%)
Voluntary	5 (5.4%)
Other	1 (1.1%)

Supplementary 13: Questionnaire results for those who have not undergone the train the trainer approach but work in organisations where individuals have done so

Questions	Likert scale				
	1 (Strongly disagree)	2	3	4	5 (Strongly agree)
I understand what ACEs are	7	8	26	31	19
I understand what the impact of ACEs may be to an adult who has experienced them during childhood	5	8	19	38	21
I understand the role stress and trauma plays on the brain	3	9	17	38	24
I understand what a trauma-informed approach is	16	22	25	19	9
I understand what resilience is	3	2	19	47	18
I understand how resilience can be built	5	13	23	38	11

I am confident in knowing how to support a child who has experienced ACEs	19	20	32	15	4
I believe my organisation are trauma-informed in their approach	4	13	37	26	10

Supplementary 14: Details of the Outcomes Stars used across Hampshire local authorities

Outcomes Stars		
Southampton – ‘Client’s Journey Travelled’	Portsmouth – ‘Client’s Outcomes Star’	Hampshire – ‘Client’s Outcomes Star’
Domains included		
Housing and finances	Education and learning	Physical health
Unemployment and progress to work	Boundaries and behaviour	Where you live
Crime and antisocial behaviour	Being safe	Being safe
Family health	Physical health	Relationships
Domestic abuse	Emotional health and wellbeing	Feelings and behaviour
School attendance	Family	Friends
Other issues	Where I live	Confidence and self-esteem
	Substance misuse	Education and learning
	Social networks	
	Progress to work	

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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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