PROCESS EVALUATION OF THE NEW ORLEANS INTERVENTION MODEL FOR INFANT MENTAL HEALTH IN GLASGOW

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• The New Orleans Intervention Model in Glasgow (GIFT) is for children aged 0–5 who come into care on the basis of maltreatment. It differs from social work services-as-usual in that there is a multidisciplinary infant mental health team with a treatment component for birth and foster families.

• The mental health focus of GIFT has been received positively in the wider system; however, there are concerns within services-as-usual that the different lens of the GIFT model may lead to permanence decisions that are at odds with their judgements. Related views about the perceived weightier influence of GIFT reports in the legal system are found, with both positive and negative factors identified in relation to this premise.

• GIFT timescales have generated significant discussion and debate. From the perspective of services-as-usual, there are barriers to the acceptance of the longer GIFT timescale in the context of a system that is concerned about delays for children in care; on the other hand, there is a view that the opportunity of treatment in the GIFT model may have the potential of improving accuracy in decision making. From the perspective of GIFT, delays for children in care are related to the wider system rather than to the addition of the GIFT treatment phase; particularly the lack of child-led timescales within the legal framework, and resource issues and drift within social work procedures.

• A key component of the GIFT model is the lens that it takes to the skills needed by foster carers and the variability that can exist in the quality of foster care commitment. Carers report the value of GIFT support and the thoroughness of the GIFT assessment; however, they can also perceive their involvement in the service as burdensome.

• The existence of GIFT has highlighted particular aspects of the foster care system that can create a barrier towards thinking about the long-term wellbeing of the child during assessment and treatment. Working within the context of temporary foster care arrangements, and, therefore, with short-term child–carer relationships, poses a particular challenge in cases where the child cannot be rehabilitated home with their parents and where a further move to a long term or adoptive placement is usual. The merits of a dual registration system – where foster carers are prospective adopters and vice versa – are proposed.
• Overall, equipoise – balanced views on GIFT versus social work services-as-usual – have been found throughout our process evaluation; a central question remains about whether the best method of assessing and making recommendations about children in care, in the Scottish context, is delivered by GIFT or services-as-usual. An ongoing ethical basis for the trial is, therefore, identified.

• This study has underscored the value of qualitative process evaluation in understanding the context of randomised controlled trials of complex interventions and the effects of introducing transformative change in the way that decisions are made about the future of young children who come into care on the basis of maltreatment.
EXECUTIVE SUMMARY

Introduction
The Chief Scientist Office (CSO) of the Scottish Government Health Department funded the Best Services Trial (BeST’), which is an exploratory randomised controlled trial (RCT) that compares two new services for maltreated preschool children and their families. The first service is the Glasgow Infant Family Team (GIFT) – a multidisciplinary infant mental health team based on the Tulane Infant Team developed in New Orleans. The second service is the Family Assessment and Contact Team (FACS) – a social work service developed in Glasgow that represents a modest enhancement of services-as-usual (including better standardisation and monitoring of social work services).

Aims
This report describes the process evaluation funded by the NSPCC and run alongside the exploratory RCT. This project focused on the following research questions:

1) What are the key components of GIFT that impact on the wider system and how can these be optimised?

2) Are there ways in which barriers to the optimal delivery of GIFT can be removed?

3) What are the components of the FACS intervention and does it change during the study?

A subsidiary aim is to understand the process of the evaluation itself – in particular, the random allocation to study groups.

Methods
Semi-structured interviews and focus groups were carried out with key stakeholders in the trial: FACS and GIFT teams; social work area teams; foster carers; birth parents; and children’s panel members. Data was recorded and transcribed verbatim, and was subject to thematic analysis to illuminate key components of the GIFT model that impact on the wider system. This was in order to understand the key components of the control intervention, FACS, and to identify any change in these during the study. Related barriers to the optimal delivery of these components were identified in accordance with the research questions, and key views about aspects of trial design were extrapolated for the purpose of the subsidiary aim of this evaluation.
Findings

Analysis of qualitative data from the various participant groups involved in, or affected by, the trial has unearthed key features of GIFT that distinguish it from FACS enhanced services-as-usual. This allows us to say something about what the key ‘ingredients’ of an infant mental health model are and how they sit within the surrounding context. In summary, these are:

- Multi-disciplinary nature – in contrast to the uni-disciplinary nature of FACS
- At least some of the professionals being perceived as having a higher status than social workers (a ‘GIFT clout’ perception)
- Being seen as more objective and regarded as external to social work services, who are often seen as biased
- Using very detailed video-based examination of parent–infant relationship functioning – compared with the more naturalistic observation used in FACS
- A more current here-and-now view of the child – in contrast to social work service’s more long-term, historical perspective
- More detailed focus on certain aspects of the parents’ history, such as trauma – in contrast to the focus on the wider context used in FACS
- Therapeutic work on foster carer–child relationships where necessary – not conducted in FACS
- Therapeutic work on birth parents’ parenting problems – not conducted in FACS
- Therapeutic work on birth family relationships – not conducted in FACS

The key components of GIFT that impact on the wider system, and that relate to specific barriers to implementation, were found to be those that are associated with:

1) The mental health component of GIFT – introducing a mental health model into current systems

2) The timescales involved in GIFT (with the addition of a treatment phase after assessment)

3) The requirements that GIFT places on foster carers and the ways in which foster carers perceive their involvement in GIFT.

These three main themes are summarised below:
1) *The mental health component of GIFT.* The addition of GIFT to the assessment and treatment of maltreated children has largely been viewed positively by our different participant groups. A mental health focus was seen as GIFT’s key contribution and participants reflected on how this relates to the needs of both the child and the parent in assessment and treatment. There was also a perceived sense of GIFT having weightier influence (what we have termed as a perceived ‘GIFT clout’) than ‘services-as-usual’ in decision making about the future of maltreated children in care.

Challenges are identified, however, in terms of the potential for disagreement in decision making regarding permanency when methods of assessment between GIFT and FACS are different. In this perspective, the ‘flip side’ of GIFT generating evidence that is perceived as more influential is that it can add an element of doubt (rather than ‘clout’) to the claims and recommendations made by social workers. This identified issue of GIFT evidence being seen as more influential is, therefore, a ‘double-edged sword’ for many social workers and can make them feel undermined in the process.

2) *GIFT timescales.* GIFT timescales have generated a significant amount of discussion and debate. GIFT typically follows a three-month assessment model (a similar timescale to FACS) with a six- to nine-month treatment phase added on (that FACS does not offer). Mixed views over this lengthier timescale are evident: on the one hand, the addition of a treatment phase is seen as necessary to improve the accuracy of decision-making by improving the quality of evidence in a case; on the other hand, there are barriers to the wider system accepting the longer timescale in a way that can obscure positive views about other aspects of GIFT.

These barriers are mostly related to concerns over the ‘changeability’ of some parents – both in terms of them managing any change in the first place and in being able to sustain change after treatment. In addition, there is a reported lack of synchronicity in timescales between GIFT and the wider system, particularly in the timing of social work permanence reviews and GIFT processes, as well as reflections from GIFT about there being no legal framework around timescales that fits with, or supports, a focus on working towards the child’s timescale within the wider legal system.

3) *GIFT and foster care.* A key component of the GIFT model is the lens that it takes to the skills needed by foster carers in understanding and responding to the various challenges that are presented by the children in their care. Foster carers report the value of the thorough assessment of GIFT in relation to understanding the child’s needs but also in supporting their own role in the process. This is a level of support that foster carers have not experienced within the system before. The caveat of GIFT’s focus on foster care, however, is that
their involvement in GIFT can sometimes feel burdensome. GIFT accepts this perspective and reflects on the ‘newness’ of their advice to foster carers, empathising with the challenge of accepting ways of working with children in their care.

GIFT also reports a significant amount of variation in terms of the quality of emotional care and commitment of foster carers; when foster carers are not ‘on board’ with the methodologies and aims of GIFT, it can be a barrier to progress. GIFT, therefore, continues to push the dual registration agenda (where foster carers are routinely registered as prospective adopters) in order to work with foster carers who are more likely to be able to offer a long-term and committed relationship to a child. Our data from foster carers suggests that this is a change in the system that receives mixed responses in terms of its usefulness to individual fostering roles. While foster carers are generally positive about dual registration as a concept, in practice the system may not always fit with the ways in which they perceive their own role. More data collection is needed, however, to explore this topic with adopters and long-term foster carers.

Overall, the optimal delivery of GIFT continues to be affected by barriers that have remained since the start of the trial. Even when GIFT is viewed favourably, there are factors that prevent its ‘fit’ within the wider system, which prevents its optimal delivery. Importantly, however, none of the identified barriers have had the effect of destabilising the trial and most are either being negotiated among services or are naturally eroding due to GIFT methodologies and aims becoming more familiar, understood and experienced in the wider system.

**Conclusion**

The process evaluation has underscored the value of qualitative work within a randomised controlled trial by supporting our understanding of the surrounding context and in documenting significant aspects of the trial ‘journey.’ In addition to a focus on the aims of the study, it has also provided a lens to issues that have implications beyond the trial itself – for example, the nature of foster care and timescale issues in the wider system. Key themes of debate across and within the different participant groups evidence that equipoise in the trial continues to be maintained; balanced views on GIFT versus FACS have been found throughout our stakeholder groups and a central question remains about whether GIFT or FACS will generate the best outcomes for children in care.
1. Introduction

The Chief Scientist Office (CSO) of the Scottish Government Health Department funded the Best Services Trial (BeST®), which is an exploratory randomised controlled trial (RCT) that compares two new services for maltreated preschool children and their families (1). The first service is the Glasgow Infant Family Team (GIFT) – a multidisciplinary infant mental health team based on the Tulane Infant Team developed in New Orleans (2). The second service is the Family Assessment and Contact Team (FACS) – a social work service developed in Glasgow that represents a modest enhancement of services-as-usual (including better standardisation and monitoring of social work services).

Both the GIFT and FACS interventions fulfil the criteria for a ‘complex intervention’ in that they comprise a number of interacting components: there are a range of behaviours required by those delivering and receiving the intervention; a number of different groups and organisational levels require to be targeted by the intervention; there are a number of different possible outcomes of the intervention; and the intervention itself entails a degree of flexibility and tailoring in its delivery. The aim of both interventions is to make a recommendation concerning the child’s future placement to the Children’s Hearing System based on the best outcome possible for the child, be this rehabilitation to their birth family or adoption.

Glasgow Infant and Family Team (GIFT)

This is the Glasgow version of the New Orleans model. GIFT is delivered by a multidisciplinary team of mental health professionals and social workers. Participants randomised to GIFT take part in a detailed attachment-based assessment involving each actual and potential caregiver. The GIFT assessment is manualised, standardised and uses structured interviews, self-report measures and observations. An intervention is then tailored for every family, drawing on a small ‘toolbox’ of relationship-based therapeutic techniques for the GIFT treatment phase. Parents are also referred as required to other
existing services agencies. Following the GIFT treatment phase, a recommendation for the future placement of the child is based on the final assessment of the child’s mental health and parental capacity. Figure 1 below illustrates the GIFT pathway, demonstrating the various stages of the intervention, from initial assessment, through to tailored GIFT treatment and, finally, a permanency decision.

**Family Assessment and Contacts Service (FACS)**

FACS is the control intervention in the BeST³ exploratory trial. This is an enhanced service provided by Glasgow City Council. FACS is delivered by a team made up entirely of social workers who arrange contact between the child and birth parent(s), which is monitored and assessed. Parents are also referred, if required, to other existing services. The recommendation for the future placement of the child is based on the final assessment of parental capacity. Figure 2 below illustrates the FACS pathway, demonstrating the various stages of the intervention.

The qualitative interviews leading to Figures 1 and 2 suggested that the GIFT intervention might be more intensive than the FACS intervention and, hence, likely to be more resource intensive of NHS and social services staff time for the tailored intervention in the GIFT treatment phase. It is hypothesised that, in comparison with FACS, this will lead to more timely permanency decisions and fewer repeated episodes of being taken into care.
**KEY**
- **ABC**: Attachment Biobehavioural catch-up
- **ASQ**: Ages and Stages Questionnaire
- **ATSW**: Area team social worker
- **BF**: Birth family
- **BSQ**: Behavioural Screening Questionnaire
- **CBCL**: Child Behaviour checklist
- **CPP**: Child–parent psychotherapy
- **DAI**: Disturbances of Attachment Interview
- **FC**: Foster carers
- **FFC**: Families for Children
- **FFCSW**: Families for Children social worker
- **GTL**: GIFT team leader
- **GTM**: GIFT team member
- **SPI**: Security Parenting intervention
- **VC**: Visitation Coaching
- **VIG**: Video interactive guidance
- **WMCI**: Working Model for the Child interview

**Figure 1: GIFT process early in the trial**

**1. Initial Assessment with FC**
- Assess the ‘fit’ of a child and FC
- **CBCL**
- **WMCI**
- **DAI**
- **ASQ**
- **BSQ**
- **CROWELL with each FC**

**2. Parental Assessment with BF**
- Consent
- Intake interview
- **CROWELL with each parent**
- **WMCI**
- Screening questionnaire

**3. Case Conference**
- All working professionals involved with the case and GTM/GTL
- **Other agencies**

*(all information is reviewed for report)*

**PRELIMINARY REPORT SENT TO COURTS AND SOCIAL WORK**

**TREATMENT PHASE**, which may include:
- **VIG**
- **ABC**
- **VC**
- **SPI**
- **CPP**

**FINAL REPORT**

*(informed of randomisation)*

*(information gathering)*

*(informed of randomisation)*

*(information gathering)*
Figure 2: FACS process early in the trial

KEY

AOIP  Any Other Involved Professional
ASWTL  Area Social Work Team Leader
FA  FACS Administrator
FTL  FACS Team Leader
FTM  FACS Team Member
BP(s)  Birth Parent(s)
BF  Birth Family

Randomisation Referral Email

FA  (sends blank referral form)
ASW  (returns completed referral form)
FA  (enters information into log sheet)
FTL  (reviews and allocates case)
FTM  (reviews all available information)
FTL  (sets date for Planning Meeting)
FA  (sends out invitations with 3–4 weeks’ notice)

Part 1. Professional Review

(FA, FTL (chair), FTM x 2, ASWTL, ASW, AOIP)
(FTM confirms FTM allocation and SW contacts)

Part 2. Parental Feedback & Planning

(working agreement & consent signed, contacts planned Midway and Final meetings set)
(FTL, FTM, ASW, ASWTL, BP(s)- with support if required)

Visit to FC  
FTM  (Case file reading)
(FTM, FC)

BF(s) Contacts in FACS Premises
(8 individual parent or joint contacts)

Parenting Capacity Interviews x 6 conducted in FACS premises (FTM, BF)

FTM Contacts FC for update on child following each contact
(FTM, FC)  

MIDWAY REVIEW MEETING
(FTL, FTM x 2, ASW, AOIP)

Parent(s) Contacts in FACS Premises

FTM  (Collates all information)

FINAL REVIEW MEETING
(2 parts)

Part 1. Professional Review
(FTL, FTM x 2, ASWTL, ASW, AOIP)
Part 2. Parental Feedback & Recommendations
(FTL, FTM x 2, ASWTL, BP)

2 weeks

FINAL REPORT
The BeST? trial

The CSO-funded exploratory RCT aimed to answer questions regarding the likely size of any effects of GIFT on the mental health of Glasgow’s maltreated children, and give information allowing development of a definitive study, if this seems necessary. However, in order to make the exploratory RCT viable, and to better understand the outcomes of the trial, data collection was needed regarding recruitment of participants. It was also important to understand changes in the complex network that the intervention will influence: fostering and adoption; children’s hearing system; and social work, among others.

In addition, it would be beneficial to construct a health economic analysis, using preliminary data from the feasibility trial to provide information on the likely costs to the NHS and social services and to birth families and foster carers, both now and in the future. The NSPCC funded this additional Process and Economic Evaluation to be undertaken alongside the CSO’s exploratory RCT.

At this stage of the trial, this report presents the findings from the main process evaluation only, since the presentation of data pertaining to health economics while the trial is running may have the potential to threaten equipoise.

Following the commencement of the exploratory study, the National Institute for Health Research (NIHR) funding body funded a multi-centre definitive RCT, under their Public Health research funding branch, to determine definitively whether GIFT is an effective and cost-effective intervention for maltreated children in the UK.

In January 2015, amendments were made to the BeST? CSO protocol to enable the first 100 participants recruited to BeST? to be included in the sample for the definitive trial as an internal pilot. We will not, therefore, analyse the data by group (GIFT versus FACS) at this stage, as this would jeopardise equipoise for the definitive study. This means that the effectiveness data from the BeST? CSO-funded exploratory study will feed directly into the UK-wide definitive RCT, and the primary and secondary outcome data on the effectiveness measures (SDQ, ITSEA and pedsQL) will remain blinded to the researchers and analysts at this stage.
2. Research questions

This NSPCC-funded process evaluation was undertaken to answer the following research questions relating to the trial:

- What are the key components of GIFT that impact on the wider system and how can these be optimised?
- Are there ways in which barriers to the optimal delivery of GIFT can be removed?
- What are the components of the FACS intervention and does it change during the study?

A subsidiary aim is to understand the process of the evaluation itself – in particular, the random allocation to study groups.
3. Methods

Qualitative work in the first part of the trial focused on the implementation and delivery of services from the perspectives of key stakeholders; social workers, foster carers, and the GIFT and FACS teams. The main data collection method for this purpose was focus group discussions, which were repeated throughout the trial in order to track changes and developments over time. The exception was data collection with foster carers; it was found that they preferred the more personal and private nature of an individual interview.

The second phase of the study, although still tracking the development of issues already gleaned in the first phase, adopted case study methodology to focus more specifically on the impact of GIFT and FACS on a selection of children and families involved in the trial. This narrower focus allowed a more in-depth investigation into the process of experience from the perspectives of the birth family, foster carers, social workers and health professionals surrounding specific children enrolled in the trial. The primary methodology for this part of the process evaluation was individual interviews.

Data collection is detailed as follows:

- **GIFT team**: three focus groups over the course of the evaluation + three interviews with GIFT managers
- **FACS team**: three focus groups over the course of the evaluation + three interviews with GIFT managers
- **Foster carers**: two focus groups at the start of the evaluation followed by 15 individual interviews mid-way
- **Social work area teams**: focus group with each of three area teams at three different trial time-points = nine focus groups overall
- **Children’s panel**: two focus groups representing two different areas
- **Case studies**: individual interviews about four children going through the trial (two from GIFT and two from FACS), totalling 18 individual interviews
- **Data on specific issues** (where previous data has indicated a need for exploration): one focus group on permanence reviews\(^1\) with GIFT team members and social work area teams; seven interviews with birth parents about consent; two interviews with recruitment coordinators about lessons learned from the consent process; and three focus groups on foster carer/adoptive parent dual registration

\(^1\) Social work structures for making recommendations about whether a child can return home or is to be adopted.
All members of GIFT and FACS teams were invited to take part in the process evaluation based on their ability to provide views about the models being implemented. Similarly, social workers were invited to take part in focus groups if they were aligned to either of three local area teams representing the geographical spread of area team social work services across Glasgow. Panel members were purposively recruited from six sectors across Glasgow to provide views that represent the spread of panels across the city.

For data gathered pertaining to specific issues from professional perspectives, such as dual registration, the sampling strategy was purposive; professionals were recruited from meetings that were already externally arranged in relation to these topics. The data collected on the consent process from birth parents, however, was obtained from parents invited by the process evaluation who had consented to the trial over a period of six months. The parents who were invited to take part in interviews were those who were contactable and regarded as safe for the researcher to visit at home after risk analysis by the recruitment co-coordinator.

For the case studies of four children participating in the trial, sampling was also purposive but random; GIFT and FACS identified a number of cases where there were indications, during the process of assessment, about the nature of the final recommendation and the process evaluation, then randomly selected two cases from each service where it looked likely that there would be opposing outcomes; one case from each service where indications were suggestive of the child/ren being rehabilitated home, and one case from each service where it looked likely that a recommendation would be made for permanency. Participants were invited to take part in case study interviews based on their involvement in the case and their ability to provide a view on the child from their specific perspective; that is, from the angle of the parent, the foster carer, the area team social worker and the key workers involved in the case from either FACS or GIFT.

The data collected from foster carers was at specific time points over the course of the process evaluation and carers were invited from each arm of the trial on the basis of their child/ren’s participation in GIFT or FACS at the time of data collection.

The focus groups and interviews used topic guides that evolved iteratively from the thematic analysis during the process of stakeholder engagement. For example, analysis of the data generated from consultations with health and social work professionals led to the development of topic guides that specifically explored issues of consent with birth families (4).
In order to analyse the data, a thematic analysis was employed where each transcript was examined in detail, noting reflections and preliminary themes. Transcripts were read a number of times to identify repeating patterns and/or differences between transcripts, and any new themes identified at this stage were noted. Themes that were found to relate to one another were then clustered together and became sub-themes of main theme headings that captured the essence of overall categories of themes.

Views about the key components of GIFT that impact on the wider system and barriers to optimal GIFT delivery were mostly found in three main areas of data collection in the trial; that is, from the GIFT team themselves (focus groups and individual interviews with managers); social work area teams (focus groups); and foster carers (interviews). Other pockets of data, however, were found to also contain relevant views and have been used in this report; these are the focus group on permanence reviews and two focus groups comprising of children’s panel members (please note: the panel focus groups have already been written up as a peer reviewed paper2).

Names have been removed in quotes to protect anonymity.

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4. Findings

Focus groups and preliminary quantitative process data from GIFT and FACS have resulted in the process diagrams for the two interventions (see previous Figures 1 and 2).

Neither intervention changed significantly during the study, although GIFT has identified time-saving processes that are beginning to be implemented. These include overlapping the foster carer and birth family assessments, and the introduction of pre-treatment conditions in the GIFT model (referred to as a bridging period between assessment and treatment) in cases where there is substantial doubt over the parents’ ability to engage with, or cope with, treatment.

Analysis of our qualitative data suggests that there are three main GIFT components that impact on the wider system. These, therefore, represent our main themes in this report:

• Theme 1: The mental health component of GIFT – the impacts and related barriers that result from the introduction of a mental health model into current systems
• Theme 2: The GIFT timescale – the introduction of a treatment phase after assessment, and its fit with the wider system
• Theme 3: GIFT and foster care – the impacts of the GIFT model on illuminating what is required of their foster carers and the ways in which foster carers perceive their involvement in GIFT

Although not an exhaustive list, these themes represent particular components of the GIFT model that have generated debate across and within our various participant groups and are divided into sub-themes in each section. In relation to research question 2, barriers to the optimal delivery of these components are identified throughout.

4.1 Theme 1: The mental health component of GIFT and its addition into current systems

The addition of GIFT to the assessment and treatment of maltreated children has largely been viewed positively by our different participant groups. The addition of a mental health focus was seen as GIFT’s key contribution and, within this perspective, participants reflected on how this relates to the needs of both the child and the parent in assessment and treatment (the first theme of this section). Participants in this study then also reflected upon the reporting of GIFT cases and spoke about a perceived sense of GIFT having weightier influence than services-as-usual in decision making about the future of maltreated children in care.
A perceive sense of ‘GIFT clout’ was related to evidence being seen as more objective, more in-depth and attributed to the opinions of mental health professionals being held in higher esteem than those of social workers. Challenges are identified, however, in terms of the fit between the two models and the potential for disagreement in decision making regarding permanency when methods of assessment between GIFT and services-as-usual (FACS) are different.

In this perspective, the ‘flip side’ of GIFT generating evidence that is perceived as more influential is that it can add an element of doubt (rather than ‘clout’) to the claims and recommendations made by social workers. This identified issue of GIFT evidence being seen as more influential is, therefore, a ‘double-edged sword’ for many social workers and can make them feel undermined in the process. The following sub-themes categorise these views:

4.1.1 The positive addition of GIFT’s mental health focus

Participants who we have spoken to in the wider context of the trial are generally positive about GIFT’s mental health component and see it as adding ‘a string to the bow’ of assessing and treating maltreated young children. Participants reflected on the positive addition of a mental health focus on the needs of both children and parents:

**A mental health lens on the child**

In the wider context, the mental health nature of the GIFT assessment is seen as a more thorough assessment of a child’s needs. In one of our case studies, the area team social worker felt that GIFT had picked up on developmental issues that might otherwise have been missed:

“When you do have a case like that with a child who has got additional needs, things can be masked, like her development. GIFT had picked up on the clinical side of it, which has given us a much better and thorough assessment.”

*(Area team social worker, case study 4)*
The treatment phase of GIFT was generally seen as an opportunity to improve a child’s mental health; an element that has been seen as a gap in the system:

“Some cases that we’ve had where children have been in care before, but haven’t received the kind of treatment that GIFT offers and the child has come back into care having never received the opportunity to work in the kind of way that was making differences – positive changes for them – that’s the important thing as well.”

(GIFT team member)

This was a point that was echoed by foster carers, although, interestingly, one foster carer reported mixed views within foster care on the premise of early intervention:

“The only problem I have with fostering in Glasgow is the psychological part of it; it really does let them down slightly. A lot of carers say to me ‘Oh there is no use trying to open up a can of worms with kids at an early age, it can mean their behavior can deteriorate and things like that’. I think it is so important that you get these things sorted at an early age…you really need to get to hear of things because it is like a bereavement for children; I’ve had children come to me in an emergency whereby they are straight out of the community, they have never been away from their mum and, don’t get me wrong, they have come from a horrendous background, but that’s the background they know. They don’t know any different, you know what I mean? Going to bed at a safe time, and being safe in your bedroom and getting up, getting three square meals a day, going to school – that’s not normal to these kids. You know, it is the right path, but for these kids that’s not their path; their lifestyle is their lifestyle, so that’s alien when they first come into care. I just think that you need to solve these things for these kids as early as possible so that it stops the festering of their personality.”

(Foster carer F6)
The needs of parents
Social workers spoke positively about learning more about the parents’ history through GIFT; an area that social workers do not typically go into. In this sense, the historical perspective of social work is more centred on the child than the parent, especially in cases where immediate concerns have to be prioritised. A focus on the mental health of the parent was seen as adding a multi-lens approach to the cases of maltreatment:

“I’ve had training in observation in infants’ mental health, so I will look at it from that point of view. They [GIFT] do a similar thing, but they also tend to do much more with mum, you know, which isn’t something we would usually do that much of. After the child is accommodated then the child is your focus and their needs. So having someone go back and look at the mum and look at all that, you know, where they come from, their parenting style and that sort of stuff, that does help…it does give you a lot of insight into why things are the way they are that you wouldn’t have had otherwise.”

(Area team social worker, case study 3)

Where the GIFT assessment indicates that it is appropriate to provide treatment to work towards the possibility of safe rehabilitation of the child to their parents, GIFT offers interventions that focus on the parent–child relationship. These interventions can have a secondary effect of addressing difficulties for parents that relate to their own experiences of being parented. This is contrasted to FACS where interventions for parents would be referred to external services. A focus on the parent was seen as a key element that distinguished GIFT from services-as-usual:

“I would see GIFT probably, in theory, as being probably a more beneficial service because they do offer the treatment part of it…so I suppose if there is some treatment there that can be completed it might be that children could go home, whereas if a FACS assessment was done and…they can’t identify anything to improve that, that might be a slight difference…our priority for resources is always going to be children and…it is difficult for us to tap into services for parents to make a difference.”

(Area team 2 social worker)
In our two case studies of a child going through GIFT, the parents reflected positively on the team looking at their own needs. Here, the mental health focus of the model was valued, both in terms of its identification of problems and in a general supportive capacity:

“They [GIFT] mostly talk about feelings and stuff like that, but she noticed that I’d been suffering from depression and through a lot of things and that, so she actually also wanted to talk to my doctor...and spoke to the doctor about it. So that helped as well. They have been really helpful and things and they do help you through. It is not the case of with some people you go to the meetings and then once you leave that’s it. They will actually give you a phone and make sure that you are okay and things. xxxx [GIFT worker], that’s the one who is dealing with me, she is amazing, absolutely amazing, she is, she phones me up and everything and anything that I need...if I need just to chat to somebody I can just phone her.”

(Birth parent, case study 3)

“She [GIFT worker] phones us sometimes during the week just to see how we are...they talk to us like a normal person; they talk away to us. They are really good...we can just be ourselves in here.”

(Birth parent, case study 4)

4.1.2 The ‘clout’ of the GIFT mental health ‘lens’ in decision making

In addition to providing perspectives about the addition of GIFT’s mental health focus on assessment and treatment, participants also talked about the impact of the model on how reports and recommendations are received in the wider context. A central theme to emerge from the data is that GIFT reports are seen as more influential than those from FACS and area teams. This is particularly reported in cases where the social worker feels a child should not return to the care of their parents and where GIFT’s assessment of the case provides evidence that further supports this judgement. A perceived element of GIFT having more ‘clout’ than FACS or area teams was related to two issues: 1) reports coming from mental health professionals and not just social workers; and 2) GIFT being seen as an ‘external’ service that was perceived as adding a sense of objectivity and depth of focus to the assessment of maltreated children:
The ‘clout’ of mental health professionals
Social workers point to the presence of psychologists and psychiatrists in the team as adding an element of ‘clout’ to judgement and opinion. There is a view that GIFT’s mental health component brings in the “medical model,” which is seen as particularly influential in the hearing system:

“GIFT seems more like a medical model almost, and panels respond much better to medical models and they tend to trust doctors and psychiatrists and psychologists. They don’t tend to trust social workers and people who aren’t, you know, medically trained.”

(Area team social worker, case study 3)

“The fact that a child psychotherapist was sitting there [at the children’s panel] saying the same thing about contact that I was saying…I wouldn’t have just won it on my own, but because a child psychotherapist from GIFT was there, saying the same thing, it was a done-deal then.”

(Area team 2 social worker)

GIFT’s perceived objectivity and depth of focus
GIFT was cited as ‘external’ to services-as-usual, engendering a perceived sense of objectivity in terms of assessment and recommendation. This is a potential barrier to the integration of GIFT into the wider system, given that it has been envisaged that any future GIFT would be commissioned jointly by health and social work and, at present, all partners see GIFT as deliverable as one of the services that social work may be able to offer as services-as-usual. GIFT’s perceived objectivity was identified by social workers, however, as a strength of the service – an additional ‘clout’ factor, particularly in the legal system and panel members were found to echo this view. Coupled with this was a depth of focus; information about the parents in a case was particularly valued and panel members reflected that GIFT’s detailed information about a case aided and eased their decision making. The following extract houses both a perceived objectivity and depth of focus in relation to GIFT reports:
"I think that the reports carry a lot of weight, especially if you are presenting that as part of an evidence to panels, because panels, whether we like it or not, sometimes maybe think that the social work or area team are not as objective, but they see them [GIFT] as being external...you know not just based on social work bias because obviously sometimes the families can feel that we are very biased towards them and that we are not giving them a chance and I feel in my experience if the panels have looked at that and thought that this a more objective assessment and it is very detailed and really goes into the case history in terms of like the trauma for mum and dad and picking up on things that maybe perhaps in our own integrated assessments have just been skimmed over if you like, but they have had the opportunity to really unpick that and work out why the parents are functioning the way they are now, as opposed to just all the historical stuff all the time."

(Area team 1 social worker)

Further relating to the perceived objectivity of GIFT, social workers reported that GIFT’s involvement in one of their cases reduced their workload, whereas there was more joint working between area teams and FACS. This appeared to enhance the notion of GIFT as ‘stand-alone’ and objective from an area team point of view:

“With FACS, the social worker works alongside the [FACS] worker, so to do the assessment it would be a FACS worker and the social worker and both of them would do that...but what it [GIFT] does it takes some of the workload away because they will do the work with mum. So we’re not doing any of that work, GIFT will do it. So certainly it does ease the workload slightly, I would say.”

(Area team 2 social worker)

“It seems like a different type of assessment, but there is an element where they just run with it themselves, which takes a lot of pressure off of us.”

(Area team social worker, case study 4)
On the same theme of workloads, there were mixed views from area teams about FACS. Social workers, in general, see FACS methods as similar to their own and some view FACS involvement as “another social worker doing the same assessment but adding complementary information”. Others, however, viewed this joint working as more cumbersome than working independently:

“[GIFT] are very very good, they are very hands on, they take over the role, it is like...and it is separate, whereas with FACS I am not so sure it is; you know, you are very much joint working and in terms of...and it is time consuming, you are almost like jointly doing that assessment.”

(Area team social worker, case study 4)

The perceived ‘clout’ that social workers have experienced in relation to GIFT evidence can, however, make them feel undermined. This can be a barrier to positive relations between GIFT and social workers:

“I feel as if we are undermined at times because we are trained social workers, our job is to assess. In terms of the legal situation, the fact that FACS is there or GIFT is there, if you choose not to use them they will use that to beat you over the head with at court – ‘Why didn’t you use that specialist service?’ – And, you know, social workers are skilled to assess, they do have the skills to do that, and they can come to some kind of judgement. So, I do think there is certainly an issue for me around about that, and that’s been a bit controversial.”

(Area team 2 social worker)

There are, however, mixed views from social workers about working alongside GIFT on a case. In addition to sometimes feeling undermined, there is also a perspective that any ‘alternative lens’ on a case is of benefit:

“I mean there are people that are precious, certainly I am not...so I am like ‘Bash in - I would like to see your opinion’. I think that’s a confidence thing; I think if you are a confident enough social worker, and you are confident in your own assessments, you probably wouldn’t have a problem with somebody coming into your case.”

(Area team social worker, case study 4)
4.1.3 Potential clash of judgements; when GIFT adds ‘doubt rather than clout’ to social work judgements

On the other side of the coin, GIFT being perceived as more influential than services-as-usual posed challenges for social workers in cases where GIFT may not be in agreement with their judgement. Social workers identified three main issues where there could be a potential mismatch of focus between the models:

The rehabilitative aim of GIFT

In general, social workers have expressed most concerns over the cases where they already strongly felt that the child should not return home, yet rehabilitation is a potential aim of GIFT treatment. The very fact that GIFT has examined the possibility of rehabilitation in a case (with the added perception of their recommendation having more ‘clout’ than their own) is seen as adding an element of doubt to social work’s view that the child should not return home. This is a point where most difference of opinion is felt between area teams and GIFT:

“I know a social worker who was saying ‘There is no reason for your son to be in care if it wasn’t for GIFT’…but it is more often been the social workers saying ‘There is no way this child should be going home’. It’s commonplace for social workers, and particularly social work managers, to say to us ‘We wouldn’t be doing this if you weren’t involved - there would be no talk of these children going home’ and that’s the commonest difference.”

(GIFT worker, case study 4)

We do not yet know whether there is any difference in the rate of rehabilitation between GIFT or FACS; however, the treatment towards the possibility of rehabilitation in GIFT can be seen by social workers as an approach that makes it more likely that the child will be returned home and can engender a perceived sense of powerlessness if they disagree:

“I think we believe we should have more professional credibility than we sometimes have. I think probably people have got an anxiety that if we disagree with the GIFT assessment and then you get two conflicting assessments going to family court, our assessment will be seen as the lesser, and I don’t know whether that has happened, but I think it would be interesting to see if that happened.”

(Area team 1 social worker)
The intricate focus on child–parent interactions

The intricate focus on child–parent interactions that GIFT typically assess are thought by social workers to reflect more favourably on a parent than a general observation of the relationship. In this perspective, social workers can sometimes fear that evidence generated by GIFT will clash with their own judgements in a case, particularly in the legal system:

“I think because there are health professionals there at GIFT, they certainly assess it in a much more thorough way I would say, I don’t mean...no thorough is not the right word...they go into the ‘nitty gritty’ a bit more...they video it, they analyse very small snippets of contact, for example. If they see one thing positive – like very good eye contact where there was maybe issues with attachment – they would say ‘Well we might have something to work with there.’ So they would assess it or they would judge it in a slightly different way whereas FACS are looking through two-way mirrors and they are just looking generally at the contact and whether mum does have the capacity to meet the child’s needs; for example, can mum change a nappy when the child’s nappy needs to be changed? Does she recognise that? Is she able to stimulate them by getting the right toys? Able to feed them? You know, the practicalities more rather than going into some of the psychological. So I think that does take longer and I think you can look at that more optimistically rather than just looking at the way that social work would assess it.”

(Area team social worker)

In one of our case study cases, the social worker’s fears over reunification in a case where it would be strongly contested by social work were alleviated, however, when GIFT’s more intricate evidence appeared to document and categorise her own concerns in more depth. It appears that anxieties are starting to settle as area teams start to work with more GIFT cases and experience that, in general, (based on those we have spoken to) recommendations between GIFT and area teams are the same:

“I think the case conference was quite reassuring for xxxx [area team social worker] because she got to hear an overview of...the depth of our assessment, but also saw the video clips as well that we were using to underpin what we were saying, which I think was helpful because then they were categorising concerns...”
that she had already, so she knows that they were being acknowledged.”

(GIFT team members working on case study 3)

In this particular case, GIFT felt that there were particularly positive relations with the social worker. This was seen as key to the successful management of the case and appeared to contribute to a view that working relations between GIFT and area teams are a key driving factor to GIFT successfully embedding into current systems:

“One strength though has been the relationship with the social worker, and the work that has been done from her side of it has made our jobs a lot easier I think…she has been available for us to speak to and to share assessment and has been open to the assessment being shared with two other social workers, which is hard. I really can’t emphasise what a difference that makes to the assessment process, because in other ones where all of the good things we have been saying about xxxx [area team social worker] haven’t been in place and it makes it really difficult…xxxx [area team social worker] has been lovely to work with, she really cares about xxxx [the child], she has been really committed to him, she has known him for a long time, you know some social workers while they want to doing every weekly contact they just can’t fit it in. xxxx [area team social worker] has made sure of that…to keep the consistency of the face for xxxx [the child].”

(GIFT team members working on case study 3)

Current focus versus historical contexts
There is also a feeling that GIFT, although providing a required current assessment, can miss a historical context about the child that area teams have been immersed in for a while. Again, there is a perspective among social workers that GIFT’s focus on more intricate details of the parent–child relationship in the ‘here and now’ can paint a more favourable picture of parental capacity, adding doubt to their judgement that the child should not return home:

“I think it is different because we are not just doing the contact assessment, you know we are assessing kind of dynamics in the house, and all the stuff that is provided in that…we are looking usually before they are removed so it is home environment that we are assessing rather than just the contact once the kids have been removed.”

(Area team 2 social worker)
Some social workers also feel that the support given by GIFT, particularly in getting to appointments, can artificially inflate the parent’s ability to care for their child and can clash with their past experience of the family in the community:

“I am not saying they [GIFT] are unrealistic, and they will still say what the concerns are as well, but I am thinking that this is all a bit artificial…mum and dad are doing OK just now, but you know that certainly wasn’t my experience, for example, when I had the children registered for a year, you know, and weekly visits and everything, but now…you know they are able to pull some of that together, and my anxiety is that once the assessment phase is over, and if that child is returned home, that things would revert back to the previous behaviours.”

(Area team 1 social worker)

4.2 Theme 2: The GIFT timescale – the introduction of a treatment phase and its fit with the wider system

GIFT timescales have generated a significant amount of discussion and debate across and within the various participant groups. GIFT typically follows a three-month assessment model (a similar timescale to services-as-usual – FACS) with a six- to nine-month treatment phase added on (that FACS does not offer). Mixed views over this lengthier timescale are evident: on the one hand, the addition of a treatment phase is seen as necessary to improve the accuracy of decision making by improving the quality of evidence in a case; on the other hand, participants grapple with the introduction of a lengthier timescale in a system where delays are already highly problematic. Whereas the first view (the first sub-theme below) is a more general perspective about the need to improve accuracy of decision making, the second view about timescale concerns (the second sub-theme below) is sub-divided into particular facets of concern. A further theme identified is about a lack of synchronicity between the timescales of GIFT and those in the surrounding context.
4.2.1 Improving the accuracy of decisions requires more time

While GIFT is longer, it aims to improve the accuracy of decisions made about permanency by either maximising the parent’s ability to change, or demonstrating clarity in relation to their lack of change. The timescale of GIFT, albeit an issue that many participants grapple with, is a component of the model that is seen as necessary in generating the level of evidence about a case that is required in the current system. From this perspective, the longer time spent may be merited by the end product:

“I have to say people then who have gone through the [GIFT] process though by the end of it are saying ‘Well actually it is worth it’ because the evidence that is there in terms of parent incapacity, even if people have only met with parents a handful of times, the evidence is there. So certainly the feedback I am getting from the finished articles is very very positive. I think people get very frustrated with the timescale, you know, and there is no getting away from that.”

(Area team service manager, permanency focus group)

This view is particularly evident within discussions about the level of evidence required in today’s legal system; the need for a thorough assessment of the current situation where proceeding straight to permanence without a thorough and current assessment may be contested:

“We have such a legal presence around all of our meetings, the panels, or whatever…and the advice is for parents just not to agree to anything, whether it is a legal order or accommodation on a voluntary basis or whatever it is; they are just not agreeing to anything and the worry would be then that if they were not taken through that trial that would then be a reason that could be questioned in court, especially because we have got the new legislation now where we have to be talking about a parent’s circumstances here and now. So I think there can be difficulties in looking at a proceeding straight to permanence.”

(Area team 1 social worker)

In this perspective, the issue of GIFT reports potentially adding more ‘clout’ to a case, again, becomes relevant. The longer timescale of GIFT can be seen as giving parents more opportunity to change, so that if sufficient change is not evident within the GIFT timescale, a decision to not return a child home is seen as more accurate.
The longer time period of GIFT can also be offset by reducing timescales in relation to drift in and out of care in the long term:

“There are some cases where there would probably be that process where the child might have returned home, but potentially would have come back into care without the right support, and that feels like a real strength of what we are doing.”

(GIFT team member)

Views from foster carers support this claim; the GIFT process was felt to be a significant improvement on previous models and provided a more thorough system to anything they have experienced previously. The GIFT treatment phase was seen as necessary, and particularly suitable for children who had already experienced significant drift in the system:

“I just feel like these parents have had their children in care before and there has always been drugs there and I just think to myself ‘I’ve got these kids in my house and I’ve worked so hard with them and I do not want these children to go back to their parents if it is not done properly’ because these kids were in care before and went back to their mum and dad and failed within six months. I would hate for the children that I’ve got in my home just now...I am not saying that I don’t want them to go back to their mum and dad, I don’t mean that, but what I mean is they need to be spot on this time and I feel that this long assessment, because it is like a three-month assessment and then a further six months, is the right road for this family.”

(Foster carer F2)

4.2.2 Concern over the GIFT timescale

Concern over the lengthier timescale of GIFT, with the addition of a treatment phase, were voiced in two main ways: as a general view regarding the need for more timely decisions; and as a concern about the ‘changeability’ of certain parents. This second view is broken down into sub-themes of concern about a) spending time on treatment when change may not be sustained, and b) as an uneasiness about continuing treatment with what are seen as ‘hopeless’ cases.

The following sub-themes represent these three different facets of timescale concerns:
The need for more timely decisions
The drive within policy is to produce a faster system and some participants struggled with GIFT having a treatment phase after assessment:

“I don’t mean it as a criticism but…I think we have got quite different training and things so the social work assessment seemed to be arrived at a lot more quickly and the outcome was clear from that point of view, but it was the health intervention stage, I guess, that postponed it.”

(Area team 2 social worker)

“It is going to take time for this model to embed and for people to, I suppose, have confidence in it…I think a huge issue for the area teams is this view that this [GIFT] will delay things for the child and that can be a really big barrier to joint working and things like that.”

(GIFT worker, case study 4)

For parents, the timescales are often difficult to accept:

“Many parents when we’re at this stage [end of assessment] are saying ‘Why is it going to take another six months?’, ‘Why are they not coming home?’.”

(GIFT worker, case study 4)

Although this is very much dependent on the individual case, the following extract from a member of the GIFT team exemplifies the mixed – and changeable – views that parents can have about timescales during a case when the addition of a treatment phase is not something they have experienced before:

“I think it has, at times, been difficult in terms of thinking about the timescales. They have kind of both swung from ‘I don’t care how long it takes, as long as we are getting the right support, we are really happy with where she is in her foster place’ – a real sense of not having urgency around it – to then swinging back to, you know, struggling with the GIFT timescales and maybe how that is different to the way things normally work, or usually work, because this is a case probably where the child might have been rehabilitated home quicker.”

(GIFT worker, case study 4)
Foster carers are also particularly concerned about timescales and provide many examples of children in their care who have stayed lengthy periods of time before decisions are made. This is often an emotive subject for this participant group and, when asked about their views on GIFT timescales, foster carers often reflect more broadly about their experiences of delay in the wider system:

“I spoke earlier on about the wee one that I had who didn’t get adopted until 15 months; that seemingly is a success story because he was ‘only 15 months’. Whereas I just think he was so attached to us and we were so attached to him at 15 months and it would have been so much better if he had been moved on so much quicker and had his ‘forever’ family so much quicker. He eventually got adopted by a couple who already had his two siblings…So, therefore, why did it take so long if that family were already there waiting for him and they knew before he was born that he never got home and his parents would never get him? Why was he with me for 15 months? So why is that an achievement?"

(Foster carer F12)

The sustainability of parental change
From an area team perspective, there is concern over the time taken for the GIFT treatment phase where the changes made to parents’ ability to care for their children may not be sustained in the longer-term. Again, drift, is a central concern:

“I think that the family, for that period of time, may really do everything that they need to do, but that whole sustainability thing once you are taking away that intensive support they will revert back…because we still know that history is the greatest indicator of future patterns of behaviour despite this assessment and the treatment plan, albeit I think GIFT do offer more options in terms of what treatment is out there than FACS can and GIFT are able to a bit more of that in-house because of them being clinicians. They can do some of that trauma-based work that FACS are not in a position to do unless they were to refer on."

(Area team 1 social worker)
Sustainability of change is a question mark for many social workers and most of those we have spoken to underscore the need to reduce the current drift of children in and out of care. The timescale of GIFT can, therefore, be a barrier to the “buy-in” of practitioners in the surrounding context. Conversely, the trial is posing questions about timescales and sustainability that appear to echo areas of interest to social workers; there is some feeling of optimism about the trial potentially informing the development of services for children in care:

“If there was longitudinal evidence that actually that change is sustained...I mean I’ve worked in social work for 24 years or something and what we all know is that you kind of get to see the same families time and time again, so what I want to see is something that doesn’t just make a change in the short term, but actually is sustained over a longer period of time.”

(Area team 1 social worker)

Continuing treatment with seemingly ‘hopeless’ cases
Social workers in area teams were found to hold the view that there are certain families where it is clear early on – and often based on a historical perspective – that the parents are highly unlikely to ever achieve a level of sufficient parenting ability.

In these cases, the continuation of GIFT to the treatment phase can be a barrier to a positive view of GIFT in the wider system:

“I know we want to give families the best opportunity we can, but there has to be a cut-off point as well where you say, you know if they are on to baby number 2, 3, and nothing literally has changed and then you are just going through the process.”

(Area team 1 social worker)

“We had a meeting where it was quite clear, to me, that there should have been no rehabilitation plan from the evidence that was there, but certainly GIFT were reluctant to make that decision at that time because they were saying they hadn’t gone through the whole assessment. There was support after support went on...there wasn’t any evidence of change at that point and I just felt that we were flogging a dead horse, you know, and giving some false hope to mum as well. The argument put forward was that ‘Well okay we can get to the end of assessment and then identify treatment for mum’, which I don’t disagree with, you know essentially, but it shouldn’t be to the detriment of the children.
If she became pregnant again it might help us in pre-birth and whatever...you understand, but for me that treatment of that mum is going to take years rather than months and do we wait all that time? And if you go to court with that it puts doubts in people’s mind that maybe mum can come through this and maybe she can parent her child or her children. So, I just think that kind of thing needs to be teased out a bit I think, certainly when there are cases were it does appear obvious that the children shouldn’t go back home at an early stage.”

(Area team 2 social worker)

This extract also demonstrates that there is a particular concern, legally, that the longer timescale spent implementing the treatment phase with cases that are seen as ‘hopeless’ can be seen as conveying an unrealistic suggestion of potential in terms of the parents’ ability to change. The continuation of treatment in a case where it is later concluded that the child should not return home is seen as, again, adding an element of ‘doubt’ to that conclusion (a converse view to the one discussed earlier about longer timescales potentially providing more ‘clout’ to evidence). This is thought to lead to questions about ‘how long is enough?’ when it comes to giving parents opportunity to change, particularly when longer timescales are often detrimental to the child:

“At the end of the GIFT process, they [GIFT] had said that mum was now at the place where we would have wanted her to be, like a few months ago, but I think that inevitably leads to the question then why not give her a few more months then and see?...well she is at a place now where she has moved, but not enough to send the children home so it leads to the legal argument of ‘give her more time’.”

(Area team 2 social worker)

In New Orleans, however, it is felt that the cases that are given longer are those where parents are showing good evidence of change but require a slightly longer timescale. In this sense, there is a view that there is only question about whether a longer timescale is suitable in cases where significant change has already been evidenced:
“I know that in New Orleans they work for longer than 12 months and the cases that are likely to work for longer than 12 months are the cases where if they worked another month or two they think they could get the child home safely. So the cases that they keep going are not the kind of hopeless cases.”

(GIFT team member, focus group on permanency)

One of the rationales given by GIFT for continuing treatment with what sometimes looks like a ‘hopeless’ case at the beginning, however, is the potential inaccuracy of judgements made about parents at an early stage. One GIFT member reflects on the view of New Orleans:

“When I went over [to New Orleans] in 2009, we sat in a case and we had seen some of the assessments over the week leading up to the conference and the three of us were like ‘There is no way this child can go home, this family is hopeless, they are not going to…’ And they decided that they would work with them and we are going ‘How come?’ And they said, ‘You know, we routinely find that if we try and predict at this stage which families we will get there with, we get it wrong’ – and that’s them after how many years they have been doing it?”

(GIFT team member)

And then continuing the treatment phase when there is little evidence of relationship repair with the child relates to a longer-term view of the potential for the parents to have another child. In this perspective, parents may have the ability to change during treatment and may show parenting capacity, yet their relationship with their current child is too damaged for that capacity to be applied in the current situation:

“Parents who don’t get their children back are still far less likely than they would have been without the intervention to maltreat another child. So, quite a number of those parents go on to have children, and indeed it is part of the rationale for when things are looking a bit ropey to press on and keep trying to deliver the intervention because even if the parent can’t make it for this child, like if there is too much water under the bridge – you know, the relationship was too damaged and trauma soaked and you can’t undo that or enough of that – if the child becomes adopted but the parent has engaged quite well in treatment then there is some evidence that they would be better able the next time round.”

(GIFT team member)
This perspective was also found among foster carers views:

“It might have been too late for a child that’s in care – it could be too late to go back – but working with the parents, it is learning them parenting skills and it might help. It might help if they go on to have more siblings...more children...it might benefit them. So in the long run it would be less children in care if we could catch, you know, some of the problem at home.”

(Foster carer F1)

GIFT report some changes in their practice, however, in cases where treatment benefits look unlikely after the assessment phase. The introduction of pre-treatment conditions in the GIFT model (referred to as a bridging period between assessment and treatment) is happening in cases where there is substantial doubt over the parents’ ability to engage with, or cope with, treatment. GIFT sets out clear indicators of what will be required of parents, placing specific expectations on them, and supports parents to reflect on the task ahead. At this point, some parents will come to the conclusion themselves that there are too many obstacles in the way of them being able to manage treatment and GIFT will support parents in trying to come to terms with this situation. In cases where parents are not engaging with either the assessment or treatment, and it is clear that the case is not progressing with too many risk factors for the child to go home, GIFT report that they are now more likely to recommend permanence at an earlier stage than they were before. Confidence in adapting the model to suit the Glasgow context seems to have grown with an increased understanding about how the Scottish context differs to that of New Orleans:

“What we had learned about New Orleans was that they did have a higher rate of rehabilitation than what services-as-usual in Glasgow City Council had, but very quickly it became apparent that things are different here in Glasgow, like we’ve got social work services involved in lots and lots of preventative work and Glasgow has got a very high threshold [for taking children into care]...whereas in New Orleans immediately the legal system is very different and parents are told by a judge there ‘You will attend the Infant Team’. So lots of these factors made it very different for the type of families that they were working with and where they are in the child’s journey through care as well.”

(GIFT team member)
There is a feeling among the GIFT team that the adaption of the model in cases where it is clear that the child should not go home – where treatment effects look unlikely, leading to an increase in recommendations of permanence at an earlier stage – is starting to sit better within the wider context. GIFT feel that the headway in their relations with social work is partly due to this change.

Whereas parents will always be offered some type of support after the assessment stage, such as space to reflect on what has happened, GIFT reports an increased acceptance among the team that there are some cases where the model cannot be applied in the same way as New Orleans:

“In the New Orleans model, treatment will always be offered and certainly a case comes to mind where we very quickly, based on chronic history and so much evidence, it just felt that it would not really be ethical to offer treatment in that case. So there was lots of kind of grappling with... well how do we fit the model and what do we do? You know, what’s our involvement going to look like with this family? And I suppose that was the first case that we’d really had those questions, but thinking about some of the new cases where we’ve actually had to make a decision that it wouldn’t be right for that child for us to go through this process when the conclusion appears to be quite... yeah there has been a few... I guess that just reflects a change in generally being more confident about using the model and adapting to fit in within the context. To not keep moving forward blindly with a case where actually there are such clear indicators, I think probably in terms of social work’s buy-in that’s maybe being helpful – there have been cases where we’ve all been in agreement that we are not going to be able to apply this model in a way that we would hope to.”

(GIFT team member)

4.2.3 A lack of synchronicity between timescales

There are also specific procedural points of difference between GIFT and social work timescales that have been seen as misaligned in some regards. For both GIFT and social work area teams, the timing of permanence reviews and how that sits with the work that GIFT is doing at the time has been a barrier in some cases. For GIFT, the permanence review is most fitting with their work when it takes place at the scheduled time of six months and a second that fits with
the end of the GIFT treatment phase. This is described as concurrent intervention between services:

“If the first permanence review is at six months as planned, it is often a helpful point, not long after we have completed our assessment, to have clarity in the social work care plan that both rehabilitation (by working with GIFT) and permanence are being actively considered. The permanence review can underwrite for the parents the importance of working with us in GIFT. If it’s late, that opportunity is delayed.”

(GIFT team member)

When there is a perceived sense of fit between the timescales of GIFT and area teams, working relations between the services are reflected upon positively:

“They [the area team] are going to arrange their permanence review to schedule it just after our conference, which again is good in that xxxx [child] doesn’t drift in care…so social work can begin to think about permanence options, while GIFT continue to work towards rehabilitation.”

(GIFT team member, case study 3)

“I think once people have been able to go through the process and understand actually that there is a real structure about this and we are encouraging the area teams to progress with alternative planning alongside what we are doing as well.”

(GIFT worker, case study 4)

For some in area teams, however, it feels premature to be doing a permanency review at six months when they are awaiting a GIFT recommendation. Related to the previous sub-theme, it is also apparent within this view that, in some cases, GIFT are continuing to the treatment phase but area teams have already decided that the child should not be rehabilitated back with their parents. The perceived mismatch in timescales, therefore, becomes entangled with differing views about whether there is potential for rehabilitation or not:
“I chaired a conference recently where GIFT came along with a ‘No rehab decision,’ but it took a long time for that to happen. We are having to have permanence reviews at a six-month stage. So quite often we will be having a permanence review at six months and the GIFT will be completed maybe in seven and a half months, or if there has been a delay or whatever at nine months. And although it is a chance for us to review the situation, it can be quite a difficult and stressful time for the parent and sometimes we are clear that rehab isn’t going to be an option, but that assessment [with GIFT] isn’t completed yet to say that’s the case. So the timescales don’t fit with our procedures – now that might well be that we need to be rethinking our procedures.”

(Area team 1 social worker)

Within this discussion point, the ‘clout’ issue again becomes visible; some social workers would prefer to delay their permanence review in order to incorporate supporting evidence from GIFT or FACS in their case:

“Sometimes we are not having the permanency reviews at six months, but procedurally they should be aiming to do that. I think…I mean I’ve certainly had discussions about staff, have sometimes being really keen to wait until the assessment process is finished so that they can then write a permanence report with some kind of outcome, and I am saying ‘How can they make a permanence report when there is this assessment that still has three months to go?’ and our service manager would say ‘Right, you still need to do the permanence review, you still need to go and we still need to write a report and the concurrent plan’, but I think it is difficult for people to get their head round, it is such an important assessment and I think social workers want to feel as if their permanence assessment is kind of backed up by evidence from a GIFT or a FACS assessment. So if you don’t actually have that completed it kind of feels like half a permanence report because the meat of what you are looking for you might not have.”

(Area team 1 social worker)

A second significant difficulty in timescales was identified in relation to GIFT operating in a wider legal context where there is no legal framework that fits with, or supports, the timeline involved in GIFT:
“A major challenge to the successful implementation of the [GIFT] model is the absence of inherent child-led timescales for children within legal processes. So, for example, numerous appeals of contact decisions by parents and the time taken for social work to complete a report to request a hearing will influence the timings of hearings, rather than hearings being arranged to best fit the child’s timescale.”

(GIFT team member)

As a result, there were instances where GIFT reports were being seen as ‘out of date’ in some cases where there had been delay between GIFT making a recommendation in their final report and a hearing being arranged. In these cases, the perceived influence of the information was substantially reduced, conveyed as a frustration by panel members who would otherwise reportedly have held the information in high regard:

“I thought ‘This will be really…I don’t mean easy, but it is uncomplicated that these people [GIFT] who are experts, have come in and their recommendation is such and such’, so you would put a lot of weight on that, but when I was on the hearing I was still thinking ‘But that was in June and things had moved on’ and so I felt that I couldn’t put the same weight on it and I felt very guilty about that because I felt all the work had been put in.”

(Children’s panel member)

The perception that GIFT recommendations can become ‘out of date’ had also been reflected upon by the GIFT team and it was reported that, in a few instances, reports had been viewed as out of date within a period of weeks. It was felt that there might be confusion among panels due to their previous experiences of receiving new reports at each panel from social work area teams:

“We have had occasional experiences of our reports being viewed by panel members as out of date if four weeks old. I think that is mistaken and relates to the expectation that social work submits a new report to each hearing. GIFT final reports make a recommendation about rehab or permanence within the child’s timescales – the child’s timescales don’t go out of date.”

(GIFT team member)
4.3 Theme 3: GIFT and foster care

The qualitative data contains interesting views resulting from the interactions between GIFT and foster carers. Foster carers have mixed views about their involvement with GIFT. On the one hand, the assessment process and supportive capacity of GIFT are reflected upon favourably; on the other hand, foster carers can find the GIFT process more intensive and this can be experienced as a burden at times. These two views are represented in the first two sub-themes of this section. The third sub-theme of this section highlights some of the learning points that GIFT have reflected on from their work with foster carers, proposing that the model illuminates the demands of the foster care role and the challenges of working with and supporting foster carers during the GIFT process. In relation, the fourth sub-theme presents opinions about proposed changes to the fostering and adopting system and the ways in which foster carer perspectives of this change have been found to relate to their personal perspective of the foster caring role:

4.3.1 GIFT is thorough and supportive

Foster carers report the benefits of experiencing the GIFT model for both themselves as foster carers and for the child. In the following extract, the foster carer reflects on the more detailed assessment during the GIFT process and compares it with her experience of FACS. From this carer’s perspective, GIFT was more child-orientated in their focus:

“GIFT, because of all the questions they were asking me, were getting more and more information on this child’s needs. Whereas FACS didn’t take on board as much of what I said so they wouldn’t be able to sift out information with the questions because there was much more onus on the actual parents. Yes, so therefore because I’ve got deep, deep concerns [about the child] I feel as if, in the long-term, GIFT’s assessment was better for him.”

(Foster carer F12)

GIFT is also seen as a support to some foster carers, particularly in helping them to better understand the complexities and reasons for the ways in which a child might be presenting in the placement. This was also seen as a difference to FACS; whereas foster carers reflected very positively on their interactions with FACS, the benefits were more about positive communication and being ‘kept in the loop’ regarding the assessment of the child. GIFT was seen as going a step further:
“He [the child] was really hard work and to be honest with you I thought I wasn’t going to see it through. So at that time, at the very beginning, I think she [GIFT worker] did help a lot, and then she came out to the house and we were out in the garden playing and things like that and then we went to the park, but that just gave me a wee kind of break, you know, because at that particular time the two of them weren’t in nursery, I couldn’t get a nursery placement…I mean when he [the child] first came he just screamed and I mean just had all these tantrums, you know, whereas now he is less frustrated than he was before. A lot of things about his emotions she [GIFT worker] was talking to me about and it kind of made me…you know, think about it. I mean don’t get me wrong, I’ve had difficult children before, but I feel that she helped me through that at the very beginning. She put it to me in a way that I could understand better, if you know what I mean.”

(Foster carer F11)

4.3.2 The ‘workload’ of GIFT

Concurrent to data gathered on the positive aspects of GIFT from interviews with foster carers, there is a theme beginning to emerge about the workload and, sometimes, burden that GIFT impacts on the role by involving the foster carer in the assessment and impacting a longer timescale on the child. Being videotaped was also reported to have caused some anxiety, although this was mostly overcome and eased over time. In the following extract, a foster carer reflects on the challenges when two of her children – siblings – were going through the GIFT process at the same time. It should be noted, however, that this is the same carer who reflected positively on the thorough nature of GIFT questions, exemplifying the mixed feelings that foster carers can have about the service they are randomised to:

“People [from GIFT] were coming out to the house to do it so, therefore, I’ve got three under-fives at that point – it is a long time to sit and concentrate on things while you are running about after a baby, a 3-year-old and another child that’s kind of hyperactive and with problems and all that kind of stuff. It is a full time job just looking after the three children without looking after visitors if you know what I mean and trying to concentrate on the job. The questions that have been asked…it was very time-consuming. And I didn’t realise my husband…that we would both have to do it, so he was taking more time off his work to go and be
interviewed and taped with both children. So, it is quite time-consuming when you have got all those other meetings going on and people are taking days off as holidays.”

(Foster carer F12)

GIFT reflect on the work that they ask of foster carers in the cases they deal with, particularly on the difference in advice and support that they may experience when going through a GIFT case. There is an understanding of some of the barriers that can arise in foster carers being asked to accept a new way of working with children in their care:

“Relational thinking about children isn’t the norm, although it should be and actually it is possibly a more simple way of thinking about it, but if you think that you are against every parenting book that they have ever read and Super Nanny programmes they have seen on the telly, but it all adds into their understanding of parenting, doesn’t it. So we are this kind of lone voice coming in and saying ‘Actually disregard some of that, not all of that, and try this and take a leap of faith with us and try this whole new approach’. I don’t know how safe that must feel or how plausible we must seem when you have had all these other voices.”

(GIFT team member)

4.3.3 The ‘lens’ of GIFT on foster care

GIFT continue to spend considerable time working with and supporting foster carers; recently, they have changed their assessment model so that there is an allocated GIFT team member working specifically with the foster carer/s in a case. Previously, this person split their time between working with both the parents and carers in a case. This is said to have allowed a more dedicated focus on the role of the foster carer in supporting the child. The GIFT team reflect on the challenges experienced in their work with foster carers and, echoing the variation in views that we have found among foster carers themselves, GIFT reflect on the different experiences that they have had of foster carers:

“It (work with foster carers) is a bigger part of the work than I think we are expecting it to be, and I think there is just such huge variation in the quality, for the want of a better word, and commitment of foster carers and I think we’ve had lots of cases where we’ve had to really think about how we manage that. We have been offering quite strict intervention to placements, it was
more than we expected to, and we’ve also a couple of times recommended the child move from the foster placement based on our assessment, which I think has been really uncomfortable in terms of relationships with Families for Children. Thinking about thresholds and thinking about putting a spotlight on all foster carers, there is this kind of question of ‘good enough’ and what we know is that these kids need much more than ‘good enough,’ you know some of them more than others, but actually all of them have quite extraordinary needs and what we are finding is there seems to be a base-level of foster carers who were doing an okay job, but actually struggle to do all that extra bit and what we are saying is that we need them to be doing those extra bits and have that understanding and I suppose perform quite a therapeutic role and I think we’ve had mixed experiences as to how Families for Children receive that. I think some workers are very aware of that and want to work with us and want to support their carers and I think, again probably for resource reasons, are quite defended against that idea of what these children’s needs are, but it is a big big part of our work.”

(GIFT team member)

The GIFT team’s work with foster carers continues to shed a specific light on the role of foster care more generally and what is required in terms of being ‘good enough’ for children in care. We are currently working on a paper for a peer-reviewed journal on this topic. GIFT reflect on their premise that, rather than requiring something extra from foster carers, their work instead takes a lens to the everyday demands that are placed on foster carers and the skills that are required to meet the complexity of some of these demands:

“In the area team, you would never have the opportunity to do a systematic focused assessment and offer structured support to a placement; you know, it would be much more kind of an ad-hoc and fluid assessment and support would be…there wouldn’t be that same level of intervention that we would be able to have the chance to offer. So I think it is not raising the bar [of foster care] but potentially giving a lens and raising understanding about it.”

(GIFT team member)
GIFT reflect on some of the skills required of foster carers that continue to be pivotal in the cases that they are dealing with. The following extracts identify aspects of GIFT reflections on this topic, illustrating the types of skills that are central to meeting the needs of maltreated children from a GIFT lens. Managing the diversity of the challenges that children present with, and understanding their impacts on how the carer feels and reacts to the child, are identified as key attributes:

“[Foster carers need to have] attunement and reflective capacity and openness to thinking about the needs of the child and, I suppose, caring for children who are often disorganised and their attachment and really complex exceptional needs, and just being open to thinking about that and thinking about the impact on themselves.”

(GIFT team member)

“I think that’s a big one, is perhaps really difficult for a lot of foster carers is what buttons the children press in them and owning them as being their emotions and working that through. I think that’s possibly one of the biggest tasks, because I don’t think a lot of them thought for a minute that would be part of the work that would be done; that they are a big part of how they feel and what comes out of it all.”

(GIFT team member)

“I think they need to be held themselves by the supportive team and I think you can only contain somebody if you yourself are being contained, so I think the foster parent needs to feel supported, needs to feel understood, needs to feel accepted, needs somebody attuned to them so that they can do that for the child.”

(GIFT team member)

### 4.3.4 Foster care views on proposed changes to the system

When GIFT was initially developed, it was hoped that it could operate within a ‘dual registration’ system where foster carers are registered adopters and vice versa. In New Orleans, the great majority of foster carers are dual-registered, which means that if the child is not able to go home, there is no need for another breaking of attachment relationships when a new permanent placement is found.
This has not been achieved in Glasgow as yet, and can be seen as an important difference between the Glasgow and New Orleans context. Furthermore, it has been cited by GIFT as a barrier to their work with children who are unlikely to go home and/or whose parents are not engaging in the model; a lack of an alternative long-term attachment figure for the child during the GIFT process means that some aspects of the model are difficult to deliver.

In light of dual registration as being a current agenda topic, foster carers were asked for their opinions on it within interviews. Views about dual registration among foster carers appear to be directly related to the way in which they see themselves in their role; foster carers who see themselves as potentially long-term parents of a child give the most favourable opinion in relation to whether dual registration is something that would be relevant or beneficial to their own role.

In discussing the benefits of dual registration, some foster carers reflected on the barriers that they have experienced in trying to adopt a child in their care:

“They made it a wee bit difficult for me and I had a wee bit of a fight on my hands [to adopt the child] but we got there in the end, which, you know, the child's social worker was angry about because she said 'You've had him since birth and it is the best place for him to be', and, you know, so it is. They are not getting messed about then, straight from birth or any age really…if they have got a stable environment, especially having them since they were babies, they are not shifting and they have had the nurture of the person who brought them out of the hospital or whatever, so yes I would strongly agree with that [dual registration].”

(Foster carer F7)

It is important to note, however, that a long-term view of caring for a child in foster care was not always synonymous with seeing a relevance to become dually registered as an adopter. For the following foster carer, there was a long-term view of caring for the child, but not a long-term view that involved adoption. Being a foster carer as opposed to an adoptive parent was more about semantics than a beneficial change to his role. The foster carer did, however, see the benefit of dual registration to foster carers who have motivations to adopt but who have struggled to overcome reported barriers between moving from fostering and adoption:
“We have been long-term carers for eighteen years now and my role more or less has been like an adoptive parent… I just say ‘I am a parent’, you know, that’s what we do… obviously I’ve never tried to adopt any of the children I’ve looked after, I’ve always kind of got on with what I am doing, but I spoken to some carers who have tried to adopt children and about the barriers that are put up.”

(Foster carer F6)

In contrast, some foster carers see themselves as a shorter-term intervention for a child and place emphasis on the positive role that they play in preparing children for their longer-term plan. These carers perceive a general usefulness of dual registration, yet see it as superfluous to their own role:

“I can see the thought process behind that [dual registration], you know, to save time. Personally, we’ve suddenly decided that we will not adopt; we are foster carers and we are happy with that. I mean it is almost like we are putting a psychological Band-Aid on a child to be able to pass them on. So hopefully by the time a child comes here and then leaves they are in a better place within themselves.”

(Foster carer F5)

Some foster carers who see themselves as short term also convey a strong emotional investment in the child so that, importantly, it is not as ‘cut and dry’ as a longer-term view being synonymous with a higher level of commitment or emotional investment in the child. Within this perspective, there was a view that short-term carers can feel undermined by the wider system.

In the following extract, the foster carer reflects on their emotional ties with the child and, in this particular case, it is adoptive parents that are seen as undermining the role of short-term foster care:

“I do really think adoptive parents need to be aware that foster carers are not just doing a wee holding job for them to come along and go ‘Thank you, bye-bye’. That’s hurts because, I am sorry, but we are very much emotionally involved with the children that we have got and they are a big part of our lives. Yeah we love it when everything is sorted and they are moving on, especially if they have got a wee mum and dad for the rest of their lives – that’s what they deserve – but I think sometimes adoptive parents should be just that wee bit more understanding.
if you like. It is just making an adopter just that wee bit more aware, a wee bit more sensitive, if you like, to the carers that are actually looking after the child because they do have feelings, and it does hurt when the child goes away, trust me.”

(Foster carer F4)

Overall, the qualitative data in relation to foster care reveals multiple interesting issues in relation to the role of foster care and how it is affected by the wider system. The data on the issue of dual registration, however, would benefit from data collection with adoptive parents and more foster carers who have gone on to adopt. It is possible that these groups might have an alternative view that is not expressed here given that the foster carers who took part in interviews were looking after children at the timepoint of the initial assessment, and were therefore mostly in a temporary foster caring role. The aforementioned paper that we are developing for a peer-reviewed journal will examine these issues in more depth.

4.4 Views on aspects of the trial

4.4.1 General views of being part of a trial: parents and foster carers

Early in the trial, we captured different levels of understanding about the rationale for comparing FACS and GIFT. There was general support for the need to make comparisons through the process of an RCT within wider concerns about the need for general improvement in the system:

“Basically [the trial] needs to happen in order to make a comparison. So…at the end of the day I am all for it because if this is an improvement…and it works then surely it has got to be a good thing, whether it is the BeST or GIFT or the Family Contact Centre.”

(Foster carer, focus group 1)

Although less detailed in their discussion, most of the birth parents we spoke to saw a rationale for the trial in improving outcomes for children:

“I really don’t mind doing the trial if it is helping kids.”

(Birth parent 3)
Recent interviews with birth parents, however, highlighted the difficulties that ‘lay’ participant groups, and especially vulnerable groups, can have in retaining an understanding of their involvement in a trial, even though they reflect that they comprehended the information when giving consent.

A recent paper has been written on this issue, and as a result of these findings, changes have been made to the consent and randomisation procedure in order to address these factors identified (4). This is an example of the ways in which qualitative work can be valuable to the emerging design of a trial by informing the need for adaptation where necessary.

Furthermore, the data gathered from birth parents suggests that the stress of their circumstances and drive to have their child returned largely overrides any interest they have in reflecting upon aspects of trial process. Whereas some parents talked, for example, about perhaps preferring to receive one service over another in the randomisation process, most reflected that their thoughts were largely consumed by their child and current circumstances. In some cases, parents appeared irritated by us asking them their thoughts on the process of the trial:

“While it is laudable that you’re trying to improve the services and all the ins and outs of the blind trial etcetera etcetera, our concern has to be stated straight out that our primary concern is the return of our son…I understand these are points that your study intends to address, and if you forgive us our timeline is a bit different from yours; our timeline is whether we get our son back in two weeks, not the study after a year and collation of the results and so on…but we don’t mind helping.”

(Birth parent 1)

Parents were, however, more interested in the service that they were being randomised to. At the time of interviews, most parents were in the process of randomisation and were yet to find out whether they would be going to FACS or GIFT. There was a level of uncertainty over what was going to happen in the process of each service:

“We are alright with it [the trial] but we just want to know what’s next? What are we going to be doing?”

(Birth parent 3)
“Well in general terms I have grasped that FACS is one and they have got this new thing – GIFT – that’s an American thing…but if I was called into the hospital with cancer and they said ‘We would like you to join this study to do with whether treatment is better or worse’…the first question I would say was ‘Well tell me what the treatment is first?’, ‘Tell me…’...I am more focused on the treatment than I am on assisting in a study to see which works best; to be frank, I am interested in myself, you know, how it impacts on me first of all…I don’t know just now whether we are talking about radiotherapy or chemotherapy, I really don’t, and I don’t know what either of those words means; if you reduce them to letters, FACS for example, I don’t know what FACS is. My only concern is that I don’t really know what we are comparing because no one who knows what either of them are…neither a radiotherapist or a chemotherapist has spoken to me yet.”

(Birth parent 1)

There was also some hypothetical discussion about which service they would prefer if given the choice:

“I’ve got behavioural problems and I’ve dealt with psychologists and that’s how I’ve grown up so you know what to do. They [GIFT] talk to you better, do you know what I mean? It is done better.”

(Birth parent 2)

“FACS is alright…I have been before and there was a lady that worked in that and xxxx and xxxx [FACS team members] and they were quite helpful to us and stuff…and we got our son back.”

(Birth parent 7)

In addition to personal preferences, there were influences in the wider system that impacted on parents’ views of which service was best for them:

“We like the sound of GIFT but we have been advised that going to FACS…will assist us, or may be of assistance in getting our son back into the house; that’s what we have been told.”

(Birth parent 1)
Within the wider system, there were views found among area teams that echoed the idea of GIFT or FACS being differentially suitable for different families. There is an interesting view that GIFT may be most suitable for families where there is a clear therapeutic need. In some of our data, this leads to discussion about the potential differential suitability of GIFT and FACS depending on the individual circumstances of families. This view is sometimes a barrier to the concept of randomisation:

“In one particular family that I am working with, I think that approach has worked well with GIFT and they have given them a bit more flexibility because this parent does have mental health problems – there has been trauma-based issues and we know that there has been dips where they haven’t been able to commit and engage as fully as had hoped – and maybe if that had been FACS they would have maybe just drawn a line under it and in some incidences, yeah, that is the right thing to do, because we don’t obviously want to delay things for that child. But GIFT’s approach with this particular family I think has probably worked better because of their clinical input because a lot of this parent’s mental health issues are all trauma-based from their own childhood – there is bereavement issues and they said to me ‘Dad made that clear from the outset’ and they said that they could actually support the parent with some of that as opposed to just assessing it and, perhaps, you know, passing it on, and they said that they would assess and also support, counsel, and whatever intervention they thought necessary and they could maybe do that in-house potentially, which I thought was going to be useful for that parent in terms of continuity and consistency. I think that has worked well for that particular family but it is hard to generalise.”

(Area team 1 social worker)

4.4.2 Views of the trial within the wider system

In a similar vein to the views of parents and foster carers, stakeholders in the wider system were less concerned with trial aspects and more concerned with the services and the ways in which they are working. In recent focus groups, there was a general lack of awareness among social workers that GIFT and FACS are part of a trial, and also a lack of understanding in terms of the rationale for comparison:
“I think, one of the problems is that even though people know that the trial is happening, I still think there is a lot of ignorance really about what the trial actually is…I kind of knew all about GIFT because I’d heard about the development of it, but I didn’t realise that it was part of a trial. I didn’t realise GIFT and FACS were both part of this trial. I think social work often think that trials are quite a medical sort of thing and quite unethical and if a child or young person needs a service they should be able to just get the service and the whole randomisation thing, I think people struggle with.”

(Area team social worker)

In a similar vein to parents, stakeholders have also been found to reflect less on being involved in a trial and more on aspects of the services that impact on their own work and particularly those aspects that generate the most debate (see themes 1 to 3). One particular aspect that has dominated debate in relation to the trial is the separation of siblings in assessments if randomised to GIFT; that is, GIFT is a 0–5 age group and older siblings are, therefore, dealt with by area teams. While seen as the responsibility of GIFT in their model set-up, it is also seen as a trial issue in that families who are randomised to GIFT are dealt with differently than they would traditionally be in the wider system. Furthermore, it is an issue that has been potentially destabilising to the trial. We unpick some of the thinking around this particular debate point:

4.4.3 GIFT 0–5 age range

GIFT is a targeted infant mental health service working only with children under the age of five, and thereby potentially separates the assessment and treatment of sibling groups. This has been a debate point since the start of the trial. We refer to it here as the ‘sibling issue’ in reflection of the participant’s use of language on this topic.

There is a feeling that the 0–5 age range continues to be a barrier to ‘buy-in’ within the wider system to the trial:

“The sibling issue is the biggest thorn in our side and a big obstacle to our relationships with social work and credibility and all those things.”

(GIFT team member)
“As social workers, we don’t go in and say ‘I am just going to assess you with that one child there because they are of a certain age’, you know you assess the whole family dynamics and if GIFT had went against what we were saying and said that the child could go home, how could we possibly say ‘Right, you have only done an assessment on one, so we are going to put both boys home’. You know there is a big conflict there.”

(Area team 2 social worker)

While the experience of working alongside GIFT appears to be generally positive among area teams, the ‘sibling issue’ continues to be a fundamental component of the model that participants grapple with:

“One case that we have got at the moment, which has just been randomised, is where one of the children is over five and I was dreading it going to GIFT, not because I’ve got any issues with the work that GIFT do, because I think the one I have done with GIFT was excellent – it really strengthened our case for permanence for this particular child – but I just couldn’t get my head around how we could work with this particular family if GIFT were only assessing the youngest one because it was the oldest one who had made allegations of physical assault, which lead to the children being accommodated in the first place, and I just couldn’t quite get my head around that.”

(Area team 1 social worker)

This view is potentially destabilising to the trial in that its knock-on effect in practice has sometimes been for social workers not to allocate cases for randomisation:

“I’ve certainly heard another social work manager in another area, basically saying that there are times when he just refuses to go ahead with the trial – to make the referral – because his feeling is if there is a sibling group and one’s over five and one’s under five you can’t be having the one under five going for contact 3 or 4 times a week to get the assessment and one that’s over five going once a week. I’m only getting a second-hand view of it but I think that’s a major issue.”

(Area team 1 social worker)
Since learning this view, work has been done by the research team and the social work liaison officer\(^3\) to attempt to increase understanding of the need to maintain randomisation and recruitment. This is a point on which the value of qualitative work throughout a trial was underscored and, where necessary, it exemplifies the importance of continuing to unveil the views of the different partners involved. On this point, a recent paper has been developed about the lessons learned in relation to partnership working in the trial (3).

Some participants in the wider context, however, see the need for individual-based assessments for siblings in some cases and give examples where parenting capacity can be very different for one child in a family compared with another:

“[In the case of] this wee boy with a learning disability, his needs are so complex…but the younger child has a chance. The difficulty is if the 12-year-old was in there, there would have been no chance for either and when you get that kind of complexity it’s not that you are playing god, you want the child that has a relationship and an attachment to have a chance, but where there is a child that doesn’t have that attachment…they couldn’t live together any longer in the foster placement because the foster placement was breaking down with the older one, not because of the older one, because of the stresses of him having to live with this younger brother, who he didn’t identify as anybody but a trouble-maker for him. You know, everywhere he goes everything is fine and then this wee thing comes along then everything goes to pot. I think at his age, while he is 12, his thinking is about 3, so in a situation like that I think we have to look at, you know that child’s needs are paramount regardless of what we are doing here for the younger one.”

(Team manager, area team, permanency focus group)

In reply to this view, and in the context of discussion about GIFT’s age range, another participant proposed that siblings are already separated through social work processes. In this perspective, GIFT is not the only model that is seen as synonymous with the idea of focusing on individual children within sibling groups:

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\(^3\) The social work liaison officer is a senior manager in social work who has a specific role to troubleshoot any difficulties between GIFT and area teams.
“But we do that all the time, we split siblings, we do play God, and we do make a decision that children are better off sometimes apart than they are together.”

(FACS team member, permanency focus group)

The GIFT team appears to take the view that not working with older siblings has a clear downside. Concurrently and overriding that potential downside, however, they see a clear need for a dedicated infant mental health service. The following extract from a GIFT member summarises the rationale that is accepted among the GIFT team:

“I've got mixed feelings about it because I think that we do have a very clear focus on the period of maximum impact on the child, which is early childhood. You know the question becomes about...but it is the 7-year-old who is causing real problems. Yes, but if we had started with that 7-year-old when they were the 2-year-old we might not have been here, so I am absolutely committed to that, but on the other hand they are whole families and you know it is very hard for us to consider making recommendations about one child when there are other children whose presence in the family might have an impact on whether the demands outweigh the resource of the family or they might present special problems. So, I don't think we can ignore the fact, on the other hand I think the focus is right that we focus on the youngest children.”

(GIFT team member)

GIFT reflect on the difficult balance that they experience in the degree to which they can relate aspects of their assessment to an older sibling who is not being assessed by them. There has been a considerable amount of reflection on this premise, as GIFT seek ways to resolve tensions while maximising the benefit from the focus on the infant. Appendix 1 is a guideline document that outlines recent thinking about the key features of the GIFT assessment and recommendations that have applicability for care planning for older siblings:
“We are trying to think in-house about how we might be most useful [to the assessment of siblings] because we don’t think we are completely useless to those children, but we need to make sure that we are being ethically responsible about what we can say, how much we can say, how much talk about transferrable skills and things like that.”

(GIFT team member)

This is a delicate balance that is also recognised by social workers, who see the legal challenges that can result from attempting to make generalisations about parenting across the family based on the assessment of only one child:

“We get lawyers who question every single thing that we write down…so if you have got a situation like that where there is an assessment of one child and you are trying to suggest bits of that assessment fit the other child, you know solicitors are going to have a field day with that because the assessment wasn’t for that child and they will try and argue that there is a different relationship with that child or that it isn’t relevant.”

(Area team 1 social worker)

A sub-theme of the ‘sibling issue’ relates, again, to timescales, with area teams proposing that GIFT is ‘holding up’ the progression of their cases with the older child/children in a family. This appeared to be a point of confusion, with GIFT arguing that area teams should continue with their cases as they would normally and not delay. There is a feeling from GIFT’s perspective that the ‘real issue’ may be more to do with area teams becoming very aware of the older sibling not receiving the same depth of assessment and treatment opportunity as their younger sibling in GIFT:

“There’s no one to do it, really is the issue, so we are creating a ‘gold standard’ for children and from the outside it looks as though that’s just been withheld; you know, one child gets it, one child doesn’t – and anything that the social work department could do, even with the best will in the world, would not be as intensive as what we can do and often is just so minimal, like observation rather than input.”

(GIFT team member)
4.5 Future plans

Throughout the different issues raised in this report, there is an underlying theme running in our qualitative data about the impact of the growing legal presence within cases in both arms of the trial. This is an area that we are just about to embark on exploring in terms of the impact on both the trial and services, and we are currently designing a data collection plan involving lawyers (both council and family representatives) and Sheriffs. This will add a much needed deeper level of understanding about the rationales for legal advice to parents going through the trial and the different ways in which the legal system is interacting with both GIFT and FACS. This is a gap in understanding that has significant ramifications for any work within current systems, which is also identified as crucial work among participant groups in our qualitative data:

“Even the fact that we are looking at it and we are doing it and we are looking at systems for children and thinking about permanence plans is great, but unless we are dragging the panel with us, the Sheriffs with us, it’s actually not going to make any difference at all.”

(Area team 1 social worker)

It is clear among participant groups that no matter how well services work together and make progress in more accurate and timely decisions about children, the legal system can disagree with those decisions. This is described as a “door that needs opening”:

“When making permanence decisions, it is certainly easier a lot of the time to do that when you have got the assessment from FACS or GIFT as well supporting what social work is saying in the permanence report. So it is one of these things that when it works well it is good and it can all work really well...right up until the legal process until we hit that big metal shut door, and if that could be opened up then that would be making a real difference.”

(Area team 1 social worker)

Clearly, these are issues that warrant in-depth exploration and, again, exemplify the importance of qualitative enquiry throughout the process of the trial. This aspect of the work has been funded by the National Institute for Health Research as part of the next phase of our work.
We also plan to gather more data from birth parents. We have already carried out a substantial piece of work on their views of consenting to the trial, leading to a change in consent procedures (4), but require more information about their views of the services and on some of the issues raised in this report; for example, it would be advantageous to gather perspectives from birth parents on the themes gleaned from our work with foster carers; on the supportive capacity yet workload of being involved in GIFT; and their experience of the treatment phase, including timescales and the mental health component of the model.
5. Summary and conclusions

The data from our qualitative process evaluation has been invaluable in supporting our understanding of the context surrounding the BeST trial in Glasgow and in documenting the ‘journey’ of the research in relation to the way that it affects, and is affected by, factors in the wider system. The qualitative data is multi-layered in its ability to take a lens to, and illuminate, key issues within the margins of the trial (for example, in relation to the components of GIFT) and also those with further reaching implications (for example, the role of foster care in improving outcomes for children). It also stimulates intervention in the trial where required – points of concern that we have termed ‘red flags’ where it has been necessary to improve points of communication or reduce factors that might cause a delay in the system (see (3) for a more detailed discussion of these points).

More specifically and in relation to the research questions for this report, the key components of GIFT that impact on the wider system were found to be those that are associated with: 1) GIFT’s mental health focus; 2) the timescales of GIFT, and; 3) GIFT’s requirements of foster carers. These three main themes were found to have particular points of impact in the wider system and were related to specific barriers. We now summarise the key impacts and barriers that were identified within each theme and the different ways in which some barriers have been, or are in the process of being, overcome.

1. GIFT’s mental health focus:

Participants in the wider system generally appreciated GIFT’s mental health focus and the ways in which information and evidence from GIFT assessments provide detailed insight into the needs of both children and parents. Understanding about parents’ history was an aspect that was identified as a gap before GIFT was implemented, yet social workers felt that they had more of a historical perspective about the child than GIFT. Social workers and panel members, in particular, identified the benefits of GIFT involvement in a case and saw it as a key component of assessment and support that has been missing in the system. More specifically, it is the detail, objectivity and addition of a health professional perspective that is particularly valued. Evidence in this regard is often viewed as adding an element of ‘clout’ to social work’s opinions about a child and, legally, can be particularly supportive of the claims that are being made about a case in children’s panels and in court.
Within the ‘clout’ theme, GIFT was referred to as a “medical model”, which is interesting given its multidisciplinary make up; those from a social work background make up half of the team and the health professional mix includes those who would not be classed as “medical”, such as psychologists. Similarly, further exploration may be warranted of the fact that social workers, in particular, cited GIFT as “external” to services-as-usual. It has been envisaged that any future GIFT would be commissioned jointly by health and social work and, at present, all partners see GIFT as deliverable as one of the services that social work may be able to offer as services-as-usual. The perception that GIFT is external is, therefore, a concern and a potential barrier to the integration of GIFT into the wider system.

Barriers within this theme were mostly related to the notion of GIFT evidence as having more ‘clout’ in the system – this issue became a ‘double-edged sword’ in cases where area teams felt that a child should not be rehabilitated back with their parents. Social workers’ judgements can feel undermined and it was felt that the opinions of GIFT would mostly supersede that of area teams. There were particular components of GIFT’s methodology that were seen as making it more likely that a child would be sent home; the overall rehabilitative focus of GIFT, the intricate parent–child relations that GIFT assess, and a perceived lack of a more historical view of a child’s past were all seen as aspects of GIFT that can view parents in a more favourable light than they would otherwise. There was fear, therefore, that ‘doubt could replace clout’ in terms of GIFT providing detailed evidence that could contrast with, or obscure, the more general concerns of social workers.

Barriers to the optimal delivery of GIFT within the first main theme were mostly about the relations between GIFT and area teams; the challenges of the wider system ‘buying into’ a model that is seen as undermining traditional judgement. It was evident, however, that as time had passed and area teams had more experience of working alongside GIFT on their cases, they had come to identify more common ground between the two models. An example is the social worker who had experienced that, rather than disagreeing with her concerns in a case, GIFT had actually categorised her concerns and evidenced them in more detail. In this sense, working relations appear to be easing as stakeholders in the wider system experience benefits of GIFT involvement in their cases.
2. GIFT timescales

The timescales of GIFT continue to generate mixed views. On the one hand, the addition of a treatment phase is seen as impacting on the accuracy of decision making and the quality of evidence, thereby reducing drift; on the other hand, there are barriers to the wider system accepting the longer timescale in a way that can obscure positive views about other aspects of GIFT. These barriers are mostly related to concerns over the ‘changeability’ of some parents – both in terms of them managing any change in the first place and in being able to sustain change after treatment. Continuing on to the treatment phase in these cases is seen as causing delay in the system and creating an artificial sense of hope with what are seen as ‘hopeless’ cases.

In addition, there is a reported lack of synchronicity in timescales between GIFT and the wider system, particularly in the timing of social work permanence reviews and GIFT recommendations being made. It is apparent that views that can sometimes become entangled with opposition to GIFT considering the possibility of rehabilitation in some cases where area teams have a strong view that the child should not return to their parents. GIFT also views the lack of a legal framework that prioritises the child’s timescale as significantly problematic and perceives a fundamental misalignment between the aims of GIFT and the consequences for the child of delays created within the legal system.

Views about GIFT timescales may change over time in reflection of the team changing aspects of its methodology in cases where the progress of parents in the model is looking highly unlikely. The introduction of pre-treatment conditions and stopping work with some cases at an earlier stage is sitting more comfortably in the wider context. Rather than responding to concerns in the wider system, however, GIFT reports their changes as a result of better understanding about the differences between the Scottish and New Orleans contexts. In this perspective, the reduction of barriers with the wider system is a by-product of GIFT settling into the Scottish context and adapting aspects of the model to fit.

Barriers in relation to procedural timescale differences are being targeted by communication; GIFT continues to ask area teams to proceed with their cases as usual while it progresses with its treatment phase. A multi-agency focus group was also set up to discuss the difficulties and brainstorm solutions. Communication between GIFT
and the wider system, and educating the wider system about GIFT methods and rationales, continues to be a key task for the GIFT team.

3. GIFT and foster care

It is clear that a key component of the GIFT model is the requirements that it places on foster care and the lens that it takes to the skills needed by foster carers in understanding and responding to the various challenges that are presented by the children in their care. The impact on foster carers is that they report the value of the thorough assessment of GIFT in relation to understanding the child’s needs but also in supporting their own role in the process. This is a level of support that foster carers have not experienced within the system before. The caveat of GIFT’s focus on foster care, however, is that their involvement in GIFT can sometimes feel like a burden, and barriers are identified in relation to the practicalities of attending GIFT appointments and engaging in the GIFT process. GIFT accepts this perspective and reflects on the ‘newness’ of their advice to foster carers, empathising with the challenge of accepting ways of working with children in their care.

Overall, GIFT report a significant amount of variation in terms of the quality of emotional care and commitment of foster carers; when foster carers are not ‘on board’ with the methodologies and aims of GIFT, it can be a barrier to progress. There have been rare occasions when GIFT has had to recommend a move of placement, which has affected relations with Families for Children who make placement decisions. GIFT, therefore, continue to push the dual registration agenda in order to work with foster carers who are more likely to be able to offer a long-term and committed relationship to a child. Our data from foster carers suggests that this is a change in the system that receives mixed responses in terms of its usefulness to individual fostering roles; while foster carers are generally positive about dual registration as a concept, in practice the system may not always fit. A fuller range of views on this topic, however, is needed given that most of the foster carers in this study are providing temporary care. Further data collection with adoptive parents and long-term carers is warranted.

4. Views on aspects of the trial

In general, it has been found that there is a lack of focus and discussion on the services as being part of a trial and more of a focus on aspects of the services, particularly those that impact on the wider system (as detailed previously in the first three main themes.) There is, however, a particular debate over the 0–5 age range of GIFT and this continues to be a barrier to both ‘buy-in’ and, at the start of the trial, as a potential physical barrier to consent rates, with some social workers
feeling that certain families were unsuitable for GIFT. Although this has occasionally led to negative views about randomisation, on the whole, social workers appear to see the need for randomisation in order that we can eventually evidence whether GIFT or FACS is the better model for children.

Other key learning points

Distinguishing the key components of the GIFT model, compared with FACS enhanced services-as-usual

The qualitative data has allowed us to investigate and unearth the key features of GIFT that distinguish it from FACS enhanced services-as-usual. This allows us to say something about what the key ‘ingredients’ of an infant mental health model are and how they sit within the surrounding context. In summary, these are:

- Multi-disciplinary nature – in contrast to the uni-disciplinary nature of FACS
- At least some of the professionals being perceived as being of higher status than social workers (‘clout’ issue)
- Being seen as more objective and regarded as external to social work who are often seen as biased
- Using very detailed video-based examination of parent–infant relationship functioning – compared with the more naturalistic observation used in FACS
- A more current here-and-now view of the child – in contrast to social work’s more long-term, historical, perspective
- More detailed focus on certain aspects of the parents’ history, such as trauma – in contrast to the focus on the wider context used in FACS
- Therapeutic work on foster carer–child relationships where necessary – not conducted in FACS
- Therapeutic work on birth parents’ parenting problems – not conducted in FACS
- Therapeutic work on birth family relationships – not conducted in FACS

Barriers have not destabilised the trial

Overall, the optimal delivery of GIFT continues to be affected by barriers that have remained since the start of the trial (such as negative views of GIFT only working with the 0–5 age group) and those that we can identify as potentially ongoing challenges, as changes to the wider system of care are debated (such as wide variation among foster
carers in terms of their commitment, which may be at odds with the rationale for introducing dual registration). It is clear that, even when GIFT is viewed favourably, there are factors that prevent its ‘fit’ within the wider system (for example, a lack of synchronicity between timescales and differences between the Scottish and New Orleans system) that prevent its optimal delivery. Importantly, however, none of the identified barriers have had the effect of destabilising the trial and most are either being worked on (for example, through improving communication and understanding) or are naturally eroding due to GIFT methodologies and aims becoming more familiar, understood and experienced in the wider system.

**Equipoise remains**

The main themes of debate evidence that equipoise in the trial continues to stand strong; balanced views on GIFT versus FACS have been found throughout our stakeholder groups. The ‘clout or doubt’ theme is an example of where views about GIFT are very much double-sided, with mixed views being largely apparent within individuals as well as among them. The same can also be said of our social work and foster care data, where very mixed feelings about their experience of both GIFT and FACS are documented – with positives and negatives balanced throughout. Overall, the views given by our participants underscore the need for the trial; the debates and questions raised by the various participant groups very much mirror the rationale for, and overall aims of, the research. We continue to be in a true position of equipoise with a central question prevailing throughout our data about whether the best method of assessing and making recommendations about children in care, in the Scottish context, is delivered by GIFT or FACS.
6. References


Appendix 1: Guidance for Children and Families

social workers: GIFT assessments and older siblings

The Glasgow Infant and Family Team (GIFT) is a service for children under five years of age who are in foster care. GIFT provides assessment and treatment for families with a view to making a recommendation at the end of treatment about whether the child can return home safely or whether adoption is indicated. GIFT’s relationship-based assessments and interventions are developmentally appropriate for infants who enter care when they are under five years. This means that the procedures are not appropriate for older siblings.

Mindful of the challenges that this can pose for care planning for sibling groups, this guidance aims to outline key features of the GIFT assessment and GIFT’s recommendations at the end of treatment, which have applicability for care planning for older siblings:

• Responsibility: GIFT continuously assesses whether parent(s) can take meaningful responsibility for the maltreatment that led to the accommodation of the child/children. GIFT’s recommendation at the end of treatment will be based on the extent to which the parent(s) have made progress in this area. Responsibility is a key predictor of whether a child can return home safely or not. The extent to which a parent has taken responsibility for one child’s maltreatment is likely to be directly relevant to older siblings; usually sibling groups are removed because of the same child protection concerns.

• Reflective capacity: the parent’s ability to reflect upon the following issues will have relevance across siblings:
  • the link between their own experiences of being parented and their parenting of their children.
  • the impact the maltreatment has had on the child and what that means for the kind of parenting the child now requires.
  • Social and financial circumstances: given the intensity of GIFT’s involvement, GIFT often gathers information alongside social work colleagues about families’ circumstances that will be relevant for all siblings.
  • Parental mental health: as a multidisciplinary mental health team, GIFT often offers preliminary assessment of parents’ mental health and learning ability assessments. Where indicated, GIFT makes referrals to adult mental health services, and liaises closely with adult mental health colleagues. In other cases, the relationship
intervention that GIFT offers to the parent may address parental mental health concerns, such as the parents own experience of trauma as well as the child’s.

- Parent’s response to and engagement with intervention: GIFT is resourced to develop therapeutic relationships with parents and offers intensive treatment. GIFT gathers information about the parent’s ability to make changes to become more attuned to their child’s needs and development. While some of this may be specific to the parent’s relationship with the child GIFT is working with, aspects will often be applicable to older siblings as well. Examples might include the parent’s capacity to make changes regarding addiction or domestic violence during the course of the intervention.

Implications for social work assessment of older children:

- Concurrent intervention: where GIFT is involved in treatment, the recommendation at the first Permanence Review is for concurrent intervention. Unless there are particular reasons to separate siblings care plans, concurrency for older children is usually indicated. GIFT formally reviews parents’ progress with treatment at case conferences every three months. Social work colleagues are invited to these meetings where implications for older siblings can be discussed.

- Assessment by the Children and Families social worker about the older child’s needs and their relationship with their parent(s) may be indicated in parallel to the GIFT assessment of the child under five. Observation of contact and regular meetings with parents may be required. If there are concerns about the older sibling’s mental health, a referral to Child and Adolescent Mental Health services may be indicated.

- Close liaison with GIFT throughout assessment and treatment to share learning about the family that is relevant for older siblings.

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