The Gwella Approach: Evaluation Report

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Section 1: Introduction and overview

The Gwella project was a pilot for the Gwella approach, an intervention developed and run by Barnardo's Cymru across North and South Wales, funded by the Welsh Government.

The intervention was designed to support children aged between 5 and 11 years old who were involved with social services and had experienced trauma and abuse, providing a trauma-informed system of supportive professionals around them, and improving their relationships with their primary carers. This aim was to be realised through a Gwella practitioner working with a child and their parents or carers on a weekly basis over a 12 month period; focussing the work around relationship-based play activities, while also working with parents, carers and the professionals around the child, to encourage an understanding of the impact of trauma and abuse on the child's behaviours and of their support needs, and to help make existing provision 'trauma-informed'.

The initial 'year one' of the project ran from July 2017 for 17 months, and additional monies were granted by Welsh Government to further fund the project for an additional 12 months. The second year of the intervention began in January 2019 and all cases were completed by the first week of February 2020. In total, 31 children and their parents and carers were supported through the project.

The evaluation began at the beginning of the pilot through to the project end, and took the form of an organisational 'process' evaluation and an 'outcome' evaluation, with a strong focus on documenting the experiences of all those involved with the project. The research design utilised play-based creative methods to facilitate the involvement of children. It aimed to address two research questions: 1) what is the Gwella intervention, and how can it be delivered effectively?; and 2) what are the outcomes from the Gwella intervention for children and families, and what is the 'added value' of the project ? This evaluation reports on analysis from research with the Gwella team, parents and carers, children consultant specialists, and external professionals from social care and education.

1.1 Background

The Gwella approach and project forms part of 'Gwella': a four-year Welsh Government funded innovative research and practice project operated in partnership between Barnardo's Cymru and Cardiff University. The overarching aim of 'Gwella' was to reduce the risk of vulnerable children and young people experiencing Child Sexual Exploitation (CSE) or demonstrating Harmful Sexual Behaviour (HSB), through the development of a prevention model for use in Social Care, in order to improve the wellbeing of children and young people and respond to the Wales Social Services and Wellbeing Act (2014) requirements. The interrelated project outcomes for the Gwella project were:

- To build capacity in/provide an evidenced practice model for a multi-agency workforce working with children, young people and families so that they:

1. are equipped to identify and respond to childhood trauma and abuse at the earliest opportunity to reduce risks of CSE or HSB later in childhood or adolescence; and
2. can identify when referral to more specialist services is or is not appropriate.

In order to deliver on this, the respective commitments from each organisation were as follows:

- Barnardo's would develop and pilot an innovative prevention and early intervention approach to reduce the likelihood of young people becoming victims of Child Sexual Exploitation (CSE) or perpetrators of Harmful Sexual Behaviour (HSB).
- Cardiff University would carry out academic research and an evaluation of the pilot model, in order to create an early intervention toolkit for social care practitioners within statutory and preventative child and family services.

1.1.1 Premise and evidence base

The original premise for 'Gwella' came from two hypotheses from Barnardo's: 1) that there is a link between childhood trauma, CSE and HSB; and 2) that support for a child in their early years will reduce the likelihood

of experiencing abuse through sexual exploitation, and/or of displaying harmful sexual behaviours. These two hypotheses informed four areas of research and knowledge generation undertaken by Cardiff University in year one of 'Gwella'. These consisted of:

1. a literature review exploring the relationship between childhood trauma, child sexual exploitation and Harmful Sexual Behaviours;
2. a mapping exercise exploring the service provision across Wales in relation to identification and responses to children who have experienced trauma and adolescents exhibiting risky sexual behaviour;
3. interrogation of data held by Barnardo's CSE and HSB services, making an original contribution to the existing knowledge generated through, and in support of, the other elements of the Gwella research.
4. a systematic mapping exercise to comprehensively 'map' available literature relating to interventions, responses and approaches to working with 'at risk' children and young people, in accordance with key risks relating to CSE and HSB.

The findings are summarised as follows:

Review of the literature - the links between childhood trauma, CSE and HSB

The links between childhood trauma, CSE, and HSB are evidenced in the literature both through the high rates of prior trauma in studies of both CSE and HSB, and through the overlap and discursive similarities (i.e. how these are understood and defined) in how these topics are approached in research. The literature supports the Gwella aim of taking an holistic approach to the support needs of children and young people regardless of whether the concern relates to CSE or HSB – and, at the same time, the research provides ample evidence of how necessary such approaches are, and how often they are absent. Other key findings of the literature review include:

- The fields themselves, especially CSE and HSB, are difficult to research because of uncertainty about definitions and significant changes in professional understanding over time;
- At the same time, HSB and trauma especially, are based upon earlier research which have problematic aspects in terms of the methodologies (or aspects of the research methodologies), and these have not been fully addressed in the literature;
- In particular, there is unclear and inconsistent information about appropriate sexual behaviour for children and young people, and disagreement within the professional community about what this entails;
- The evidence base supports connections between trauma, CSE, and HSB, however the character and extent of these connections is variable within the literature;
- Sexual abuse, more than any other type of abuse or traumatic experience, is linked to both HSB and CSE. There is an assumption in the research that CSA (more than other types of abuse) *will directly lead* to CSE and/or HSB, however there is limited information in the same research that makes such claims to support this interpretation. However, it is possible to claim that CSA is the abuse with the strongest connection to both CSE and HSB.

To conclude therefore, the findings from the scoping review are in line with Gwella's aim to improve understanding and support better interventions for children and young people who experience trauma.

Existing service provision

A service mapping exercise was conducted to gather information about current services working in the areas of CSE and HSB across Wales. The outcome of the mapping task illustrated that provisions vary across service areas, and particularly, that there is confusion around thresholds for referral to services, especially for HSB. Perhaps unsurprisingly, many respondents raised concerns about lack of funding for services. There were also concerns raised about lack of purpose-built training around identifying and responding to children and young people abused through CSE or HSB-displaying children and young people.

Service user data analysis

A total of 1550 referral cases from 2014 to 2017 were analysed from across the Barnardo's CSE service database (n =1319 cases) and their HSB service database (n = 231 cases). We were able to look at the demographic

characteristics and abuse histories across the two cohorts, revealing the following[1]:

- The majority of children and young people for both services were aged between 12– 17 years-old. 90.1% of children and young people referred to the CSE service were aged between 12 and 17 years. In comparison, the HSB service involves a much younger population with nearly a third (30.1%) under the age of 12. As these data only tell us the data of referral, we are not able to say at what age any concerns over CSE or HSB first arose;
- The majority of those referred for concerns in relation to CSE are female (83.2%), while the majority referred over concerns for HSB are male (87.4%), meaning that the two cohorts have almost the opposite gender ratio;
- These data show a roughly similar pattern of experiences of prior trauma and abuse among children and young people who either experience CSE or exhibit HSB;
- 56.6% in the CSE cohort and 60.2% of the HSB cohort had prior experience of emotional abuse/ neglect; and 28.4% in the CSE cohort and 32.5% of the HSB cohort had prior experience of sexual abuse;
- In particular, the prevalence of a family history of domestic violence is almost identical between the two services: 46.9% for CSE and 46.3% for the HSB cohort;
- The experience of physical abuse is somewhat higher for children and young people in the HSB service (36.4% compared to 29.1% in the CSE service).

These high overall rates of prior abuse experience are supportive of the Gwella aim to provide support to children in their early years.

Systematic mapping

The purpose of the systematic mapping research was to comprehensively 'map' available literature relating to interventions, responses and approaches to working with 'at risk' children and young people, in accordance with key risks relating to CSE and HSB. Unlike the scoping review of literature outlined above, a systematic mapping of research literature is undertaken to inform practice, and to look specifically at whether current practice is based on relevant and appropriate evidence. Moreover, unlike the more widely-used systematic literature review, a systematic mapping of the literature allows for a substantial amount of literature to be reviewed in a short period of time, giving an overview of the field of study. Developed by SCIE, the systematic mapping procedure takes a fraction of the time (a systematic review takes between 12-24 months and must be conducted with a team of researchers) and is better suited to a small field in which there are many qualitative studies of varying scope (SCIE 2009). The Gwella systematic review covered all research recorded in the prominent databases used in health and social care research[2] which matched our search criteria around sexually harmful behaviour and child sexual exploitation. Excluding publications which were discarded prior to review because of relevance (N= 879) and those discarded upon review because of relevance or publication type (N=343), the eventual map comprised 231 primary academic, policy and practice research publications which were subject to in-depth analysis. Taken together we note:

- One limitation of the systematic map approach is that it over-emphasises academic research at the expense of practice-based and policy research. Although there is likely additional research on interventions from policy and practice, the systematic map results are predominantly academic publications. The mapping exercise also found scarce evidence of formal evaluations of services.
- The publications were also coded against criteria including: characteristics of the subjects such as age and gender; details about the type of study and methodology; level of service user involvement, level of practitioner involvement, and so forth. The analysis of this data finds that the study types cluster in a few areas, largely comprising descriptive, exploratory research rather than more structured evaluations, randomised control trials, longitudinal

[1] Further detail on this analysis is available in Hallett, S., Deerfield, K., and Hudson, K. (2019) The Same but Different? Exploring the Links between Gender, Trauma, Sexual Exploitation and Harmful Sexual Behaviours. Child Abuse Review., 28: 442– 454.

[2] Databases searched included Scopus, Sociological Abstracts, SSA, PsycInfo, SCO, ASSIA, IBSS, and ERIC.

studies or other quantitative methods.[3]

- The majority of the publications reported on research that had little or no involvement with children, young people, other service users or practitioners as participants in the services or research. 20.35% did not involve them at all and 68.83% only as the subjects of a research study.
- The breakdown of the ages of service users of concern in the publications in the systematic map is of interest, particularly because it differs slightly from the results of the quantitative analysis conducted as part of the Gwella project, discussed above. Publications largely reported on HSB services working with those aged 13-18 years (56%), with only 26% supporting those aged 4-12 years; for CSE, 42% were concerned with those aged 13-18 years, and 36% with those aged 4-6 years.
- Another finding of the systematic mapping task is that a large proportion of work in this area focusses on children and young people with learning difficulties, and particularly on individuals with Foetal Alcohol Spectrum Disorders. The reason for the preponderance of FASD-focussed research is not clear from the data collected.

The systematic map produced is a detailed extensive database providing information on the services and interventions for responding to risks around HSB and CSE. The possibilities for producing 'findings' are numerous, depending on the search criteria applied. As detailed below, we later returned to this database to consider and inform the evidence base for the underpinning principles of the Gwella approach, developed by Barnardo's.

1.1.2 Summary of the research findings

The four elements of the research indicate support for the hypotheses put forth by Barnardo's that there is a link between childhood trauma, child sexual exploitation and sexually harmful behaviours; and that support for a child in their early years will reduce the likelihood of experiencing abuse through sexual exploitation, and/or displaying sexually harmful behaviours. This is evidenced most clearly in the literature review aspect of the research as the main knowledge source for the first hypotheses, but this also finds support from the three other elements of the research project. Key findings considered to note are:

- There is unclear and inconsistent information about 'appropriate' sexual behaviour for children and young people, and disagreement within the professional community about what this entails;
- The evidence base supports connections between trauma, CSE, and HSB, however the character and extent of these connections is variable within the literature. This is supported by the data from Barnardo's, which provides a similar pattern of previous abuse experiences amongst those referred for HSB and CSE concerns;
- Provision in Wales varies across service areas, and there is confusion around thresholds for referral to services, especially for HSB; and there is a concern in Wales about the lack of funding for services and about the lack of purpose-built training around identifying and responding to CSE and HSB;
- In the international evidence base there is scarce evidence of formal evaluations of services; much of this evidence base has had little or no involvement from service users or practitioners; the majority of the evidence base is from services that work within the 13-18 age bracket;
- There is a clear need to improve understanding and support interventions for children and young people who experience trauma, who are sexually exploited, and who display harmful sexual behaviour;
- The evidence base substantiates the Gwella premise, of the need to provide support and early intervention for children who have experienced trauma and abuse.

1.1.3 Progression to a new practice approach

Drawing on the learning from these early stages of Gwella, and building on the practice experience generated through Barnardo's work in these two fields of safeguarding, the Gwella practice approach was developed by Barnardo's,

[3] Where details about design and methods are coded as unknown or uncertain, either the publication is unclear about its design or the publication is not available in full and so coding was based on abstract alone, such as where a database entry exists for a study which has not been published or the document is no longer available from the source.

to progress a practical preventative intervention approach which could recognise and address links between trauma and CSE and HSB in Wales.

Section 2. The Gwella project and practice approach

2.1 The Gwella project

The Gwella project aimed to support children aged between 5 and 11 years old who were involved with social services and had experienced trauma and abuse, providing a trauma-informed system of supportive professionals around them, and improving their relationships with their primary carers. This aim was to be realised through a Gwella practitioner working with a child and their parents or carers on a weekly basis over a 12 month period; focussing the work around relationship-based play activities, while also working with parents, carers and the professionals around the child, to encourage an understanding of the impact of trauma and abuse on the child's behaviours and of their support needs, and to help make existing provision 'trauma-informed'.

There were two overarching project outcomes set to improve outcomes for children who have experienced developmental trauma:

1. **Provide a trauma-informed system of support around the child.**

   A key aim of the Gwella approach is to increase understanding of how the child's presentation or behaviour has been influenced by adverse childhood experiences. We hope that by getting all actors within the child's ecosystem to the same point of understanding we create an environment able to accommodate the child's needs and support them to overcome their trauma and become resilient.

2. **Improve the relationship between the child and the primary carer(s).**

   Gwella practitioners will do this by focusing on improving the 'inter-subjectivity' between child and parent/carer – this involves supporting the carer to engage in relationship based play activities and supporting the carer to understand that the child's behaviour has been influenced by adverse childhood experiences. In practical terms this means the Gwella workers going into the home on a weekly basis and working with the child and carers.

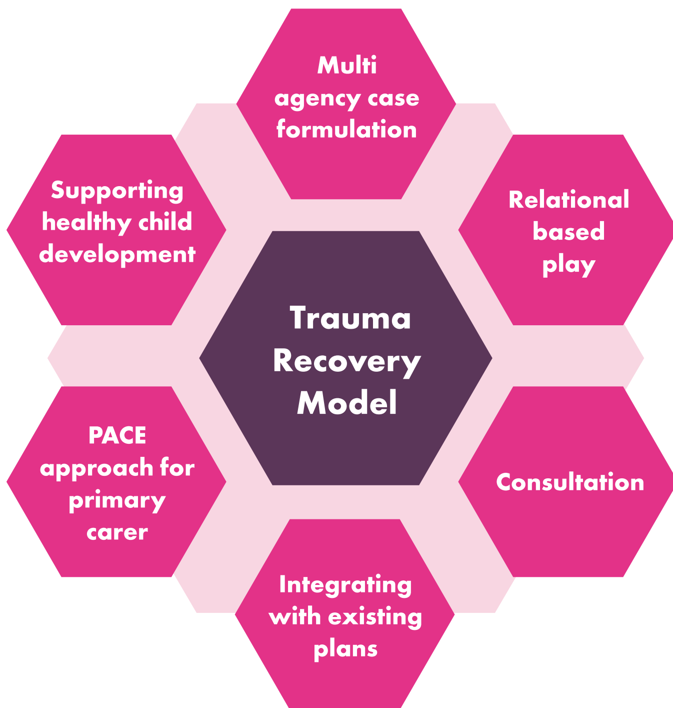
The Gwella project was established to support the delivery of the Gwella approach. The approach includes a number of elements with an established evidence base, such as multi-agency working, relational practice, supporting healthy child development and professional consultation and supervision. It also draws on emerging models such as the Trauma Recovery Model (TRM) and the Playfulness, Acceptance, Curiosity and Empathy (PACE) approach to supporting primary carers, promoted in Dyadic Developmental Practice (DDP).

The Gwella approach can be considered with reference to the diverse principles and elements of its design, but is itself a novel initiative providing a bespoke response to trauma as a broadly preventative intervention for CSE or HSB.

2.2 Key principles of the Gwella practice approach

The following outlines the key principles and modalities forming the rationale for the 'Gwella approach' as set out by Barnardo's.

- Understanding the impact of the trauma on the child's development;
- Establishing a 'trauma informed system' around the child;
- Enhancing/deepening the relationship between child and primary carer(s) is a prime goal;
- Enhancing/deepening the relationship between child and other significant adults a prime goal;
- Children will receive a bespoke response that meets their unique strengths and needs.



1. Trauma Recovery Model:

- Provides the conceptual map for child, sits at the core of the approach
- Assessment activities determine where child is on the TRM
- Therapeutic and other activities intend to support positive change
- Progress made can be mapped on the TRM

2. Multi agency case formulation:

- Establishing a trauma informed system around child
- Utilising the existing team around child
- Developmental mapping
- Facilitated by Trauma specialists

3. Relational based play:

- Theraplay informed
- Engaging child in home environment
- Enhancing attachment, engagement, self- esteem & trust in others
- Activities geared to emotional level of child not chronological age
- Carers & worker collaborate to engage child in healthier relationship

4. The Playfulness, Acceptance, Curiosity and Empathy (PACE) approach for primary carer:

- Exploring experience of parenting
- Exploring carers own attachment history
- Encouraging empathy for the child
- Exploring strengths carers perceive in the child

5. Supporting healthy child development:

- Working with child's developmental age not chronological age
- Tailoring therapeutic activities to reflect bottom up brain development
- Supporting carer(s) & professionals to understand impact of trauma on the child's development

6. Integrating with existing plans:

- Complimenting existing arrangements around the child
- Informing not duplicating plans
- Maximising resources – informing decisions for 'specialist' interventions

7. Consultation:

- Clinical supervision provided by psychologist to Gwella staff
- Psychometric measures scored & interpreted by clinical psychologist
- Reports quality assured by clinical psychologist
- Supervision offered to other professionals re: trauma informed practice

2.3 The evidence base for the Gwella Project and the approach

In order to support its development and implementation of the project outcomes and the approach itself, Cardiff University returned to the literature generated through the scoping review and the systematic mapping research. Due to the psychological focus of the intervention, Barnardo's commissioned a further short piece of research to review the principles in relation to psychological theory and intervention.

Key messages from the systematic literature submap review

The systematic mapping resource was utilised by applying as search criteria the key principles of the Gwella approach, to evidence where and how the literature may support (or be ambiguous, non-applicable, or not supportive) of the intervention. The key messages from this review of the literature speak to the principles of the approach and the project outcomes and some have greater relevance for particular aspects of the approach. The following three key messages are particularly pertinent to the case formulation and multi-agency principle of the approach. They also have relevance to considerations of who forms part of the trauma-informed system or network around the child:

- The evidence base supports the importance of a holistic approach, particularly where multi-agency working can share identification of issues and needs early;
- Multi-agency relationship building needs to be grounded in a clear identification of which relationships are key from the child's perspective and how relationships are differentially supported, given evidence of challenges to building and sustaining multi-agency working;
- The consistent features across strengths based approaches are non-judgmental relational working. Different approaches vary in terms of how much this relational working focuses on the family or the service system, but effectiveness involves attention to both elements and to the interactions between them.

The following key messages are of particular relevance when considering the emphasis on the relational bond between children and their primary carers:

- A focus on trauma as disrupting normal attachment and development can create normative assumptions which could obscure a child or young person's agency, and need to be balanced with recognition of other perspectives such as situational and social factors;
- A focus on a structured program of work towards trauma recovery should be balanced against individual circumstances, particularly with foster carers who may have close bonds, some understanding of trauma already, and a positive caring history with a child;
- Attempts to create trauma informed systems need to differentiate levels of competence across the system, as some carers or family may have less or greater needs in this area;
- There is value in being more inclusive of family networks and there is strong evidence in HSB literature for working to improve family attachments or developing new healthy attachments. Where family attachments are a focus, careful assessment is necessary to ensure that there is no further risk to the child.

The following key messages are of particular relevance when considering how prescriptive the principles of Gwella are to the intervention in practice:

- An overly prescriptive approach to intervention modalities may miss the benefits in diverse individualised responses. For example, a particular child may respond to dance therapy more strongly than play or talk-based work;
- Variability in the character and extent of connections between trauma, CSE and HSB highlight the importance of flexible, case-based responses which can adapt to the unique situation and needs of the child or young person;
- The TRM emphasises a progressive model of work, with a need for the child to establish a secure base and relational safety prior to more progressed therapeutic outcomes. This is in contrast to a number of programs which work simultaneously rather than progressively, so experiences from the Gwella practice approach will be useful in contributing to understanding of this area;
- Assumptions in the literature about the importance of structure and professional monitoring of children and young people's progress must be balanced with evidence from children and young people that prioritises informal and proximate caring relationships;
- There may be challenges implementing TRM

within the family/foster home given its origin in institutional settings. How workers recognise the unique circumstances and strengths of that different context and draw on other elements of the Gwella approach more familiar to 'in home' working in conjunction with TRM will be of significant interest.

The following provide key messages for organisational aspects of the project:

- Regardless of the formality of contact or the specific nature of the relationship, it is clear that stability, sustainability, and responsiveness are the primary relational criteria for a key worker within this literature;
- An emphasis on relational practice as a principle may create tensions should the child's desire for or expectation of the relationship conflict with the expectations of workers for entry into, participation in particular activities and for closure;
- The evidence shows that these types of CSE and HSB related interventions are both rewarding and challenging for workers, and that their experience of supervisory support is a key success factor.

Overall, the review reinforced support for Gwella's aims and highlighted both the strengths and challenges which might emerge in realising the Gwella approach. It evidenced significant support for a relational focus that could work at the child and carer's pace and connect their needs to help from a system which could be hard for them to navigate. It also highlighted challenges in unfolding a flexible, novel practice approach which could draw on principles and elements of multiple methods whilst also being attentive to how these would be applied to fit the child's unique situation and respond to what was important from their and the carer's perspective.

Findings from the rapid review of the neurological and psychological impacts of trauma relevant to Gwella

A separate rapid review of literature was undertaken through Barnardo's, to identify evidence in regards to the neurological and psychological impacts of trauma and how this evidence could inform understanding of elements of the Gwella approach. The review was not systematic, and as with rapid reviews generally, its findings need to be taken as suggestive rather than conclusive.

- The review identified substantial international evidence of neurological and psychological impacts from trauma, particularly where trauma occurs at an early stage in the child's life. The review found that these impacts can cause limitations for traditional behavioural or cognitive therapies, and indicated a need for interventions which focus more on building a secure base for the child.
- Neurological impacts were connected in emerging literature to a broad range of psycho-social challenges for children and young people. Challenges include difficulties in self-soothing and responding to complex interpersonal and social scenarios, particularly where these can involve conflict or perceived threat.
- The review found similar themes between the neurological literature, studies of attachment difficulties connected to trauma, and the emerging literature around Adverse Childhood Experiences (ACEs). Overall this literature indicated challenges of children developing low self-worth and maladaptive styles of relating and behaving, particularly as a child matured and faced increased social expectations and exposure to scenarios involving the need to form new attachments. The review also found some literature indicating a need to recognise a child's neurological and emotional development may not have been in keeping with their chronological age.
- The review found that the evidence from a wide range of studies was supportive of the relational and holistic focus of Gwella. It particularly stressed that therapy focused primarily on addressing problem behaviour or cognition can be experienced by children with a trauma background as unhelpful and even threatening due to the background impacts of trauma on their self-worth and their limited capacity to respond to more complex reflection.

Overall, the review supports the principles from elements of the Gwella approach, such as Theraplay, DDP (in regard to PACE) and TRM, and supports the aim of building the child's sense of safety, worth and relational capacity, and

it's focus on enhancing a secure base through working with a primary carer.

The report now details our approach to evaluation and the methods employed within the research design.

Section 3: Research design and methodology

3.1 Research design

The processes and practices which surround new initiatives provide rich opportunities for exploring how elements of project design are realised and experienced. This is best understood by obtaining perspectives of different participants involved in that process. Moreover, in a practice approach with manifold elements (such as Gwella), it is important to explore how these elements are balanced and implemented differentially. As a novel small-scale pilot, Gwella was suited to an evaluation which could enhance understanding of its organisation, implementation and delivery.

To this end, the evaluation took the form of an organisational 'process' and an 'outcome' evaluation, with a strong focus on documenting the experiences of those delivering and working with the project, along with the experiences of those in receipt of support. The evaluation reports on analysis from research involving the Gwella team, parents and carers, children, consultant specialists and external professionals from social care and education. This was an approach suitable to the relatively small size of the Gwella project and the numbers of those involved.

The research design utilises important participative features, particularly in its use of play-based research interviews with child participants. Our focus on listening to children and to the experiences of diverse participants accords with our aim of evaluating Gwella as an approach oriented to child-centred and relational practice.

Whilst essentially exploratory and qualitative, this evaluation highlights potential avenues for quantitative and cost-benefit approaches to further evaluation should a larger scale approach be developed.

3.1.1 Process evaluation

The overall aim of this element of this aspect of the evaluation was to present a detailed outline of the scope and organisational aspects of Gwella so that it can be replicated in other areas in Wales and nationally. Our rationale for attention to process was informed by the consideration that the Gwella approach was itself novel with no clear comparison, the delivery of the approach was not 'manualised' and the project was operating as a pilot. A detailed attention to organisational implementation and how the intervention emerged through project delivery is therefore crucial to inform future replication or expansion – which was one of the aims of 'Gwella'. The evaluation draws on the perspectives of key individuals engaged with the project to:

- consider the rationale, scope and limitations of 'Gwella', as well as other aspects of its implementation and delivery;
- explore organisational issues relating to the implementation of 'Gwella', in order to identify both effective and ineffective practice, and any obstacles to successful implementation;
- identify those methods and strategies found to 'work best' in project delivery, to ensure that lessons can be learnt and to identify potential strategies which can avoid recurrent problems and/or ameliorate their impact more successfully;
- identify and compare the vision and intentions of the original designers and various partner agencies with the reality of its implementation;
- explore how well 'Gwella' has been integrated and promoted to other agencies working in relevant areas.

3.1.2 Outcomes evaluation

The overall aim of this element of the evaluation is to detail the impact of 'Gwella' upon outcomes for children and families. A key focus of this aspect of the evaluation was to examine 'Gwella' from the perspectives of children, families and carers, and those involved in key areas of their family life (i.e. education and social work) as well as Gwella practitioners. This part of the evaluation:

- considers progress against child and parent/carer specific objectives, as identified through the service;
- captures information about the service provided to children and families/carers and its subsequent impact on outcomes related to Barnardo's outcomes, and referral to other services as appropriate;
- considers whether any changes instigated by the interventions transcend into other areas of child/family life;
- and analyse and explain why any changes have occurred;
- where service users have previous experience of similar service supports, comparisons will be made with any help and/or intervention offered and/or received at that time;
- attention will be paid to areas in which improvements can be made in all of the areas listed, and the service users suggestions with regard to how best to achieve this.

When exploring outcomes, we gave consideration towards the fact that the Gwella project and approach is designed to provide a bespoke response to the needs and experiences of children, parents and carers, and, as part of the aim to understand 'what works', their voices should be at the centre of evaluating how that response 'worked' for them. In addition, our rationale for an approach to outcome evaluation particularly oriented to the experiences of children, parents and carers supports Barnardo's central focus on listening to and believing the experiences of children. It is further supported by the findings from our systematic mapping exercise, which indicated a paucity of evaluative work which positioned children and service users as central to the design, and prior research which emphasises the obscuring of voices of young people in CSE interventions specifically and in social care systems more generally.

To this end the evaluation seeks to answer the following research questions:

1) what is the Gwella intervention, and how can it be delivered effectively?; and **2)** what are the outcomes from the Gwella intervention for children and families, and what is the 'added value' of the project?

3.2 Methodology, sampling, and data collection

The majority of data collected for the evaluation consists of qualitative data in the form of transcription of recorded interviews. Our sampling approach to the evaluation has been to include all those with involvement in the Gwella project, who can provide a meaningful commentary on the process and/or the outcomes aspect(s) of the evaluation. Ethical approval for the project was granted by the School of Social Sciences Research Ethics Committee (Project ref: SREC/2384) prior to any data collection.

3.2.1 The Gwella team

All those involved in the delivery and management of Gwella were interviewed for the evaluation. All were given the opportunity to decline from taking part, and to withdraw any or all of their data from the evaluation. All agreed to take part. In interview staff were also given the opportunity to indicate any detail provided that they were happy for use in analysis but which they did not want us to quote from directly.

The research team undertook a series of individual semi-structured interviews with all but one of the Gwella practitioners who held cases (N=8)[4]. Interviews were conducted face-to-face or via telephone where more practicable for them to make involvement as less intrusive on their time as possible. In order to capture changes in perspectives, themes around the implementation of the pilot, changes in practices, perspectives on outcomes and how the project has worked, practitioners were interviewed at the start of the roll out of the pilot. Each of the practitioners were interviewed again at the end of their cases, and again when they left the project. Their final interview took place whenever they left the project, whether this was earlier than planned or when their last cases closed. Interviews focussed on the practitioners' experiences of working with the project, their perspectives on the interventions, and their thoughts about the impact

[4] See Section 4.2 for further details of the Gwella team. As detailed there, the ninth practitioner who was not interviewed was excluded because their time on the project was short and they ceased to hold active cases following a period of sickness absence.

on service users. The opening and closing interviews covered similar material, in order to capture the development of the practitioners' views and experiences. The final interview differed slightly in that it involved more questions about the specific nature of the work and of the working practices of the practitioners, and asked for more detail about service user outcomes. During the initial pilot year we also interviewed the Service manager (N=1), the Assistant Director with overall responsibility for the service (N=1), and the associated professionals (N=3) who had provided support and training to the Gwella team around the therapeutic interventions. The original Service manager and the Assistant Director were interviewed again at the close of the project. Interviews lasted between 45 and 67 minutes.

3.2.2 Parents, carers and children

The children, parents and carers involved in the project were also integral to the evaluation. Where possible, involving families was initially approached through the specific Gwella practitioner working with each family. All parents, carers and children had the opportunity to 'opt-in' and were given multiple opportunities to decline and or withdraw from any or all of the evaluation. In the majority of instances, the researcher met with parents and carers prior to their taking part, with their Gwella practitioner there to introduce them, to give them the opportunity meet the researcher and have the opportunity to hear about the evaluation and what their involvement would entail, giving them the opportunity to ask any questions and consider whether they wanted to be involved. In some instances, because the worker had left, or because of the logistics of time for the parents and carers, the researcher contacted parents or carers direct and made arrangements for interviews. (These families agreed this approach with the Gwella practitioner or the Gwella project manager.) Aside from one instance, carers and parents were interviewed separately from children – with interviews taking place on a different day or before the child came home from school. Parents and carers were there when the children were involved but generally were engaged in some other activity, or were in another room with the door open.

25 parents and carers involved in the project took part in the evaluation. These include interviews with the following participants across 18 of the 24 families involved in the project[5]: Fathers/stepfathers (N=5); Mothers/stepmothers (N=9); Grandparent kinship carers (N=3); Foster mothers (N=7); Foster fathers (N= 1)[6]. Two parents were interviewed twice, as they had different children involved with the project across both years. Families from year one contacted again for a follow-up interview either could not be contacted or declined to take part.

In year one, all but four families were involved: three families declined to be involved – two foster carers were invited to take part and had agreed to be contacted but one never returned the researchers calls, and another cancelled due to family commitments and then never returned the researchers attempts to contact them to rearrange; it was decided that it would not be appropriate to attempt to contact one family due to the nature of the involvement with Gwella being limited and minimal, and not positive, and the practitioner was no longer available to facilitate the contact. For ethical reasons we felt it was not appropriate to 'cold call'. In year two, all but two families were involved: again, two foster carer families initially agreed to be involved but did not respond to the researchers attempts to contact them.

Interviews with parents and carers were semi-structured and focussed on: 1) their involvement with the project, how and why they came to be involved, how it worked and their experience of being involved; 2) their thoughts about Gwella, what they liked, if there is anything that could change, if it had been different from their experiences with other services (and if so, why); 3) what difference Gwella made (if any), was there anything promised that wasn't delivered, why and how Gwella made any differences. We were mindful of the vulnerability of some parents interviewed, and sought to generate rapport quickly, were clear that they could decline to be involved in any or all of the interviews, and focussed our questions around examples and experiences. Interviews lasted between 45-90 minutes.

[5] In some instances children had been living with foster carers and parents and we sought to involve both the carers and parents; we also did this where access provisions for parents changed and both parents became involved with Gwella.

[6] Not all biological parents were living together but cases in which both parents were supported by the project they took part in the interview together; step mothers were interviewed with fathers; no step fathers or boyfriends were involved in the project; in some instances only the foster mother took part which was a likely reflection of the involvement with the Gwella project itself.

3.2.3 Involving children through child-centred, play-based creative methods

Considerable planning was given towards ways we could appropriately engage with children. Permission to involve children was agreed with parents, and a discussion about the best and most comfortable and fun way of involving each child was discussed with the relevant Gwella Practitioner, based on the games and activities they had engaged them with, and with their parents or carers when possible prior to the interview. Children did not have to be involved, and where children indicated that they did not want to speak to the researcher then the participation stopped or changed direction if they still indicated they wanted to speak to the researcher.

19 children were involved in the evaluation. Seven children were not involved because they were part of sibling groups involved with the parents/carers who declined or who could not be contacted about their own involvement in the evaluation. In one pilot year case, and in one case in year two, the foster carers were interviewed but it was agreed that the child would not be invited for an interview out of concern for their best interests, having experienced multiple practitioners and not wanting to confuse the child further by introducing them to another adult who was in some way attached to the project. This was also agreed with the parents and carers for seven children, (four of whom were part of two sibling groups), where there were concerns about their children being upset about not seeing their practitioner anymore and that asking the child about them might cause them distress or unhappiness – particularly in the case of one sibling pair with learning difficulties who were struggling to understand why they couldn't see their practitioner anymore. With agreement with the families, these children all were sent craft materials with some activities they could draw or write about with a pre-paid return envelope, but five were not returned within the timeframe of analysis[7].

Interviews with children were guided by them, and in the main were based around play and creative activities to help facilitate their participation and ensure their involvement was fun. These included a Jenga game activity, creating sandbox 'before and after' scenes, relationships circles, drawings and word activities about their workers and of things they remembered and liked or did not like, and handprints about emotions. Narratives were elicited around what they did with their worker, what they liked and anything they did not like, and whether there were any differences for them. Interviews also followed the narratives of the children, and discussion also included how workers should be with children, understanding the worker/child relationship, and exiting the project. Materials sent to children focussed on similar activities to garner the same thoughts and perspectives. Some interviews involved a few questions, as that was deemed more appropriate than creative activities. Three took place with sibling groups together. Interviews with children lasted between 20 and 100 minutes, they also contributed 17 pages of drawings and written words which we have incorporated in to the analysis.

3.2.4 Professionals involved with Gwella

We attempted to involve all professionals from partner agencies (N=58) who have been involved in some way with the project. Information about professionals involved with cases was provided by the Gwella practitioners, and the research team regularly kept in contact throughout the 12 months of each intervention to ensure details were kept up-to-date. In a small number of cases (seven out of 65), we decided not to involve professionals whose contact details we were given, because on further discussion with the Gwella practitioner, they indicated that these professionals had had only limited awareness of the Gwella project work, i.e. through one phone conversation, or only a brief meeting at the start to introduce themselves and the project.

Professionals were contacted either near the end of the cases, or in the case of some education professionals, near the end of the academic year to ensure that we could accommodate their involvement and capture their views before they left for summer break. Were possible, professionals were invited to take part in either a face-to-face or telephone interview to ensure we were as

[7] All known returns were incorporated into the analysis, but this evaluation was completed during the coronavirus pandemic in 2020, and there is a possibility that a return of these materials may have been affected by this, and that returned materials may have arrived that the research team could no longer access after a building shutdown.

accommodating as possible to ensure disruption to their work was minimal[8]. Interviews were semi-structured, and were adapted to the professionals' responses and knowledge of the project. Questions focussed on issues around 1) the professional's overall thoughts about the Gwella project; 2) their experiences of working alongside the project, including any involvement in the referral process; and 3) any reflections on the impact they have seen for the child and/or their family or carers. Of the professionals invited to take part, 27 were from statutory social services, 29 were from education, and two were from other therapeutic services including CAMHS. Of those professionals that we contacted, seven declined involvement. In six of these instances, the professionals indicated that they had had very limited or no involvement with Gwella during their work with the young person involved. There were three failed contacts due to problems with contact information, which in all three cases is thought or known to be because the professionals have left their posts since the start of the project, and we have been unable to follow up the contact. 15 of the professionals we have attempted to contact have not replied to any of our communications. 12 professionals initially replied indicating that they may be able to be involved, but did not reply to further telephone and email attempts to schedule an interview. Involvement from professionals is entirely voluntary, and for ethical reasons, we had a maximum number of attempts to involve professionals before concluding that they did not want to take part by a nil response to attempts to involve them. It is also not uncommon for professionals to have low response rates to research and that this is impacted by factors such as professionals' other workload demands, moving from the case, or annual and maternity leave.

By the end of the evaluation, 21 professionals were interviewed. It is notable that only two of the professionals interviewed were from North Wales. The response rate in both areas of North Wales (25%) was lower than that across South Wales (50%). We are unable to explain this disparity in response rate. We were conscious of the distance between these professionals and the research team, so all North Wales professionals were offered face-to-face or telephone interviews in the first instance, at their preference. Length of interviews with the professionals reflects how much direct contact they had had with the Gwella worker(s) and whether they had been involved with the referral process. Likely for this reason, interviews with social services professionals were on the whole longer than interviews with education professionals. Interviews with professionals lasted between 10 and 35 minutes.

3.2.5 Case file data

In addition to the qualitative interview data, data recorded by the Gwella practitioners pertaining to each case has also been collected for analysis. Anonymised core data (demographic and referral information) held for each service user were gathered by the research team, along with some narrative data about sessions, communications and contact history[9]. This information is detailed in section 4.10 of this report. Data collected includes outcomes scoring for each period in which the Gwella practitioner updated this information. Section 5.6 of this report discusses the outcomes recorded for the service users. Members of the research team travelled to the Gwella offices in Bridgend, South Wales in order to securely collect copies of these administrative data. These data collected were stored securely on the Cardiff University network.

3.2.6 Data storage

Interviews were recorded using a Dictaphone with the permission of participants. All interviews were recorded and transcribed by an established and reputed transcriber. All data was uploaded and anonymised at the earliest opportunity and anonymization keys stored securely and separately. Researchers only recorded anonymised administrative data. All data, including transcriptions and electronically recorded researcher reflexive notes from each interview have been stored securely on a password protected University computer on the University

[8] In some cases, professionals in South Wales were only offered a telephone interview at first contact, and then offered a face-to-face option in a follow-up contact if they did not respond in the first instance. This was due to limited research team capacity when large numbers of cases closed around the same time. At the time of all interviews in North Wales, the research team had capacity to travel for face-to-face interviews at the subjects' convenience, so this did not impact on professionals in North Wales, all of whom were offered face-to-face interviews when contacted.

[9] Narrative data for two service users is absent from the evaluation report because the research team's final data collection day could not be completed due to Covid-19. Core and outcomes data for all cases are included as they were collected on earlier visits.

network, along with hard-copies of interview transcripts and accompanying notes which are securely stowed in a lockable cabinet on university premises, and has been accessed only by members of the research team. Data coding was conducted on NVIVO software on a University password protected computer on the University network. Data will be held for up to 5 years and then securely destroyed, in accordance with SREC requirements. When accessing NVIVO remotely due to the Government restrictions surrounding the current pandemic, this was not saved and stored to the researchers home computer.

3.3 Analysis of qualitative data

In terms of our theoretical framework, the purpose was not to test a particular theory or hypothesis. Instead our approach was thematic and informed by the aspects of the process and outcomes evaluation, listed above, to ensure we captured and analysed perspectives on these key areas of organisation, implementation, delivery, and impacts. It was also explorative, to capture additional themes not anticipated. Analysis was both inductive and deductive – data-driven and theoretically informed – linking data to conceptual frameworks, drawing primarily from relevant literatures and theories. This approach allowed for a detailed exploration of the data to enable us to answer the research questions.

Our analytical strategy has been thematic and conducted primarily using NVIVO software. There were effectively seven sets of data, organised by participant group, in order to analyse within and across these sets to allow for triangulation to explore, for example, points of difference or similarity in perspective. Overarching thematic categories and analytical themes informed by the key areas of the evaluation, and also those arising from coding and categories across the seven data sets, have been created. Initial codes were formed, related codes grouped and merged from across each data set to create a coding framework of coding themes and sub-themes. This coding framework has been guided by both the research questions, the points for evaluation and the data. This was accompanied by an iterative process of reviewing and cross checking these emerging themes and interpretations with relevant literature, research and theory (Flick, 2002).

At year one of the pilot we were able to discuss emergent themes with Barnardo's, so providing an additional element of rigour to the analysis and the associated recommendations. We also pursued a lateral sorting of reported experiences across cases, which enabled the construction of a number of case studies based on a bringing together of different perspectives around the same intervention. This allowed us to construct several robust case studies to provide an in-depth understanding of lived experiences of the intervention, reported impacts and rationales for these.

3.4. Note on the presentation of data and findings

Given the scale of the pilot, the relatively small cohorts of those involved, and the public nature of the project, there is a high possibility of identification of the staff team, external professionals and children and families, involved to themselves and in the dissemination of this evaluation report. We have tried to balance being as descriptive as we can for transparency with the need to ensure we protect anonymity and confidentiality. We have also taken additional care in presenting data and in using direct quotations. We have excluded names and chosen generic terms such as foster carer, child, parent, mother or father. When specifically referring to the practitioners involved we use this term, but we also use the term 'Gwella team' to indicate that views were present within the wider Barnardo's team structure. We have avoided using direct quotations from those who are clearly identifiable by their position i.e. the project manager, AD, associated staff and consultant specialists involved. One quote has been included, but is descriptive. The pictures drawn by children and included in this report are those with no identifiable names. Permission was given to use these by the children and their parents or carers. We have also avoided using quotations with identifiable or case specific detail.

Section 4: Organisation and implementation

The process evaluation focusses in part on understanding the practical aspects of the set-up and the implementation of the project. The following section provides detail on

and findings from our analysis in relation to: the project duration and scope, the Gwella team, geography and location, supervision and support arrangements, training and capacity building, practical involvement with other agencies; referral process and criteria, and recording. The process evaluation highlights how practices were mediated by organisational factors, and how organisational drivers interacted with principles directions of the project. For example, how funding and employment arrangements interacted with attempts to prioritise relationship formation.

4.1 Project duration and scope

The project was initially funded to run as a pilot to support children and families for two years – with each child receiving support for a full 12 months. The earliest pilot year case was opened in July 2017, with the majority (N= 6) starting in September of that year, two in October, one in November and two in December. All of these cases were in South Wales; the North Wales pilot had a later start date, so most cases opened in January (N= 3) and February (N= 1). One additional North Wales pilot year case started in May 2018 after additional delays. This means that the initial 'year one' pilot ran for 17 months, accounting for staggered start dates and excluding cases that were offered an extended intervention. While provision for each child and family was intended to run for one year, some were extended and some ended early as detailed in section 5.2. Additional monies were granted by Welsh Government to further fund the project for another year. 'Year two' of the pilot ran for 14 months, and all new cases for year two received a 12 month intervention. The first cases for this second year of the intervention began in January 2019 and were completed by the first week of February 2020. Funding for the Gwella project ended in March 2020.

We note that this wider context of time-bounded funding had implications for the implementation and delivery of the project. As the project fell within 'Gwella' as a wider research and practice project, there was a year prior to the planned two years of delivery that could, to some extent, accommodate designing and establishing the approach and the project. This meant that processes for recruitment, project set-up and establishing connections had somewhat of a head start, occurring within that set-up year prior to the expected project delivery start date. However, this was an innovative pilot project and approach, in the fullest sense, with no manual or guide, so all the practicalities for its organisation, implementation and service delivery had to be established rapidly within the timeframe for the intervention. In addition, the project was subject to pressures which impeded its start dates for beginning work with children and families (such as staff sickness, accessing training for practitioners, establishing relationships with agencies at a local level) and time pressures to begin work had implications some aspects of implementation (such as referrals and the referral process). This meant that the original plan for a project delivering 12 months of intervention within each of the two years, which would have become three years with the additional monies granted to the project, was not possible without some additional lead-in and exit time.

The time-bounded funding also had an impact on the staff team, with two practitioners leaving prior to the end of the project and their expected finish date. These practitioners expressed regret about leaving in their interviews, and wanted this to be noted as they recognised the impact of their leaving on the children and families they were supporting and on the project (we consider these further, below). However, they explained that the short-term nature of the project funding, and in turn the short-term nature of their contract of employment, meant it was necessary for them to look for other work prior to the project's end.

These pressures are not unique to the Gwella project but are notable, due to their particularity to short-term funded projects, more so when these are innovative and complex, aim to be relational and child-centred, and are designed to work with existing provision and external agencies so need time to 'bed-in'. Some negative impacts on child, family and practitioner experiences from organisational factors, such as workers breaking off relationships with children early due to short term employment contracts and funding timeframes, demonstrate how aims to be relational and child-centred can sit in tension with organisational arrangements. How organisations and commissioners consider and mitigate impacts arising from these kinds of conflicts is a key challenge.

4.2 The Gwella team

In the pilot 'year one' of Gwella, there were seven practitioners, of whom six were full-time and one was part-time, with a project manager, and additional overhead monies for administrative and senior line management support. In year two, cases were held by three of the original full-time practitioners and one practitioner who joined the team in a part-time capacity. Also in year two, one of the Gwella practitioners (who had initially been part-time with the project, and who left for a period prior to the extended funding being confirmed and later re-joined) became the primary project manager. The original project manager stayed with the project but in a part-time capacity one day per week.

4.2.1 Practitioner demographics and expertise

Of the nine practitioners involved over the project's duration, eight are female and one is male. All had previous experience of working with children and young people. The majority of the practitioners (N= 6) had a social work and social care background, while one had a background in education and one was a therapeutic professional[10]. Relationship and need-based practice with children was something they were all familiar with, and was cited as having previously been 'a luxury' in their other roles. Previous experience working with parents and carers was noted as valuable, and they were all familiar with social services systems (some were qualified social workers), which was essential for the element of their role that involved working with other agencies and complementing existing provision for families.

Only two of the practitioners had a background in therapeutic methods and techniques; one had specific experience using the therapeutic play techniques (Theraplay) built into the Gwella approach, and another was a qualified drama therapist. Given the psychological framing of the approach, organisational aspects such as training and development, and support from trauma and clinical specialists, are an important part of the evaluation and are considered in sections 4.6 and 4.5. As we discuss, there were specific modalities within the principles of the approach which potentially undermined practitioners confidence in their own expertise if these were understood to apply to rigidly to their delivery of the intervention. As the pilot progressed, however, it was evident in interviews that the professional backgrounds of the practitioners informed their interpretation of the Gwella approach, and afforded them the flexibility with which to direct their work with children and families, as well as informing each other's practise through shared learning.

The importance of this ability to be responsive is also present in the views of parents and carers about the practitioners who supported them. Parents in particular stressed the importance of the worker themselves in shaping their experience of the project, and that their worker was an essential part of what made the project 'work', and in so doing, they cited practitioners' openness and their understanding, their trustworthiness, and their sense of humour. As can be glimpsed in the below example, while these traits are clearly part of the practitioners personalities, the data suggests that such qualities were supported by the flexible and needs-based implementation of the Gwella approach.

Mum: *She's more understanding. I feel like I can open to her. She feels, like I can open in confidence and...It's because of her personality and her sense of humour...I just opened up straight away with her.*

Researcher: *Ok and was that different to like other workers that you've had?*

Mum: *It's different to other workers because obviously I am very thingy to people, if they like you then that's it, if they don't then tough. But I took [to the practitioner]from, from the start. I am going to miss her but because I used to find, there's genuine people like [practitioner] out there that helps and cares for us, not just for her work, she was there for the family as well. She was family-orientated, not work.*

[10] One practitioner's background was not known by the research team, this practitioner was involved for only a brief period and was not available for data collection.

All parents and carers participating in the research liked their workers, however their experiences of the project and particularly their trust in their worker was clearly also linked to the perception of practitioners' expertise and competency; both in the practitioner's ability to support their child – they noted, for example, that the child in their care liked their worker and liked seeing them, and how important that was – and in the advice and practical help they received. In cases where the families held concerns, while stressing that their worker was very nice, they held concerns the about whether the practitioner had sufficient experience and knowledge about the intervention. However in most instances parents and carers referred to practitioners' expertise, skill and ability to help and support them. This is evidenced in the example below:

> *"we haven't got the professional insight into asking the relevant questions to him why he's doing such and such thing. With [practitioner] obviously [they have] got experience and everything like that, we say to [practitioner] why do you think he's doing this, 'this could be because of...' and all of sudden we can see that yes of course it could possibly be that. Now us in the situation whereas his attitude to us would be off or something like that, it may be something that we've got no understanding why he's doing that, we say to him why are you like that you know why are you being aggressive and everything, I don't know. Whereas [practitioner] as a professional could turn around and maybe see the other possibilities"*
> **Foster carer**

In this respect, parents and carers recognised two qualities of what they felt characterised an effective professional: the ability to craft a positive relationship; and relevant theoretical and practical knowledge and skills, which could be exercised respectfully. Parents and carers overwhelmingly reported that Gwella practitioners displayed these qualities, with occasional exceptions where they felt workers attempted to rigidly follow intervention techniques so that this was experienced as forced rather than spontaneous.

The children who were involved in the evaluation held similar views to their parents and carer. All drew attention to their worker being valued for being kind, someone who was caring, fun, funny and made them laugh. They shared that they liked their workers because they had a beautiful smile, and were always happy, not mean and that they were someone they liked very much. The following picture was drawn by a 7 year old child to illustrate how close she felt to her worker, and she said to the researcher the words 'happy, helpful, beautiful, and fun' to relay what was important about her worker. She explained that shew drew a 'big head' for her worker because her worker had 'a big brain and knows lots and can do lots of things'.

Child, aged 7

This aligns with the feedback from parents and carers, that being skillful and knowledgeable in talking to children about their feelings and being positive in their communication with children is vital. Consistency was something that mattered to children too. The following is a child aged 10, talking about why she liked her worker so much, and comparing her to other workers she knew:

> *"I was just like, the people who thinks that I am important they would like go away for a long time but [Gwella practitioner] just went for like probably two weeks but she came back ... And but I was ok with that because it's not like she went for like almost a year because [social worker] I think she went for over two months."*
> **Child, aged 10**

Along with skill and expertise in understanding trauma and practising child and needs-focussed support, the perspectives of all those involved in the project align with findings from the mapping literature review for the approach; that stability, sustainability, and responsiveness are key relational criteria for practitioners.

4.2.2 Absences and staff changes

There were staff absences within the team, over a period of months, mainly due to sickness and also maternity leave which caused some disruption to the work with families in year one. This meant that five cases all either ended earlier than the planned length of the intervention or were extended into year two and taken on by other practitioners. In year two, one of the practitioners left the project one to two months prior to the planned end of the intervention for two of their children and families. There were no other early exits from the team, and no long-term sickness absences during year two.

Absences due to sickness were noted as problematic in some of interviews with project staff, and the consequences of such disruptions for the children affected by these absences was notable in interviews with their carers and parents, and with the external professionals working with them. These interruptions were in some cases difficult to manage, and a concern was raised in some interviews that the small size of the team gave limited opportunities for sickness cover. This was also something raised by external professionals who were involved with the cases with those who were affected by this

> *"I feel for us in [location] it was let down by the staff, the individual staff that were delivering the work. So there was, I think there was absence and staff changes which then really had an impact on the relationships that were being built between foster carers and the worker, and the child and the worker. And obviously you know those relationships are key to the model so that lack of stability if you like really sort of resulted in us having quite poor outcomes. And I don't think that was because it was a poor model or a poor theory, it was just unfortunate that it was a small team and they didn't have the resilience then to make sure they could deliver to young people in a timely way as well."*
> **Social worker**

As alluded to in the above quote, the nature of the intervention, designed to build a consistent relationship between a single practitioner and child and their parent/carer(s), in order to create a safe and meaningful relational context for the 'work', does itself create problems when a practitioner becomes repeatedly absent, because this is experienced by the child within the context of that personal relationship – they miss their worker, feel confused, feel let down and this can affect their trust in them. As one foster family observed:

Carer 1:	*She refused to see her didn't she?*
Carer 2:	*A couple of times she didn't want to, no.*
Carer 1:	*She was like well I ain't seeing her. And she'd come in and she'd storm upstairs wouldn't she? And she'd be like I don't want to see her. She called me one day didn't she, I was talking to [practitioner] and she was like I don't want to speak to her. And I was like come on, it will be fun, we ain't going to leave you, we're going to sit in the room. She was like oh if I have to. But that was again because she [the practitioner] wasn't...*
Carer 2:	*Consistent.*
Carer 1:	*Yeah because she liked [practitioner] didn't she? She said she liked her so you know they got on.*

This problem also means that the nature of the intervention works against drawing on other practitioners to pick up the support as an easy solution when someone becomes unwell or takes maternity leave, and when this did happen, it was no insurance against unexpected illnesses or practitioners leaving the project early. Ultimately one solution was to offer an extended intervention for those families affected, providing some consistency by remaining with the initial practitioner or moving to a different practitioner if the absence was anticipated to be of long duration. One of these families involved felt that for this to happen the intervention with the new practitioner should be extended to a full (additional) 12 months, and this as a solution was difficult to implement within the context of the short-term funding. We note here that one family[11] withdrew from the project as a consequence, because at this point they could not be offered a more extended intervention, and two families wanted it noted in the evaluation that they were disappointed that the child in their care had not received the support they were

[11] Another family did not re-engage following changes in worker allocation, however it is unknown if this was the reason for the withdrawal.

promised. Despite this, these they also emphasised their continued positivity about the idea of the intervention, about the practitioners themselves, and spoke of the need for the project. They understood that their experiences were impeded by organisational factors, which were in turn exacerbated by the short-term nature of the project. As one foster carer concluded:

> *"we value these people that are setting up these project because it's setting a project up that's really really looking after the needs of children. And it's the bureaucracy and it's the funding, it's everything else that can actually mess and spoil a project that it hasn't worked".*
> **Foster carer**

While the consequences of disruption through practitioner absences and giving notice are hugely significant, both to the children and families and to the success of the intervention, the attempts to organise the project to mitigate these were hindered by organisational factors and the time-limitations of the project. Such consequences are, in part, also an indication of the challenges (and effectiveness) of implementing the relational focus of the intervention.

4.3 Geography and location

In year one of the project, Gwella worked with five local authorities in Wales; in year two this was focussed to four local authorities. In year one, the Gwella practitioners based in North Wales (N= 2) both worked with cases in Denbighshire; in South Wales, two practitioners covered Swansea and Carmarthenshire, and two covered Rhondda Cynon Taff and Merthyr Tydfil. In year two, of the two practitioners who had previously worked in Denbighshire, one remained working in North Wales but with cases in Conwy, and the other was assigned to cases in Carmarthenshire. Of the two practitioners covering South Wales, one continued to work with new cases from Swansea and their extended cases from the Carmarthenshire pilot, and the new practitioner worked with new cases in Swansea and Rhondda Cynon Taff, and an extended case in Rhondda Cynon Taff.

The practitioners' office working arrangements differed depending upon what worked best in terms of their involvement with the local authorities within their geographical remit. In year one, the two practitioners based in North Wales were given working spaces by the local authority, however both reported working from home regularly due to the geography they were covering. In year two, the practitioner with cases in Conwy worked from home, as did the practitioner working solely in Carmarthenshire. Both indicated that there were likely workspaces available to them in Barnardo's offices, but that there were no formal working arrangements for them in these offices and they were not conveniently located on their routes between home and visits. In South Wales, in year one the practitioners covering Rhondda Cynon Taff and Merthyr Tydfil were given working space within the local authority in Penywaun, Aberdare. Those covering Swansea and Carmarthenshire were based in Barnardo's offices in Pyle, Bridgend, for both years one and two. Each practitioner held cases across a large geographical area, this was especially so for the practitioners who covered both Swansea and Carmarthenshire.

While the geography and working arrangements provided opportunities to support families across an extensive geographical reach, it also presented challenges for the project. Location and travel distances were determined by where families lived within the local authority, and some practitioners lived a long distance from where their families were based – and this included those who worked mainly from home, without an office local to their cases. Some practitioners commented in interviews that this presented difficulty in terms of coordinating lengthy travel times with the scheduling needs of children and families. This also impacted on the length of their working day or their working hours, particularly so when they were aiming to meet with children outside of school and separately to their parents. This is important to note, because this flexibility is an important aspect (to parents and carers) of project delivery contributing to the success of the intervention (discussed in section 5.3), and could become an exacerbated problem were caseloads of practitioners to increase; so any consideration to mitigate against this should steer towards managing the geography (as part of a consideration of case allocation and workload), rather than the flexibility built into the approach.

The lack of a project base in terms of a main location for all the team also presented challenges for the project manager, in terms of managing and supporting staff across

such a widespread project, and in creating a strong sense of team, while also impacting on the opportunities for team meetings and peer support (discussed further below)[12].

4.4 Line management, supervision and team support

In the first year of the project, the Gwella practitioners were line managed by a full-time project manager, who was line managed by the Assistant Director (AD) with overall responsibility for the service. Both the manager and AD had significant experience of working with children and young people in the practice fields of CSE and HSB, as well as managing projects in these fields. They also led the development of the Gwella approach and the Gwella project. Six months prior to the end of the project the original project manager's time was reduced to one day a week, and one of the practitioners was appointed as a new team manager who continued to work as a practitioner with active cases while managing the supervisory aspect of the project.

4.4.1 Line-management

Supervision was largely individual and was initially planned to regularly occur on a bimonthly basis. Supervisions provided the opportunity to discuss any concerns, progress and challenges about the family cases and the work with each child, parent and carer as planned.

Practitioners reported in interview that due to absences there were periods of time during which regular formal supervision did not take place, and that this covered a longer time than the project manager's period of sickness absence, however they did also report that they could make contact with the project manager at any time they needed to do so. In year two, supervision was provided on a regular basis by the new team manager.

The importance of support and supervision was stressed in all the practitioner interviews, either by drawing on positive examples and connecting this to their experiences of working on the project and their work with families, or of the negative consequences when they did not feel sufficiently supported. In the main they spoke positively about the quality of the line management supervision and support they received. In year one and two however, the intermittent formal supervision over periods of time, and the perceived lack of provision for replacement supervision during these absences, was highlighted in some practitioner interviews as a problem for staff wellbeing, morale and confidence. In year one particularly, practitioners spoke of feelings of isolation, and some relayed a lack of confidence with their approach to the intervention and of the need for reassurance. When supervision was provided on a regular basis practitioners spoke of appreciating the pastoral and wellbeing support.

4.4.2 Peer support

At the beginning of the project there were half-day team meetings for all the project staff to attend. As a way of addressing the remoteness of the team, a 'buddy' pairing system was established between those practitioners covering roughly the same locations.

The importance of peer support was raised in a number of ways. Gwella practitioners reported on the importance of the support afforded by the practitioner they were paired with, and this was particularly so for two practitioners who talked of a lack of confidence in how they were approaching their work, in terms of the challenges of implementing the intervention in practice and particularly with the use of the Theraplay method, They spoke of how they valued the opportunity to discuss their cases and activities, and indicated that they did so on a fairly regular (weekly and in some cases almost daily) basis. They also relayed that they would have liked more communication across the whole team, as many practitioners reported having little contact with anyone other than the other practitioner working in their region. The data indicates that there may be a connection between this lack of confidence and feelings of isolation with practice, with consequences both for the practitioner and their work with families. Evident in the same practitioners' transcripts is an anxiety about their work their need for further support and training.

[12] The data indicates that technology other than email was not utilised as a way of mitigating against these geographic and workplace challenges. This evaluation was completed during the 2020 pandemic, and the associated restrictions present a resonant dilemma and possible solution, as many workplaces including social care teams will have been forced to re-orient supervision to online platforms. Learning from this may be an organisational area of opportunity moving forward.

More broadly practitioners reported the value of team days as important learning opportunities, and of the value of sharing practice, learning from each other, and of the openness within the whole team. At least two practitioners stated that group supervision to talk specifically about individual cases should be introduced more formally, as should diarised team meetings for broader wellbeing and learning purposes.

Whilst it is not uncommon for regular supervision to be a challenge in busy social care environments, the importance of support through supervision for the Gwella approach needs to be emphasised. This was also a key message from the scoping review. There are emotional demands of the role, the Gwella approach is about transformation which entails a level of monitoring, while the multi-skillset aspect of the Gwella approach, in which practitioners are expected to be competent across several specialised methods and approaches, all need to be supported by regular supervision and contact with the team, particularly so given the nature of remote working. The model supported through the findings is one of regular individual supervision, a pairing system for more informal peer support, with regular group supervision and team meetings as a more formalised mechanism of peer support.

4.5 Psychological/clinical support

In addition to line management supervision, psychological supervision and assessment support for work on cases was embedded into the intervention. Psychological support is one of the key principles of the Gwella approach, which details that: Clinical supervision is provided by psychologist to Gwella staff; the psychometric measures used will be scored and interpreted by clinical psychologist; and relevant reports will be quality assured by clinical psychologist. The purpose of clinical supervision detailed by Barnardo's, is to provide an additional space outside of line-management supervision for practitioners to reflect upon their work with individuals, more specifically in terms of exploring the differing dynamics that may be at play in relevant relationships, to reflect upon the success or challenges of intervention techniques utilised to date, and to explore the impact of dynamics (emotional, psychological, developmental) on the approach undertaken and how a different approach/technique etc may work differently.

In practice, in year one of the pilot, while clinical psychologists and trauma specialists were heavily involved in the case formulation and assessment aspects of the work with children and families, the intended ongoing clinical/trauma supervision was not written in to the work the specialists were contracted for, and this was provided on a less formalised ad hoc basis. So while there was no provision for them to provide ongoing supervision, they did make themselves available for this from Gwella practitioners as needed. Some of the practitioners reported having used this, however most reported that they were not able to access this as an ongoing source of support.

Some practitioners noted that additional clinical supervision or guidance on the use of the therapeutic models embedded into the project would have been beneficial. The professional who provided training in Theraplay and Dyadic Developmental Psychology techniques, was not embedded into the project as a source of ongoing support (aside from one group supervision session early in the project), due to practicalities and costs, and some Gwella practitioners reported that it would have been helpful if they or someone else trained in these areas had provided ongoing supervision. In addition, concerns were raised by all three therapeutic/clinical consultants who were involved as consultants for the project in year one, about the lack of clinical supervision provision within the Gwella model; they reported that the therapeutic focus of the intervention would have been better served if this was inbuilt throughout the pilot, because it would help with the practitioners' confidence and skill in using the therapeutic methods. However it is worth noting that these three specialists involved in year one were aligned to a specific technique or model of the intervention (the TRM, DDP, or Theraplay elements of the approach), which does raise how far supervision could encompass an approach which draws on the three different modalities and areas of expertise:

> *"I think the training was really really good, I think it's supervision is where you like really, they [the course trainer] even said that on the course I just went on, she said obviously this is four days you've learnt a lot but where you really embed it is in your supervision with a DDP you know someone who knows a lot about this, and that is what we don't have, so we've had this training and then they were like off you go, go and do it. And you need to be able to have that someone to*

go back to all the time, who understands these things, who can go 'how about this' or 'how about that' or 'no you did a good job there if you did that' you know, that kind of thing. Just trying to remember the training, I keep reading a lot about it you know re-readings because you do forget but it's not the same as having someone who is very skilled and practised and done it for a long time there to give you guidance. I suppose I am lucky that I've got someone who wrote the TRM so at least I have that, like I saw him earlier today and I was like this is my issue with this kid and you know he talks to me a lot about the TRM and it just helps embed it with a real case so I have one aspect of it, but not the others because he doesn't know anything about theraplay or much about DDP."
Gwella Practitioner

This point about the potential conflicting modalities is supported by the practitioners reflections on the support they were also offered from a clinical professional associated with an 'in house' Barnardo's service. Some practitioners reported that they did not find this supervision suitable or particularly helpful because the Gwella intervention was very different.

In year two of the project, formal arrangements were put in place, and clinical supervision was provided on a monthly basis for the majority of the year. We note that in year two, practitioners reported and relayed a confidence with their work with children and families, and relayed that they were much more flexible with whether and how they incorporated all the different principles of the approach (for example Theraplay was not always utilised), while the clinical supervision appeared to take a less driven approach (by method or intervention) to advice and was focussed much more on relational working and understanding the behaviours and needs of the child. At the end of year two all practitioners reported feeling confident and reassured about their plan of work, and connected this to how they talked about the value of this regular supervision with clinical expertise.

The findings suggest that these two aspects are connected. Practitioners were more confident in their role when they received clinical supervision in a form less directed by specific interventions models and approaches – suggesting that clinical expertise is essential to the intervention for facilitating an understanding of trauma and talking through the practitioners' plans for work, rather than for consultation on the specific techniques and models that form part of the overall Gwella approach.

4.6 Training and capacity building

The Gwella approach is based on principles drawing on the Trauma Recovery (TRM) model, relational play (informed by Theraplay), Dyadic Developmental Psychotherapy (DDP) and the Playfulness, Acceptance, Curiosity and Empathy (PACE) approach drawing on attachment theory, and a psychological understanding of child development including brain development and the impact of trauma. These require specific knowledge, and the development of a specific skillset.

Practitioners were provided with training on the Theraplay method, DDP, the TRM and understanding harmful sexual behaviours. The Theraplay and DDP training were both provided by an external consultant and the TRM/HSB training was provided by the trauma specialist social worker who developed the TRM and was involved with the project providing psychological supervision.

Due to organisational factors, not all practitioners accessed the training prior to starting work with children and families. One practitioner attended the DDP training six months later than the others due to sickness absence at the time of the initial training. One of the practitioners was never able to access either the Theraplay or the DDP training, in part due to geography and when training was available. In this instance, their buddy practitioner had previous experience in Theraplay and in working with the consultant who provided the Theraplay and DDP training, so passed on details from the training and provided some support with these methods.

As mentioned previously, we note that in the year one interviews practitioners relayed a lack of confidence in some aspects of their work, and spoke of the frustrations of the lack of specialist input, and this was, in part, down to how committed they were to these specific methods and models in their work with children and families. The data indicates that, for example, in instances when Theraplay as a specific intervention was understood to be the main

mode of delivery for the Gwella approach, there was a lack of professional confidence among those practitioners, because they did not feel they had sufficient expertise to deliver this work to the best of their abilities (this sentiment was present amongst those practitioners who had accessed the Theraplay training, as well as those who had not). A similar lack of confidence and an expressed need for further training on childhood trauma and its effects was also spoken of in relation to the extent to which the TRM and DDP was understood to direct their practise, and their understanding of the need for specialised psychological input into their work.

However, as we discuss in further detail in section 5.5 below, by the end of year one and throughout year two, practitioners spoke very differently about how these methods and models had informed their work, and this was reflected in an increased confidence in their discussions about the rationale and purpose for their work; this adaption and flexibility with the approach was not necessarily because of an unmet training need, but because of the learning acquired throughout the pilot – as one practitioner summarised it:

> *"I think initially there was more of a focus on things like the Theraplay and the DDP and things like that. And I think when it comes to it, even though people who have had the training, there are areas that even with the training we're not particularly experienced in, and there are areas that you need quite a bit of support in you know, in terms of ongoing supervision and things like that. So I think in some respect we've not focused on those as heavily as perhaps we would have thought initially we would. But I don't necessarily think that's a negative you know, obviously I can only speak for my cases but I think the work that's been required we've sort of met the needs in other ways anyway. You know maybe even with more of a focus on DDP and PACE would we have used that anyway? ... like I said before with you know, we are tailoring the work to the families so you know it might have been that even had I done the training and had lots of supervisions and support I wouldn't have used those approaches anyway."*
> **Gwella practitioner**

Clearly, if Theraplay, the TRM and DDP are essential to the delivery of the approach, then we could conclude that further investment in training and continued ongoing support for practising these three elements is also essential; however the findings suggest that while training in these methods is an important part of developing the skillset of Gwella practitioners, the level of training and whether practitioners require ongoing support is dependent on the extent to which practitioners assess the relevance of these methods in their specific workplan with each child and their family.

The data also indicates that the pilot nature of the project, and the flexibility indicated above, encouraged an active culture of seeking new knowledge and skills, which were actively integrated into the flexible delivery of the intervention. In addition to the above training, practitioners had access to training provided by the local authority in which they were based, and some sought additional training elsewhere. One practitioner reported attending training on music therapy, learning difficulties, autism, and additional training on Adverse Childhood Experiences (ACEs). These courses were not provided as standard for the practitioners so they were accessed according to their availability to individual practitioners (as not all reported having such access in their service areas) and the individual practitioners' interest. Alongside this, practitioners it was evident in the data that practitioners brought their own expertise to their work, such as the use of drama therapy techniques or specific play-based activities, and were regularly engaged in their own research and sharing ideas about methods and activities with colleagues:

> *"one of my colleagues yesterday was saying she was introducing some music therapy and I was like oh tell me about that and she'd bought a book and she was telling me all about it"*
> **Gwella practitioner**

> *"it's more just looking online and getting books and things like that to help us. I think, and you're creating your own bespoke, for that child, ways of supporting them. Something I think is that we could do with pooling a lot of that together into something, well, creating some sort of like resource that pools our resources together"*
> **Gwella practitioner**

Training and staff development is a core part of the Gwella approach and is an important aspect of the organisation of the project. This has implications for staff turnover and induction; which also connects to our earlier point about the wider funding context. The significant investment in training, and the development of a rich skillset with exposure to specialised techniques such as the TRM and DDP, as well as creative, relational and play-based work indicates that this pilot established a highly skilled workforce, and to lose that human capital through funding related turnover is significant.

Significant investment in training and encouragement of skill development in Gwella created a culture of learning and creativity. It is challenging within this to deliver specialist supervision for each modality, and practitioners as a consequence appeared to be drawn to using modalities more flexibly and eclectically, and felt that this was in keeping with being flexible to unique family situations.

4.7 Referral criteria

The referral criteria for the project were: 1) that children were aged between five and eleven at time of work starting; 2) that they were in cases open to social services in some way; 3) that they had experienced significant trauma before the age of five; and 4) that there was evidence of particular complexity in their circumstances or behaviour.

With the exception of age, none of these criteria were applicable to all of the children, as local authority staff had flexibility and discretion in making referrals, and the Gwella project similarly exercised their own judgment in accepting cases. Some of the families were not open to social services at the time their involvement with the project started. Some of the children involved were referred in part due to concerns around their behaviour, but some were not displaying any concerning behaviours or there were concerns they were withdrawn. In one case, no known significant trauma was present in their earlier life as they had been in care since birth and subsequently adopted, but trauma in this instance referred to 'pre-birth trauma' interpreted from the birth mother's experiences of violence against her while pregnant. In addition, involvement with the Gwella project covered a wide range of reasons specific to the child[13], such as having traumatic histories that are particularly complex or extended, or being in need of support that is either more time-intensive or more broadly family-orientated than what the statutory professionals were able to provide.

The demographic and referral data recorded for Gwella cases uses a standard Barnardo's recording form, and the centralised design of this recording system did not allow the Gwella practitioners to choose from the actual referral criteria used in selecting cases for the intervention, so in the following there may be areas where this does not specifically reflect how this data was relevant to the Gwella project. This may speak to broader issues around the use of standardised systems for specific interventions.

Anti-social or criminal behaviour (n=1)
Looked-after child (n=4)
Violence, abuse or neglect (n=11)
Vulnerable person needing support (n=7)
Additional referral reason (NB. There is no freetext to detail further) (n=8)

Some of the practitioners reported that they had a number of referrals and had to prioritise, and others relayed that they had difficulties receiving referrals and supported children who they did not think were suitable for the project. It was noted by some of the Gwella team that there were no referral exclusion criteria, and that this might be helpful to include if the project were to continue. Two specific areas to consider were the involvement of Looked After children and children with learning difficulties.

4.7.1 Children in foster care

Although not included as a specific referral criteria, children in foster care were included as part of the cohort in the project alongside those living with a parent or in kinship care. This was in part to understand how the intervention worked in this specific relational context.

[13] Specific information is included in the narrative in case files, and additional detail has been discussed in interviews with Gwella practitioners and with social services professionals who were involved with referring cases into the Gwella project.

It is interesting to consider the views of foster carers in relation to this. Some foster carers specifically reported uncertainty about the need or suitability of the intervention for the child in their care, and that they felt the intervention either impeded their ability to broker their own relationships when these were being formed (which was something talked about by one child in their separate interview also). Or they spoke of how the intervention was 'a nice thing' but they were unsure whether the project might make more of a difference with other children. These concerns were stated alongside a suggestion that there were some children and families for whom this would be a suitable and important intervention, as relayed in the following:

> *"But to be fair in the past I've said to [practitioner] I've thought of so many kids that I've had here that it really would have helped. You know if I think back to one of my placements, it would have benefited him and his mum so well to have that. Be fun, that's the way to connect with a child. Listen, show interest you know all the little activities that we done that you know if that had been put into place with that child and his mother their story could have been very different ... So you know there's parents out there that need to be able to be educated on how to be a kid with your kid, as well as be an adult when you need to be an adult. And I don't feel that the whole thing was pointless, it was pointless for her [the child involved with the project]"*
> **Foster carer**

We note that whereas the parents we interviewed only had very positive things to say about the project, it was foster carers who relayed some impressions that were less positive. Such views were expressed mainly in relation to the project's implementation and delivery; some of which related to the disruption they experienced, as considered in section 4.2, and some were these concerns relating to the suitability of the project for the child – which we suggest may be connected to how far the relational aspect of the approach, and specifically the project outcome of *improving the relationship between the child and their primary carer(s)*, informed the intervention they experienced. In such cases where concerns about the suitability of the project were relayed, the intervention had focussed specifically on the relationship between the carer and the child. These same participants also shared a considerable understanding of how and why play and creative activities can be useful for nurture with children having experienced trauma, and when they discussed engaging in similar activities along with the practitioner, this had been experienced as forced and uncomfortable, or 'nice' and 'fun' but seemingly without purpose. It is likely therefore, that this focus on improving their relationship may have been the issue.

The above analysis is supported by the views of those foster carers who were extremely positive about the project. In such cases the work did not focus on building their relationship with the child through play, if at all, rather, they were involved through becoming part of that 'trauma-informed' system of support for the child, and the intervention focussed on developing an understanding of the child's behaviours and needs, and/or the work focussed on providing support through one-to-one sessions with the child only. It is interesting that there were some key benefits shared by those same participants who had concerns and suggestions about eligibility criteria, and these benefits related to similar experiences of having had the opportunity to engage in discussion and advice with the practitioner, and of the benefits of the one-on-one work the child did receive; but these were not attributed to or understood to be core to the intervention.

In summary, work with foster carers required an increased emphasis on flexibility to depart from elements of the model. Foster carers were more likely to appreciate and express support for direct work undertaken with children and for work which developed their knowledge about the child's behaviours and needs. This analysis supports the eligibility of Looked After children for the intervention.

We also note that some of the children in foster care were returned home to the care of their parent(s) during the project, and this then formed the focus for the support, but had not initially been part of the reason for referral. Had these children been excluded from eligibility to the project, this important transition would not have been supported through the intervention.

External professionals commented that the referral criteria could be broadened to involve siblings in foster care, and this would also allow for whole family approach. This

was also noted by some foster carers in relation their own children and the potential divisions that could occur when undertaking direct relational work in the family home to the exclusion of some children. Sibling groups were included in the intervention, but the age limit could be an exclusion criteria for some sibling groups.

4.7.2 Children with learning difficulties

There were also suggestions about the need to consider the suitability of the Gwella intervention for children with learning difficulties. This was also not part of any referral or exclusion criteria. This was raised in relation to cases in which the children were autistic and significantly disabled. One of the external professionals involved with one of these children did not feel that the intervention was suitable for this child, reporting that the child seemed upset or unsettled by their sessions, and raising particular concerns about the effects on the child's behaviour in the classroom, also relaying concerns about whether the practitioner had experience of working with autistic children. In this same case, the Gwella practitioner reported having sensed a breakdown in relationships between themselves and the clinical psychologist and the other professionals involved, due to differences in views on the use of restraint with autistic children. We note that the sessions were initially taking place in the school, and the foster carer in interview relayed that the behavioural difficulties that initially occurred (the location changed as a result of these) were likely due to the challenge of transitioning from the Gwella session to the school environment so immediately. Such challenges may not be unique to autistic children but are likely intensified if routine and transitions are of particular importance to the autistic child. We also note there were at least two other cases when parents relayed their children were in the process of diagnosis for autism, and commented on the ability of the practitioner to work with their child. Regardless, these views indicate that there is a clear skillset in this area, which is particularly needed for those attempting therapeutic or intensive work with children with learning difficulties. The systematic mapping review also highlighted the possibility that holistic approaches may be unsuitable for addressing HSB with children with a severe learning disability, and that behavioural interventions may be more appropriate.

Given the children referred to the project, and the focus of the intervention, the analysis suggests that for the referral criteria, Age, along with meeting at least two other criteria would be a helpful coda and provide some way of prioritising suitability. Looked After children should not necessarily be excluded from eligibility to the project. A consideration should be made about the suitability of this approach for children with learning difficulties, and this needs to be specifically supported through ensuring that as part of the approach, practitioners were equipped with the specific skillset needed to undertake such work.

4.8 Referral process

The process for referring children and parents or carers into the Gwella project took place in consultation with the local authority taking part in the pilot. For most cases, this began with senior managers and eventually with individual social workers and the Gwella practitioners. This generally involved the service manager meeting with each local authority and explaining the project and referral criteria, at which point the local authority would provide their own shortlist of possible service users. The Gwella service manager and relevant Gwella practitioner for the geographical area would then meet to discuss further refinement of the shortlist. Possible reasons for exclusion at this stage were if the placement was likely to be unstable, if there were already a number of interventions, or a similar intervention, going on for the child, or if the family was experiencing other difficulties that may mean Gwella was not the best intervention for their needs. Later, a referral meeting took place with the parent(s) or carer(s), at which point final consent was sought. This meeting was usually facilitated through social services or a relevant foster care team.

In year one, the referral pathway in the North Wales pilot local authority differed to those in the other service areas because there was a therapeutic intervention service already existing. Because of this, referrals came from this service rather than through consultation with general social services professionals.

Professionals from external agencies and Gwella practitioners largely reported positive experiences of the referral process, particularly so of the case formulation meeting which was planned to occur at the beginning of the intervention and which the external professionals viewed as part of that process (see section 5.4). Two professionals who were involved with the referral process expressed that the time commitment asked of social services professionals was not always feasible given their existing workloads, or would not be feasible were the project to involve a larger number of cases. Gwella staff reported that the pilot in North Wales experienced significant delays due to the local authority not providing cases for referral at the points when this was expected. This was in one instance related to staff absence within the local authority. However because no social services professionals from this local authority were interviewed, the research team are limited in how much we can report about how the referral process worked in practice in this area, but it is possible that this is for similar reasons such as workload.

4.8.1 Involving parents, carers and children

Involvement with the project was voluntary, and the families and children involved did not need to take part in the intervention if they did not wish to. If consent was not gained, the case would not progress from referral stage. Consent was given by all the families and carers involved in the pilot at this stage of process. Many of the parents reported hearing about the project and the support that it could provide with enthusiasm, and being willing to meet with the practitioner and hear about the project, 'jumping at the chance' or having expressed a need for help and pleased to hear about the intervention. All the parents referred to how knowledgeable, friendly and reassuring the practitioner was when they met them, and this helped to form the reasons why they were willing to be involved:

> *"She came out with the social worker first of all wasn't it? I think she [practitioner] came out with [social worker] first of all. And she told us together then a bit about the work she would do. Yeah she was really, she explained herself and her role very well ... I was very interested in what she was saying, what she would do. When she said it kind of really made sense about the way [child] was behaving."*
> **Mother**

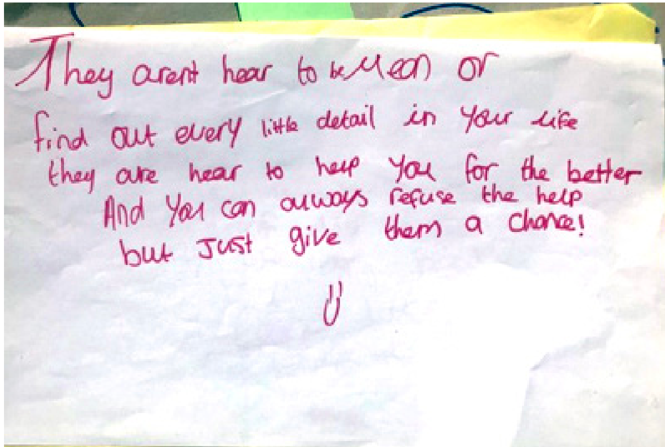
> *"Well the introduction and everything like that about [practitioner] and explaining herself like was great. She reassured you basically sort of like what sort of areas and if there's anything that she could help with and stuff."*
> **Father**

Some of the children were not living at home (or with any immediate plans to return home) when the project started, and the parents relayed how important it was to them that the practitioner met them to discuss the project and gain their consent before starting the work. This also fostered good relationships in those instances when the focus of the work changed to supporting the child returning home and directly working with the parents.

All parents in their interview expressed having been grateful to begin involvement with the project and spoke of having needed the support provided. Most of the carers talked of having become involved because of the benefit the project could have for their foster child(ren), and some stated they were happy to be involved to have bespoke support to develop their own understanding about the impact of the trauma their child had experienced so they could support them better.

As indicated previously, only three parents withdrew their children from the project, and one of these specifically did so because of the disruptions experienced, which indicates that consent was an active ongoing process. Similarly, three practitioners reported difficulty engaging some of the foster carers they were working with and therefore the provision was not in line with the intervention they would have liked to deliver. We note however that at least one foster carer did not think the support was suitable but the decision was not theirs to withdraw.

Almost all the children talked about how they liked their worker when they met them, that meeting them 'was really good because they were very funny and made [them] laugh', and they were 'really excited' to meet them. One of the children involved in the evaluation alongside stating how much she liked her worker when she met her, wrote the following message, indicating that it was clear to this child that she did not need to be involved if she did not want to:



"They aren't hear (sic) to be mean or find out every little detail in your life, they are hear (sic) to help you for the better. And you can always refuse the help but just give them a chance! ☺"
Child, aged 12

However one of the children interviewed, relayed how she did not feel able to say that she did not want to be involved. She explained that because she had to meet with a lot of professionals, she would have preferred to spend the time getting to know her new foster family, and she was worried about upsetting the practitioner because she liked her, and although she would rather have not been involved in the project this was not because she did not enjoy some of their time together. As she explains:

It was quite hard [to say goodbye] but I was quite happy at the same time because I don't want to have another, I was happy because I was, I don't have another person in my life that I have to go out with because I have to go out with quite some people. And I was quite sad because she was very nice to me. [...] I couldn't say a friend but I could say a grown up who was very nice to me. [...] It feels quite weird and it feels quite frustrating because you have another person to meet and you've already got loads that are already helping you and you don't need another one. [...] if I was someone who was really confident in talking to someone I don't know then I'd probably just say no thanks I'm fine. But if you're someone like me and you don't want to hurt someone's feeling you'll probably just say yeah I'm fine I'll meet them. It's kind of like when you're in your house or you're in school and then you're thinking about....and you're thinking about after school and what you're going to be doing with her, you're thinking I don't want to do it. And then you say you don't want to do it but then when it comes to it it's quite fun but then at the same time you just want to go home. I could spend more time with [foster parents] and all my foster family because every day I do something and I don't need to do another thing because then I have less time, less time, less time. And then things will just build up to less time. But I do like the things I do but at the same time I just want to be with my foster parents as well.
Child, aged 10

While one of the possible reasons for exclusion within the project's referral process was to consider if there were already a number of interventions going on for the child, the feedback from this child suggests that involvement with children in this decision is needed, or due consideration of the number of adults involved in the child's life from their perspective i.e. in this instance the foster family along with school support were included as part of the child's understanding of 'quite some people' . This child did not feel able to express that she did not want to be involved, and so when asked 'went with [her] brightest answer', which further highlights the difficulties and attention needed towards ensuring that a child-centred approach is adopted throughout all aspects of the organisation of the project, if the aim is to be trauma-informed and child-focussed.

4.9 Assessment

The assessment tools used as part of the intervention were primarily the Trauma Symptom Checklist for Young Children (TSCYC) and the Strengths and Difficulties Questionnaire (SDQ). The SDQ was in some cases given to the parents or carers and schools. Both measures are established, widespread approaches in social care. In some cases practitioners were also using the MIM assessment, which is part of the Theraplay intervention, and involves practitioners giving the child and parent/carer Theraplay tasks and then observing and reporting on their interactions. These assessments were supported by the psychological/specialist reports from the case formulation meetings.

While some practitioners were positive about the SDQ assessment, they reported that schools did not always fill out the SDQ, and external professionals with experience

of doing so reported that it was lengthy and can be cumbersome in practice. Practitioners also reported that the TSCYC was not a helpful tool assessing change, and in the beginning months of the project this was unnerving for some practitioners who were unconfident with the implementation of some aspects of the intervention. This chimes with the findings from the rapid review, which cautioned that the TSCYC is not something that can readily assess pre-post change, as the kind of problems it is designed to pick-up will be very deep rooted and may take years to show significant changes, so may not be useful for measuring progress within the duration of the 12 month intervention.

Practitioners reported that the three assessment tools were not helpful tools for use with families because the psychological language was relatively inaccessible or not particularly meaningful for parents and carers, and therefore was not a good fit for the relational approach of Gwella. It is also worth noting that the rapid review cautioned that the SDQ has been recognised for use in assessing change but the review is strongly oriented to a focus on difficulties, and this may lead professionals to concentrate on negative aspects of the young person to the detriment of positive areas to be built up. In response to this, practitioners introduced their own mechanisms for assessment and planning with families, which was helpful for facilitating parents' and carers' involvement in goal setting and support planning. This was understood to be an important part of ensuring that the intervention was participative and relational, and practitioners also wanted to be able to evidence and affirm the positive progress for families.

4.10 Recording

Gwella practitioners recorded their work on the computerised recording system used across Barnardo's for case management[14]. The set-up of this recording system holds demographic (or 'core') data, outcomes data, and narrative recording data. The core and outcomes data used pre-set fields the practitioners filled in, and was very similar to how such data is recorded for other services across Barnardo's. The outcomes data was based on the UK Barnardo's-wide outcomes scoring system, which involves a large number of possible outcomes from which each service chooses the ones most relevant for practitioners to score against (in the case of Gwella, five outcomes were selected, as detailed in section 5.6. The narrative recording was more open-ended; recording of sessions and contacts could be typed directly into the system or stored by uploading documents (such as word documents, saved emails, screenshots of text messages, or photographs of children's work) into the system.

4.10.1 Nature of the recording

In the narrative data recorded on the system, there was variation in length and in level of detail among the practitioners. There was no standard template or form for recording this data, so what practitioners recorded was at their individual discretion, and this is reflected in the level of variation among practitioners' data. (This is another reason why it was important to undertake qualitative exploration directly with the Gwella practitioners for our evaluation.) The data held on the service users is more detailed for some cases than others, for example, some recorded more specific information about what was discussed in meetings and phone calls with service users and family members/carers, while others recorded more generally what the contact had consisted of or the main focus of a meeting.

All practitioners recorded sessions they held with the children, the contact they had with families and carers, and contact with professionals from external agencies associated with the children. Some practitioners also recorded contact they had with other Gwella staff, such as supervision sessions with the project manager or consultations about cases. The form that this recording took varied quite a bit, with some phone conversations recorded more or less word-for-word and some recorded very briefly with scant detail. Similarly, some text messages were saved in full to the system while others were only explained briefly. Emails were almost always saved in full to the system, and in one case where they were described

[14] In Denbighshire, the Gwella practitioners also recorded their case details on the local authority therapeutic team's system. This was part of the arrangement in this service area due to the way Gwella was integrated with a local authority team, unlike the Gwella set-up in other areas. The practitioners in Denbighshire reported that this recording duplicated, with less detail, their recordings for the Barnardo's system.

rather than saved in full, the practitioner included a note indicating that this had been done due to technical problems with the system preventing the emails from being uploaded directly as usual.

Recorded communication with external professionals

On average, the Gwella practitioners were recording 33 contacts with external professionals. The majority of these contacts took place over email. Most practitioners recorded on the system the emails, phone calls, and face-to-face meetings with social services professionals that led to each child's referral to Gwella. In each case, further communication with external professionals were recorded. The majority of these were social workers and education professionals, but there were also some communications recorded with those from healthcare and housing. Most of the communication with social services professionals was information sharing and discussions of planned work. With education professionals this was also often the case, with the addition in some cases of advice being provided to these professionals by the Gwella worker. Communication with other professionals was usually the Gwella practitioner assisting in the child or family's access to services. From interview data, it seems likely that not all contact with external professionals was recorded on to the system, as Gwella practitioners and external professionals reported significant ongoing, ad hoc contact throughout most of the children's involvement with Gwella.

Recorded communication with parents and carers

The contact that Gwella practitioners recorded with parents and carers was mostly around arranging sessions and other logistical concerns, along with information sharing, and in some cases the Gwella work involved significant work with the parents and carers, such as providing support and guidance on the trauma-informed work being undertaken with the child, and in some cases providing parenting advice and support in relation to specific requests for help. The practitioners recorded on average 20 contacts with parents/carers for each case. The nature of this contact varied, which in interviews Gwella practitioners reported was usually due to how the parents and carers preferred to communicate with practitioners. Texts, phone calls, and face-to-face meetings made up the bulk of recorded contact with parents and carers. Email was used rarely, this was used was in only four cases and all with foster carers.

Recorded communication with children

The sessions with the children were recorded in more detail than descriptions of contact, although there was still a good deal of variation in length and depth of recording of these. Some practitioners used a template which consisted of: objectives; session plans; resources used; analysis; agreed actions; and plans for the next session. Some practitioners who did not use this template nonetheless recorded information corresponding to each of these fields, while some did not include all of these areas in their recording. All practitioners recorded sessions with some detail of what was undertaken and how the child responded to the work. In most cases, the practitioners outlined their overall objective for the session, the rationale for each activity undertaken, and some reflection on the effect of the work on the child and how this related to the overall plans for the intervention and the child's planned outcomes. The length of the documents recording each session varied considerably, with some practitioners recording a paragraph or two and others filling more than a page with detailed recounting of the work and reflections on its potential impact.

Practitioners recorded an average of 22 sessions of work with each child. The range of recorded sessions is from two to 46. The numbers of recorded sessions with the children are much lower than expected for most cases, and the cases where the planned work was not completed do not account for this. It is clear from interviews with the children, their families and carer, and the Gwella practitioners that more sessions were held than are recorded on the system. Overall, based on information from interviews with the Gwella team, parents and carers, and external professionals, it seems likely that the recording of all types of contact is not a full picture of the work and contact completed. This may be due to workload issues, raised below.

4.10.2 Recording as a reflective practice

The Gwella practitioners reported being aware that there were differences in recording styles among them. Although some did raise the point that a significant amount of time was spent on recording, and they wondered whether this

was helpful alongside the time required with the rest of their work, conversely some of the Gwella practitioners reported on how they saw recording as a process that supported them with their work. It was clear in interviews, particularly in year one, that Gwella was a different way of working for practitioners, due to the flexibility of the outcomes and the child-play focussed approach, and some spoke of how the practice of recording helped their confidence with these therapeutic methods; particularly for those who approached their recording as a reflexive activity that helped them to see the use of play as a therapeutic method, and to further consider what effect that might be having for the child and plan for further work; this also helped them to feel they were working towards outcomes and provided some 'validation':

> *"What I really enjoyed about recording is the analysis section because it helps you to really think about what it is that you did and sometimes I don't realise at the time that I'm doing anything good and then you go and write it up and you're actually that was interesting, that really told me a lot or I think she really benefited from that in that way, kind of gives you that time to reflect, so I was like, I think it's really important to write things up in quite a lot of detail... for me it made it all a bit more valid like I haven't just gone to play that day for an hour with that child, because that's what it looks like to the outside"*
> **Gwella practitioner**

The data suggests that while work pressures and (lack of) time account for some of the differences in style and perspective on recording, this is also down to whether recording was approached as a purposeful activity (in) forming part of the work itself, as a reflexive and ongoing opportunity, or whether it was approached as an evidencing activity to summarise work the work that occurred. This suggests that embedding time within practitioners workplans for recording as the former, more reflexive activity, would support the aims of the approach, while also promoting this as a meaningful use of time for practitioners.

Section 5: Project delivery

In addition to the organisational aspects of the project, the evaluation sought to examine the ambitions and actualities of the project aims through project delivery, and the impact of the Gwella approach upon outcomes for children and families. This part of the evaluation further identifies how the Gwella team shaped a complex non-manualised intervention involving professional flexibility and uncontrolled contexts. The evaluation particularly highlights how practitioners were more responsive to unique case situations over the first year of the pilot, by adopting a less rigid adherence to aspects of the approach's design. This section provides detail and presents the analysis in relation to the children and families involved with Gwella, duration of the intervention, logistics of service delivery, the intervention in practice in terms of involving external agencies and the work with parents, carers and children, concluding with a discussion of the outcomes for families and children.

5.1 The children and families involved with Gwella

The original intention was to involve 24 children. With the extension of the project into an additional year, 24 families involving a total of 31 children and their parents and/or carers were involved in the pilot. There were five sibling groups involved: three groups of two, and two groups of three. At time of referral the children ranged in age from five to 11 years old. 15 are female and 16 are male.

10 of the children were living with at least one birth parent from the start of the Gwella intervention. 19 of the children involved were Looked After at the start of their involvement with Gwella, of whom three were in some form of kinship care. One service user was under a special guardianship order and one was with an adoptive parent. Of the 19 who were looked after at the start of the intervention, at least five were returned to the care of at least one birth parent during the period of the Gwella intervention. Learning difficulties were not consistently recorded in core data, but from interview data, at least four children were described as having learning difficulties, and another two as having ADD or undergoing assessment for autism.

The core, recorded and child specific reasons for referral are detailed in section 4.7. In addition to these noted areas for concern, other consideration directing the focus for the support for children were: some had experienced multiple forms of abuse and neglect, along with bereavements, and multiple family and/or changes to home, living circumstances and carers. Some were presenting as extremely withdrawn while others were exhibiting compulsive, disruptive, aggressive or inappropriately sexualised behaviour, in school and being sent home, or with parents and carers. Other areas of support focussed around children's night terrors, fear of going to bed, talking about past trauma with confusion or as if it were still occurring, difficulty making friends, difficulty expressing needs or emotions, concerns about an over-willingness to please (and therefore the potential vulnerability to abusers), anxiety, low-confidence, fear of being alone.

Parents and carers were struggling to know how best to respond, some expressed anxiety or low-confidence in their parenting abilities, and some had themselves become isolated as a consequence of a fear of managing their children's behaviours in public spaces. There were additional concerns about the 'stability of the placement' or with keeping children at home. In the cases in which children were returned to the care of their parents there was a focus on supporting those relationships, and help for children and parent(s) to manage that transition.

5.2 Duration of the intervention

The project was designed to work as a 12-month intervention, and each family were assigned their own Gwella practitioner to work with them through the entire year. (In some instances the practitioner worked with siblings from the same family, and in some instances siblings had different practitioners, usually because the children were with different foster families at the start of the intervention.)

Of the 31 children who were involved with the project, 27 received the planned programme of support. 22 of these children received the service over a continuous 12 month period. Three received an extended programme due to interruptions due to worker absence; in one case this was due to a combination of sickness and maternity leave; and in two cases this was due to the worker leaving the project early and being replaced by a new worker who had sickness absences and then left, by which time their original worker had returned and took back over. For one child their support concluded slightly early (after roughly eleven months) due to the practitioner leaving the project and it being too disruptive for a new practitioner taking over. In short, the majority of children involved in the pilot received the planned 12 month programme of support, and some of the children and families were ultimately offered an extended intervention due to practitioner absences, and some worked with multiple practitioners for the same reason.

Involvement with five children ceased early. Three of these were siblings whose parent decided to disengage from the project early on into the programme of support. As discussed in section 4.2, one of the other disengagements were related to the long-term absence of the Gwella practitioner. In both of these cases, the child and parents/ carers were offered the support with a new practitioner. In one of these cases, the carers declined this due to the delay in setting up an alternate provision. The other was one of the cases held by the practitioner who left and later returned, and although this case was allocated a new worker in the interim and then re-allocated back to their original worker, the parent ceased engagement at the point the original worker returned.

5.2.1 The importance of time

The Gwella staff acknowledged it as a rarity to have funding to commit 12 months to work with children and families. They also reflected on the importance of this time period, due to the considerable amount of time that developing relationships and building trust could take, alongside the need to plan for ending the support, meaning that six to nine months was more reflective of the time for practitioners to engage with the children and parents or carers for core aspects of the Gwella approach. Many of the practitioners reported that they felt it would be better to have a period to engage with families before undertaking some of the assessment activities and establishing a plan of work, as it would allow them to base this on the needs of the family. They also spoke of feeling there were missed opportunities to continue to build on the relationships developed and the support established. However, these were not stressed as

a point, and likely so because of the positivity toward the duration of the intervention that had been made possible through the funding.

The data from the interviews with parents and carers supported the views of the Gwella team about the time needed for building relationships and trust with themselves and/or with their children, relaying the importance of giving time for this before beginning to engage in aspects of the intervention. The parents involved in the evaluation particularly, relayed previous experiences of support related to their involvement with social services, when they had felt misunderstood, judged, and they held a distrust of professionals and fear of their involvement, and it took them some weeks to trust the practitioner and fully engage with the support, as evidenced below:

Father: *Sometimes I'd hold stuff in and then when [practitioner] would go, and I would say to [partner] I wish I'd said this, I wish I'd said that. And you get a bit too frightened to say stuff sometimes you do and then after a while I just thought right when something comes into my head I'm going to have to say it like, I can't keep it in so I might as well just say it.*

Researcher: *And how long did that sort of take before, was that like a little bit longer in terms of the to trust and open up?*

Father: *Yeah. It could be about like the fourth, fifth, maybe sixth time I've seen her that I started opening up a bit more and if I needed to say something you know I would like.*

A similar acknowledgment can be given towards the concerns children may feel over the first few weeks when meeting practitioners, and their need to develop trust, not just to feel able to share their thoughts and feelings, but to feel safe to be on their own with practitioners. Something of this is evidenced in the following from a child relaying her worries about meeting her worker over the first few weeks:

> *"At the first couple of weeks I was like I don't really want to do this because [carer], most of the time [carer] wasn't, sometimes [carer] was in the room and most times [carer] wasn't with me and I was quite worried what she's going to do with me, she might be a robber. Although she isn't."*
> **Child, aged 9**

Playing games and not having to 'talk about things all the time', and feeling 'safe' were all described by children as things they especially liked about their worker, and parents talked of having trust in the practitioner because they could see their child(ren) liked them and looked forward to seeing them. Foster carers particularly, emphasised the importance of ensuring there is space for consistency with visits over a period of time, when supporting children who have been through trauma in their home life, and whose trauma has been also a consequence of the relational instability and disruption experienced when being Looked After and involved with social services:

> *"I mean it's stability, they all need stability. They can't keep being dropped and rejected, it's so bad for children."*
> **Foster carer**

Carer 1 *And this is the other thing, the trauma isn't just caused by his home life and what he's been through, he was taken away and then had seven foster carers, one or two of them were not exactly nice ok, they were all short-term.*

Carer 2: *That's not the project though is it?*

Carer 1: *No, but what I'm trying to say, this is a child that not only got trauma but social services, the industry itself has added to that trauma and then to have a project that's only half done, that to me is letting children down big time. We are responsible, all of us are responsible for that.*

These views indicate that organisation of provision itself needs to be trauma-informed and allow for consistency and stability so as not to repeat such trauma for children. It is significant that in interview, the only feedback from parents that could be deemed as negative, or which formed their views on what should change about the project, was unanimously in relation to the duration and timing for the end of involvement. Alongside thoughts about suitability, this was also one of the few changes

suggested by foster carers. They reported that they felt they or their child needed more time to receive support, given the extent of the trauma experienced and the relationships that had been established through the intervention and the possibilities for building on the progress made:

> *"[they] knows him ok and [they've] got to the level that [they] understand [child] and the way that [child] works. Nobody is going to get on that level with him unless they build up a rapport and trust and a relationship with him and this is why it's so disappointing now that god you were nearly there where you could have made some sort of impact in getting him to deal with the trauma."*
> **Foster carer**

> *'Yeah I think it should be about eighteen months and then they can go through quite a few things because he had quite a few issues like going upstairs in the dark, his attention span although it has improved a bit, I think if the programme was a touch longer perhaps with more activities that could have improved even more than what it did now ... because when you think of it a year sounds a long time but it's every other week, that's only about 24 times a year so although it sounds a lot it's not really a lot.'*
> **Kinship carer**

For some parents, in part because of the success of the project, their involvement with Gwella was pulled at the point when other agencies were also withdrawing support. While this was recognised as an important and positive step, there was anxiety about the potential for failure at this time, given the significant change in family circumstances brought about by this withdrawal of services:

> *"I chose to do it so I thought I'd do it, have a go. But with social services I got to do it. Lucky enough they've left me so it just, so everyone is going. Because I have come so far. So it was quite good for me (pauses) and I'm happy but I'm not happy, because, I'm used to that routine of people coming, doing this and doing that. But obviously I've got to learn to stand on my own two feet but I'm 30 now so obviously I've got to try and learn."*
> **Mother**

Father: *when you've got trauma-based parenting or therapeutic parenting like we are doing it's extremely difficult and you just have to take small steps and see what works. I think that's the only advice I would say is that you're tailoring the help to the needs of the family you're dealing with, I'm not saying we didn't get that help I think we did but I think we're just, unfortunately we're coming to the end of the project and this is at the point where we could actually be doing with taking on board more because we're coping with 90% of things, it's the 10% now we need that extra boost you know.*

Step-mother: *Something to fall back on.*

As indicated above, the doubt and worry about the potential for setbacks after service withdrawal was particularly marked for families for whom children had been brought back into their care. The withdrawal of services and the Gwella project represented significant change for children too, and parents and carers reported an anxiety from children about who they would now speak to, and whether they might end up back in care. In such cases these families did not necessarily suggest that the intervention should continue as it had, but rather they spoke of wishing the support had not stopped completely, and that they had the safety of knowing they could check-in if 'things went wrong' or for reassuring their children. This is also evident in the quote above: that families are not suggesting an endless service but some kind of tapering of support.

5.2.2 Endings and exiting

The above discussion connects to the exiting process with children and parents and carers. In most cases exiting was foreseen and could be managed between the practitioner and the family. There was no standard process employed by practitioners for ending the project, although there were some shared practices. These involved ensuring that children were aware and reminded in advance that the practitioners involvement was coming to an end, introducing this at a particular date towards the end of the 12 months, reminding children of this each week, and ending the project doing something special together as something to look forward to and as a celebration. Practitioners spoke of trying to ensure the children 'had

positive endings', of the importance of acknowledging their own and the child's feelings about ending the relationship, and of trying to give the child a choice about things they would like to do on their last visit as a way of introducing some control.

Almost all children who were involved in the evaluation were emotionally impacted by the realisation that they would not see their worker again. For some they were overtly upset at this, and spoke of missing their worker. Some of the parents and carers spoke of the positive changes in their children's behaviour having deteriorated because of the change in not seeing their worker, this was particularly so for the year two cohort – some of whom had received an extended intervention, and some who had returned home to live with parents while the intervention had occurred. Some children did not seem to understand that they might not see their worker again. Many of the children struggled to understand why the relationship had ended, and this was despite the parents reminding them of the final meeting and this having been explained to them, and of the careful ways practitioners spoke of trying to manage this. Parents spoke of how their child had listened but that they had not understood or did not understand or realise what the ending meant. Parents too, while acknowledging that the relationship was 'professional' spoke of how they would miss their worker, of feeling sad that they would not get to see them again or let them know how things were going for them.

External professionals shared similar views on the need to deliver interventions over an extended period of time to accommodate these challenges. They were overwhelmingly positive about the duration of the intervention, emphasising how rare and 'amazing' it was for a project to have the opportunity to work extensively with families over a year, and many professionals indicated that the duration was very important to the success of the intervention. However, they also suggested that the intervention could benefit from incorporating a more extended step down process to help facilitate better endings. Although some professionals did speak positively of the exit process as managed by the practitioners, it was noted that the intervention was still structured to be withdrawn at the end of the year (or extended timeframe) and some expressed that a gradual ending process may have benefited some of the children. Some professionals also raised concerns about recognition of entrenched issues which may require longer support, and some also suggested that support could have remained in place for transition across living circumstances or school years – with some education professionals reporting that they saw recurrence of earlier behaviours after the end of the Gwella intervention. However, all external professionals acknowledged that funding necessarily restricted provision.

Such findings support the 12 months of provision for the delivery of the intervention. The views of participants and the reported experiences of service withdrawal amongst children and parents indicate the need to embed this within a period of tapered support for parents and carers and check-in time for children at the end of the 12 months, with the flexibility to continue some element of support should an assessment indicate that planned outcomes are dependent on the need to do so.

The analysis suggests that the duration of the intervention is crucial for the immediate and long-term success of the intervention and outcomes for families in three ways; firstly to build the necessary trust that is vital to facilitate practitioners' ability to engage, appropriately assess, and plan support working heuristically with parents and children; secondly to facilitate step-down endings that provide some level of control for children and parents; and, connectedly; thirdly, to ensure that the intervention is withdrawn according to an assessment of the needs and situation of the families, rather than being driven by organisational set-up and funding limitations. The extent to which the project has the ability and resources to facilitate all three considerations will also determine the extent to which it can be 'trauma-informed' in its organisational practice and delivery. The challenges and negative experiences associated with exiting from the program ultimately raise the question of how this echoes the child's experience of past relational losses, and whether an approach can provide the child with some level of control over the exit process.

5.3 Logistics of delivery

The project was designed for the intervention to provide consistent and sustained engagement over the course of the twelve months. In the project set up, it was envisaged that support would take place on a weekly basis,

primarily in the family home. Workplans for practitioners were arranged in consideration of this, and most of the practitioners held between two and four cases at a time, however one held six cases in the pilot year, and disengagement with a parent where three children had been involved meant that another practitioner worked with a single case for the majority of that year. In year two, each practitioner managed either two or three cases.

Depending on the arrangements for the support being provided and the needs of the child and parents or carers, in practice the logistics of service delivery differed among practitioners and among children, parents and carers. This included frequency of visits, location of visits and methods of communication.

Visits usually took place weekly, for about an hour. In some instances, the practitioner met individually with the child and then individually with their parent(s) or carer(s) on alternate weeks. In other cases, the practitioner was more extensively focussed on supporting the relationship between child and family and so work was done primarily with them together and occurred weekly. Practitioners were able to arrange sessions with the children around the family's schedule, and in the organisation and contact outside of arranged visits the manner varied, with practitioners communicating regularly with parents and carers, by text, phone call, and in some cases through email.

For 14 of 31 children, the sessions with their practitioner took place primarily in school. This was either because it provided a location to meet outside of the family home, or because their experience in school was known to be an area where support was needed. Of these 14 children, one also received some one-to-one sessions at home, seven received work at home with their parent(s)/carer(s) (in three cases, also with sibling(s)), and five also received one-to-one sessions elsewhere (two received this together as they were a sibling group). In four of those cases the other location was a car, while driving either to or from school with the Gwella worker, and in the remaining case the location was flexible (i.e. a park or café). In an additional three cases, work in school was tried but did not continue. The reasons for stopping the work were different for each case: in one, the Gwella worker decided that work in school was not necessary because the child's experience of and behaviour in school were not of concern; in one, the Gwella practitioner stopped because it was not possible to find appropriate space within the school; in one, the child's behaviour in school was negatively impacted by the sessions so the work in school was stopped. For these three cases, as well as the remaining 14 cases where work was never done in school, the work took place in the home.

Families reported that this flexibility was a positive difference to their previous experiences with services. They commented on valuing being able to arrange the support to take place around their own commitments, and of how this approach help to facilitate trust and their positive engagement with the practitioner, as illustrated in the below:

> *"So like I know the good thing about [practitioner] is like she's always asked me first before she's done anything like how do you think is this so she got my insight as well as before giving like, like not before she's given her sort of like right I think this could be good, what's your opinion. And so like it made me feel like right that I can work with her more than sort of like, sort of saying right then you are this is what we've got to do, we'll do these on these days. I might not like 5, 6 and 7 do you know what I mean."*
> **Father**

Mum: *There was no pressure in it. Sort of like if you've got other things to do don't worry about it we can rearrange do you know what I mean so like you know it felt comfortable over actually sort of like right I'm pressured into this, I don't want to be here do you know what I mean*

Dad: *Yeah like sometimes she would just come to see me and [partner] and just sit down and have a chat and then she'd know then what to do for the next session then when it was all of us together.*

Mum: *She wasn't getting all pushy, she wouldn't push you to do stuff. She'd ask us you know is it alright for me to stay here for another half hour, if not it's you know and she'd go and stuff like that.*

Researcher: *Did you feel able to say actually could you go?*

Mum: *Yeah.*

Dad: *Yeah sometimes I used to say it's getting too much for me, I can feel my heart pounding like you know my anxiety. But she understood like where I was coming from.*

"There was no pressure in it. Sort of like if you've got other things to do don't worry about it we can rearrange do you know what I mean so like you know it felt comfortable over actually sort of like right I'm pressured into this, I don't want to be here do you know what I mean"
Mother

The above extracts also indicate the extent to which families can be impacted by seemingly innocuous professional-led logistical arrangements. Relational working involves the recognition of how such work practices will be experienced and may impact on families. From the data, these practices were significant in shaping the working relationship which was itself crucial to the success of the intervention. In the two instances when families withdrew as a result of practitioner inconsistency and absences, they also discussed the inflexibility of the practitioner, and the ways in which this impacted on the child. Either because the child had to miss clubs and events, or because of the timings not working well with their routines (meeting straight after the school day when they were tired and hungry, for example).

This further supports the need for interventions to recognise the needs of children and families in the logistics of practice. For example some children spoke of how they enjoyed meeting in school, but one child spoke of how much she did not like this because she felt it singled her out from her peers and made her feel like she was not like 'a normal child'. Other children said they enjoyed going on visits to places, and this had helped them to talk to their worker, while others felt more comfortable being at home with their parent or carer nearby.

The very broad diversity of arrangements reflected the bespoke intentions of the intervention, and key to enabling such an approach was the caseloads of practitioners. Practitioners reported that their caseloads afforded the ability to work flexibility with their arrangements, and with families and children in sessions, such as extending these or finishing earlier and arranging to visit again on a more suitable date. This flexibility also helped to support consistency with weekly visits.

"I think that one of the things that's given us a bit of space has been the fact that we haven't had overfull caseloads. And that's given us flexibility to move around the parent and children and what's going on for them. And I think often in the sort of families we've been working with, they've got so many pulls on their diary that they often sort of on the day or the day before they say we can't do a session. And so we've been able, or I certainly have been able to go well if I can't come on Wednesday how about you know could I come on Friday. And so still manage to get in plenty of visits. And I think that in other projects I've worked in very full caseloads has meant that I haven't been able to"
Gwella practitioner

We note however that this had implications for the levels of travel and distances that practitioners were covering on a regular basis, which also lends support to the considerations made in section 4.3 with regards to allocating cases.

5.4 The approach in practice - involvement with external agencies

There are two core ways in which work with external agencies is integral within the principles of the Gwella approach: firstly through working with other agencies to ensure the intervention integrates with existing plans for children and their families; and secondly through holding a multi-agency 'case formulation' meeting. Both principles contribute to the overarching project aim to facilitate a broader network of trauma-informed support around the children supported through the intervention.

5.4.1 Integrating with existing plans

A key principle of the Gwella approach is that the intervention should integrate with existing plans for service users, both directly, through complimenting and informing existing social care arrangements around individual children, and indirectly, by being part of a network of multi-agency professionals and providing supervision or

advice regarding trauma-informed practice with children and families. As part of the aim for the broader Gwella project, it was anticipated that the specialist nature of the practitioner role could facilitate local authorities to maximise their resources by helping to inform decisions for when such specialist interventions are needed.

Those professionals who had the most in-depth or direct involvement with Gwella practitioners were primarily from statutory social services, education, and to a lesser degree health. For the purposes of the evaluation the research team were provided with the names and contact details of 58 professionals who were significantly involved with the Gwella work with one or more child. 28 were education professionals, 27 were from local authority social services, and three were health professionals (including one professional from CAMHS, one school nurse, and one psychiatric professional). We note the difficulty with involving external professionals in this evaluation in section 3.2, and, the data from among the 21 professionals who did comment indicates that while the project was engaged with a range and number of professionals as part of the network of services around each child, a relatively small number of these professionals has had sufficient direct involvement with the Gwella workers in order to comment substantively on the project.

Gwella practitioners reported that the relationships they developed with other professionals working around each family were to be mainly positive, and this largely related to levels of 'buy-in' and support for the project from individual professionals.

Involving social work professionals

The social services professionals we were able to involve in the evaluation also mainly reported positively about the project. In interview, social workers reported having had a close and positive working relationship with practitioners, undertaking some joint visits together to the family to facilitate positive communication, being in regular communication through email and on the phone, and describing how this working practice was key in the positive outcomes achieved with parents and children. An example of this is provided in the following:

> *Oh she has been absolutely amazing. Honestly it is a really difficult case to work this one. But I feel that there was quite a lot of professional anxiety around this case for various reasons. But [practitioner] and I were very much on the same page, we came from the same place I think in our approach to working with this family which was fantastic. So we've had you know regular email updates, we've spoken on the phone, we've done joint visits to the family together. I've had monthly or six weekly MDT meetings in the school for the [child] we've been working with and [practitioner] has always attended those. She's, yeah she's been fantastic honestly I can't praise her highly enough.*
> **Social worker**

Social workers also reported appreciating having a point of contact for concerns and ideas for working with a specific child, or responding to issues raised about the family, indicating that the intervention had supported positive relationships between the families and social services. (In a number of interviews with parents, they also reported having appreciated their practitioner being involved in meetings with social services, and providing their perspectives and advocating for them, and acting as a liaison for them because they felt more able to communicate with the practitioner.) One social worker reported that the practitioner had contributed to planning follow-up work for them to explore with the family after the end of the project.

As an indication of the intervention complimenting their existing work, social workers highlighted how valuable it was for service users that the Gwella practitioners were able to devote so much time and individual attention to families, in contrast to the pressures local authority social workers face in balancing large caseloads. Some also referred to a reduced workload with a specific child as a consequence of the project, because they were no longer engaged in constant crisis management. An indication that the intervention worked well and complimented support is that there were several families for whom by the end of the intervention their case became closed to social services and other agencies (however we note that this brings its own set of challenges, as discussed in section 5.2).

Other benefits reported by social workers related to the trauma-informed expertise and perspective the practitioner

brought to the case; for professionals involved in the work with families, and for themselves, through managing professional anxiety, and informing an understanding of the family and the child's needs and behaviours.

The only negative feedback from social workers related to the disruptions related to staff absences and the lack of provision for staff cover, and the resultant impact on children and parents or carers. Some statutory social services professionals also indicated that aspects of the referral process, particularly paperwork and meeting locations, as well as the request for additional information and meetings were sometimes an additional burden that was difficult to handle alongside their existing workload.

> *"in frontline social work you know it is very difficult for us to fit everything in so you know obviously I understand that Gwella do need a lot of background information but I think once that has been done we kind of want them to kind of get on with it as best they can then rather than having various meetings to discuss it."*
> **Social Services Professional**

The lack of time available to social workers was a common theme in interviews – both from social workers themselves and the practitioners. This was often tempered by the same social workers also acknowledging that though it was difficult sometimes for them to find the time needed for their collaborative work with Gwella, it was also necessary for the work to continue.

Involving education professionals

Professionals from education reported somewhat mixed experiences of the project. This tended to reflect the professional involvement with the child, and where there was limited direct involvement, there was less understanding and awareness of the project and any outcomes. For example, some education professionals reported not having a high degree of involvement with the therapeutic needs Gwella was addressing, because the child was not displaying these needs within the school environment. In other cases, education professionals reported a high level of awareness of and involvement with Gwella, and this conversely was usually associated with situations where the child was known to have support needs within the school, or was already receiving intensive support within the school. In such cases, these professionals were effusive about the project, highlighting the rarity of a support project that was designed to work alongside education with other agencies, reporting that this had a very positive impact on their work with children, in part because of the additional support offered which impacted on the child's behaviours, but in part because of the opportunity the intervention presented for cross-agency working which centred around understanding the needs of the child and the parents. The below quote indicates an experience of Gwella which accords with the aim of the principle set out in the Gwella approach:

> *It's quite nice that when we go to the meetings that [practitioner] has got a perspective from the family then as well. So we've got the education side of it, the social worker has got her side of things but [practitioner] is the one who has been in and got the nitty gritty of the family, the family dynamics you know routines. So she has got far more knowledge of the family than anybody else, we all have a little bit but she is the one who has been into the family and can feed in really good information that is valuable for the meetings and things so we think oh right ok we could try this in school. And so after meeting the child in the school she'll come back with like I'm trying this, do you think this could be put into place in the class. So we'll liaise together and then I can feed that back to the class teacher and nursery nurse in the class and we can sort of all try and get the same strategies in place. So it's a really good link with the family and school, and obviously into social services then as well.*
> **Education**

There were also cases when the child was being supported within the school but the support professionals involved reported a lack of awareness of the Gwella work. This corresponded with cases where the Gwella practitioner reported perceiving a lack of buy-in from the social workers involved, and, in one such case, the education professional indicated that their lack of awareness of the work occurring was related to information being shared with other professionals in the school but not then cascaded to those working with the child.

Some Gwella practitioners reported struggling to make or maintain connections with other professionals involved in

some cases. Where communication was problematic or did not happen as needed, practitioners mostly said this seemed to be related to a lack of buy-in from the involved professionals. We note that where practitioners reported less positive relationships with external professionals, this usually corresponded with the individuals the research team were unsuccessful in contacting or securing an interview to involve them in the evaluation. It is therefore only possible for us to comment on these relationships from the perspective of the practitioners, however, this was particularly the case in one specific region, and we also note that practitioners talked about the existence of therapeutic services already established, so this may have impacted on how interested people were in the Gwella intervention because it was similar to existing provision.

Given that the multi-agency partnership is part of the aim of the project as a whole, the findings may speak to a need to consider how to build a robust and resilient system of co-operation among involved professionals. Involvement with social services and open communication with social workers involved with families is key in terms of facilitating practitioners ability to effect practise and existing provision, and influence the network around the child. The number of professionals involved is less important for the success of the intervention. A salient point is whether practitioners are able to work with the relevant agencies and identified professionals for whom there is significant meaning or potential impact for the case.

5.4.2 'Case formulation' and assessment

One of the key principles of the Gwella approach is to conduct a multi-agency 'case formulation' for each child. This should be facilitated by Trauma specialists, utilising the existing team of professionals around child, in order to conduct 'developmental mapping' and establish a trauma-informed system around the child.

The plan was for this to primarily take place through a meeting led by a therapeutic professional or a clinical psychologist, with all professionals involved with a child and family attending, including carers and/or parents. These meetings focussed on establishing a visual timeline of the child's traumatic experiences. This would facilitate a shared understanding of how significant events have shaped the child's development, helping the professionals involved understand how past trauma was impacting on the child, their behaviour and their wellbeing, and to understand what being 'trauma-informed' for that specific child might mean for them in their role and (working) environment. After facilitating the case formulation process, the therapeutic professional or clinical psychologist would provide Gwella practitioners with a report on each child, bringing together all the information from the timeline and incorporating a theoretical understanding of child development and attachment and trauma, with the intention of providing them with a psychological perspective on the planned intervention for each child.

The Gwella team reported how the initial visions for case formulation were hard to put into practice for logistical reasons, reporting on the difficulties trying to get all the relevant professionals to commit to the two-three hours of time needed, and diarised at the same time so they could all be present together. This presented challenges for supporting a trauma-informed network around the child when key agencies were not represented, and also connected to the levels of buy-in reported above. In cases such as this, efforts were made to include professionals in other ways, as explained by the project manager:

> *"I think when we [...] had really good buy-in from [statutory social services managers], that has been easier but we still had issues around trying to get people together in the same room for things like case formulations. So we had to develop a means of compensating for that so where key professionals couldn't come to a case formulation on the same day at the same time with others, we developed things like a professional practice synopsis form where the Gwella workers went out to those professionals who couldn't make it to the case formulations and basically did the same kind of activities with them and got them to look at developmental mapping and things like that and so that we could feed that into the case formulation so at least that person felt they were involved with the process. And then after the case formulation when we were feeding back to the system, those professionals didn't feel like they'd been left out or they were on the same page."*
> **Gwella Project Manager**

It was also noted that there were difficulties with arranging meetings because dates for these were determined by the availability of the consultant specialists involved in the project to lead these. In year one, several case formulations were postponed and there was a delay in the completion of some of the case formulation reports, due to unforeseen personal circumstances. In some cases, work had already started prior to case formulation in any case, so where these were postponed there was sometimes a need for the practitioner to carry on in the absence of immediate completion of this aspect of the intervention. In addition, some practitioners explained that the reports they received were less detailed than they had expected, and provided less clear direction in how to incorporate the psychological perspectives on trauma and child development to the work they were undertaking in their cases. The extent to which the specialist input informed the support plans with professionals therefore varied. This was not necessarily a problem for all practitioners, and some intimated that rather than the assessment report guiding the intervention, they would incorporate that information alongside their own knowledge of the family and their assessment of needs. This was particularly reported in year two, and in such instances they suggested that a delay with the case formulation to give them time to establish and build rapport with the family and the associated professionals would be a more beneficial way of working.

Aside from these concerns, Gwella practitioners reported the importance of this process for allowing them to gain a helpful understanding of history and the needs of the children, and a preliminary plan for focussing and prioritising support. Some described this as a key aspect of the approach that they felt should be incorporated into practice going forward. The psychologist and specialist involved in the project relayed the benefits of offering clinical oversight for children who have experienced trauma but do not meet a clinical threshold for support or consultation. As noted in section 4.5, they held concerns that their involvement beyond the meetings had not been written into the project plan.

All the external professionals who were involved in the evaluation and took part in the case formulation talked of the benefits of this process. They highlighted the opportunity afforded by the timeline and through bringing together the knowledge of professionals from multiple agencies, to gain a broader perspective on a child's history. Social workers were understood to be key to this process. Education professionals mentioned that in some cases, they were not aware of some or all of the trauma children had experienced outside of school, and this meeting and the visual nature of the timeline allowed them to have more insight into the child's behaviour and wellbeing. Social workers spoke of the value of understanding a child's case history with a specific focus on trauma, which they also described as a helpful opportunity to reflect on what support the child and their families may need going forward.

"Yeah, you can read it but when you actually see it in front of you in a picture diagram you actually, we actually sat there thinking poor boy, no wonder you know this is how he is because it was a case of he was either he was moved or there was upheaval in his life or there was, and it was just constant I think , for the first five years of life he was just like so many things happening. But when you actually saw it and put it into perspective and different colours so it was quite visual. And we've mentioned we'd love to do that with a lot of other children we have in school"
Education Professional

"it definitely improved you know the work that I do with families in terms of loss you know from just basically you know having to move school and having a better understanding of you know sometimes people you know trauma you assume trauma is a major incident you know we knew that the death of the father was a major incident but actually working with somebody who is going through all these things that I maybe not necessarily would identify as traumatic experiences for a child and actually working with somebody and seeing well actually that would have been at that circumstance, that would have been another loss. So being able to pick out you know things that I just wasn't aware of before. I mean and I still use, I still identify with those things now in terms of my practice. So it certainly improved my practice and it's something that you know that I, I am still aware of today when I work with families."
Statutory Social Worker

As also evidenced above, these professionals also relayed that the case formulation meeting aided their understanding of trauma in such a way that had informed their general practise with children.

Involving parents and carers

Some of the carers and parents also reported positively on being part of the case formulation process. It was not clear from the recollection of these participants whether they had been part of the meeting itself, or whether the timeline was explored with them separately to the meeting, if at all. (Not all parents and carers were involved at the beginning of the process depending on the circumstances of the child, so we cannot conclude whether those hazy recollections were because this was less important to them, they did not attend the case formulation meeting, or this work did not occur with them.) For those carers who did attend the meetings, their enthusiasm for this process was particularly marked, and they relayed that they felt that the process should be standard practice for children in care. One parent and their child also relayed how important the timeline had been for them. They had explored the timeline together with the practitioner, rather than in the case formulation meeting. When relaying what they liked about the project, one eight-year-old child went to retrieve the timeline to show the researcher, explaining that they liked this, because they could use it to point to the things they wanted to talk about with the practitioner. One family raised an important point about whether the key extended family members could be involved in the case formulation:

> *"Yeah I think that's something that again the Gwella project, difficult in these circumstances because of the logistics of it and the distance but certainly to extended families whether you know grandparents, aunts, uncles, that are dealing with them children whether they can bring them into the understanding. I mean one thing we did, it wasn't with [practitioner] it was with [other support worker]. It's called a circle of understanding, that's very useful you know what's happening in the core where [Child] is and why he does these things. [practitioner] knows all about that but she didn't approach that with us did she?"*
> **Father**

They relayed the importance of these relationships, and that it would help support them instigate trauma-informed parenting, while providing consistent messages for their children. While only suggested by one participant in the evaluation, it does raise the important point about who is recognised as being part of the trauma-informed network around the child, and the tendency within social care practice to focus on systems and professional relationships. To consider involving extended family and other key relationships would reflect the relational ethos of the approach. Experiences from Gwella are largely consistent with good multi-agency practice more broadly and with practitioners developing a deeper understanding of family situations through sharing knowledge and perspectives.

5.5 The approach in practice – involving children, parents and carers

The second of the two overarching project outcomes was to improve the relationship between children and their primary carers. In practical terms it was envisaged that Gwella practitioners would achieve this by working with the child and their parent(s)/carer(s) through relationship-based play activities, and through work to support the carer in understanding the impacts of trauma on their child's behaviour. As mentioned previously, in the guiding principles behind the approach were the TRM, the PACE model and Theraplay.

For 20 of 31 children, the planned work and support provided for the child included the parents or carers, and involved work with the parents/carers and child together[15]. For 9 of 31 cases the focus of the sessions was the child, and the support included their parents or carers but did not involve joint working as part of the planned work[16]. For example the Gwella practitioner indicated

[15] In one of these cases, the child's assigned Gwella practitioner did not do this work, but their sibling who had a different Gwella practitioner carried out work with both siblings and their carers all together.

[16] One of the children involved in the project had two practitioners, and the first did work with the them alongside their carer, but the subsequent practitioner did not.

that they supported the parent(s) or carer(s) through meeting them one-on-one and regularly speaking to them on the phone separately, to answer questions, provide updates and talk through progress and concerns. This also included supporting and advocating for the parents at meetings with social services. For two children the work and visits was planned to take place solely with them, and the interactions with family and carers was centred on arranging meetings and providing updates.

5.5.1 The pilot nature of the intervention

As stated in the introduction, Gwella was itself a unique approach and the project to deliver it was a pilot, so there was no prescriptive manual for the intervention. This aspect of the project was remarked upon in interviews, and almost all the practitioners spoke of the ways in which the Gwella intervention evolved over the two years.

In the first year of the pilot, practitioners were much more likely to be rigidly guided by the PACE approach, the TRM or the principles of Theraplay in their work, but notably not always all three. In year one, as already noted, some practitioners relayed a lack of confidence in their work, remarking that they were not fully qualified in the use of these methods, or as trauma-specialists. They also stressed the need for or raised concerns about the lack of psychological or specialist input to guide their workplans, or of a concern about conflicting guidance from the psychological support they received (see section 4.5). They were also more likely to reflect on the need to validate their work, and spoke of concerns about external professionals and carers impressions of their expertise, or their work and the impacts made.

Some of the Gwella team commented on the psychological emphasis for the project, in terms of the principles of the approach and the assessment and case formulation aspect of the intervention, and how this presented a challenge for determining what the intervention would look like in practice, especially so being delivered by social care professionals in a social care context.

> *"the project had a social care sort of emphasis and I think for me once you know like that there is also this sort of psychological emphasis. And it's... a lot of the thinking around these areas and theory and so on is psychological, rather than based in social care. And I think that how to position the project in terms of that and how to ensure that, because I think that those are two very different approaches and the real challenge is how to bring them together. And...if people come from one of those approaches and not the other than that can impact on how they think about things...I think that the right amount of emphasis needs to be given to the psychological aspect of the approach. And that there hasn't been consistent psychological input."*
> **Gwella practitioner**

For some, too heavy an emphasis on the psychological aspects of the approach was ultimately not helpful for describing what the intervention is and for how it would work in practice. This emphasis also had the potential to undermine the professional expertise of practitioners, if the assumption among external professionals was that this was a trauma-led (psychological/ counselling) intervention, when the majority of practitioners were not qualified counsellors or therapeutic specialists, and may have been part of the reasoning behind some of the lack of confidence expressed by practitioners.

There was a notable change at the end of year one and in year two, when practitioners reported a more flexible approach to their delivery of the intervention. Some of these changes were brought about by necessity; for example the previously discussed organisational issues such as a delay with case formulations, minimal psychological input into workplans, and problems accessing training meant that practitioners had to build relationships and plan work with children and families without these aspects of the approach. At the same time, the plan of work became unsuitable for the intervention; for example some practitioners experienced a resistance to Theraplay by carers, or the context for some children changed, such as moving to new carers or to their parents, and their key relationships and/ or behaviours and their needs changed. Having to adapt meant that the non-prescriptive nature of the intervention was realised to be a strength, and as practitioners became more experienced they became less driven by the PACE, the TRM or Theraplay as specific approaches. This was reflected on by practitioners, and the following quite lengthy extracts provide a good overview of the ways in which the approach evolved:

"I think the parts that we struggled with at the beginning were just not really, because it's a pilot it's not really knowing what we were doing. Now obviously I know what worked well, what went well, what didn't and I would have much more confidence if I was to take on new cases that this is what you know. And I think just having the confidence to be a bit more flexible because there was a lack of structure because it was new, I put in the structure myself as going right I'm going to do one week joint session, one week one to one, you know and then the joint session will be theraplay because that's the training we've had, the other week I'll you know try and introduce something that's meaningful. Whereas I think now I've got, because I have seen how it's panned out like one of my kids I think towards the end I realised she just, this is the one with the foster carers they do play a lot at home they didn't really need that, they didn't particularly need theraplay and joint sessions particularly. And actually I felt I realised she benefited more from one to one sessions so I took away the joint sessions for the last couple of months and just focused on the one to one and I noticed that really seemed to improve our relationship and her trust in me ... I had more, because I had worked on the project for a while I had more confidence to put that in whereas I think at the beginning I was like well I'll just stick to this structure because it's a structure and I didn't know what else to do. And the training that we'd had had kind of, it was a little bit of conflicting advice as well so when we had the case formulations it was before we kind of really were thinking about doing theraplay and a lot of the advice for us just to work one to one with the child and then one to one with the parent, for my cases anyway. And then when we went down the theraplay route it was really like you have to work with them together, this is really important. Then we were like well which do we do so that's where I did both. Whereas I think perhaps that doesn't suit them, not every child needed that. I think now I'd have a bit more confidence and experience to think well what would actually help this child the most, rather than a generic kind of plan for them all."
Gwella practitioner

"Well I think right at the beginning we were supposed to be creating some kind of toolkit to prevent CSE and harmful sexual behaviour which I mean it's not not that, and it's not a toolkit, but it is still aimed at preventing those things but it's much more about just children that have experienced any kind of trauma which obviously we know that the teenagers that we've worked for CSE and SHB, they have experienced that trauma but then a lot of the children, basically you could apply Gwella to any child that's known to social services really or that's experienced [trauma]... But it's just not, it's been much more loose than that [toolkit] and it's more of a general approach. Which is great because it's like really flexible ... I do think the nature of children that have experienced trauma it does need to be flexible and they don't fit into neat boxes so you do have to be quite like comfortable with that."
Gwella practitioner

This flexibility with the methods and techniques used within the approach was viewed as a key strength of the intervention. This flexibility made allowances for working around the potential contradictions between the methods and approaches listed within the principles of the Gwella approach, which was also raised by practitioners across both years, expressed through the need for clarity in year one, and raised as a justification for the strength of the approach being less driven by these methods in year two. For example, Theraplay is a directive method, and is specifically related to carer and child interaction and the practitioner as observer. For some practitioners this was not always useful as they felt that it contradicted a more child-led approach to practice, and that it can also sit uneasily alongside some of the recommendations through the TRM.

5.5.2 The flexible and needs-driven nature of the intervention

A uniqueness of the approach remarked on or evidenced in interviews across all participant groups is its central focus on understanding and being led by the needs of parents, children and carers, and its flexibility to draw on a range of techniques and methods to be responsive to the varied, and family specific nature of the concerns.

By the end of year one, practitioners remarked on not having to be task-led or follow a structured manual as a positive, and emphasised the importance of their freedom to work flexibly with all those involved in the case; meaning

they could be open to respond to concerns within cases, as they arose, alongside establishing longer-term goals.

> *"one of the good things about it is that we can be quite sort of open to looking at what we explore with the families, what kind of things we do. You know we don't have a strict sort of workplan, a sort of pre-written workplan of what we do on Week 1, Week 2, Week 3. We can be this is what the child needs, this is what the parents and carers need, we can adapt, we can be flexible... it's child and family led, and it's not a bad thing to not be driven by DDP, PACE and theraplay."*
> **Gwella practitioner**

This was also reported as a strength of the intervention by external social care professionals who commented on it being needs-led, strengths-based, not about general parenting advice or a workplan imposed on the family.

> *"I mean like I said it contributed to the overall rehab plan and I feel that was you know their work was a factor that contributed to that success because it involved them linking in with all the adults around the young person and being very flexible to the child's individual needs and very creative in the way in which they undertook the work. It was very sort of child-focused."*
> **Social worker**

The flexibility of the work, as well as the practitioner in their working style, was something commented on by parents particularly, in relation to feeling listened to and feeling they were understood – and because the intervention was responding to the key issues that mattered to them, they felt the approach was working and making a difference because they could see change where they needed to see change.

> *"she's obviously a person that you know can relate to people in difficult situations and obviously her background she's had to deal with all manner of different people I am sure. But no she could put you at ease, she could make you feel like you're not being judged, she was genuinely there to help. She was genuinely there to help and she wanted to give us the advice and the help that we needed."*
> **Mother**

As illustrated above, while parents did not specifically frame the intervention in terms of being 'needs-led', their reported experiences were that the intervention worked with them to identify things that were important to them. As detailed in section 4.6, this is why some of the outcomes and transformative changes reported by parents, carers and children were so specific; because alongside (or as part of) a goal to improve wellbeing, as a formal outcome, where there were (for example), difficulties with bed times, or managing behaviours in public, or children being afraid of the dark, these were responded to by practitioners and incorporated into the workplan.

This also helps to explain in part why some outcomes were not so clear or positive for families. As indicated previously, when the practitioner was rigidly following a technique, and the intervention was method-led (rather than needs-led), these were the instances the carers reported as uncomfortable or the intervention as unsuitable, and these views were supported by the practitioners reflections on those earlier cases and how they adapted to ensure the intervention was employing methods responding to the particular needs of families. We note that there were also some cases when practitioners *did* think certain methods and approaches were suitable to meet the identified (agreed) need, but could not employ such strategies because they experienced resistance from carers. In these instances the flexibility of the approach afforded practitioners the ability to redirect their focus of the intervention.

This aspect of the intervention also connects to two of the key messages from the systematic mapping review. Firstly, that there is a need to differentiate levels of competence, and that some carers or families may have less or greater needs in relation to whether they are trauma-informed. Secondly, that a focus on a structured program of work towards trauma recovery should be balanced against individual circumstances, particularly with foster carers who may have close bonds, some understanding of trauma already, and a positive caring history with a child.

5.5.3 The focus of the intervention: a trauma-informed, relational and play-based approach to working with children and families

Given the flexible, needs-led nature of the approach discussed above, there were very varied practices

amongst the practitioners in terms of how the intervention was employed with children, parents and carers and the activities and tools utilised. However, from the data it was possible to deduce that there are three key aspects directing the delivery of the intervention in all cases:

- Firstly, the intervention was 'trauma-informed', and for this intervention 'trauma-informed' in practice meant a recognition of the specific trauma experienced by a child, and the emotional or wellbeing needs that may be present or exacerbated as a result of the trauma experienced, as well as the impacts such trauma may have on the child's behaviours. The intervention in this regard did not focus on the trauma itself, and it also allowed for an understanding that there may be a range of reasons behind those needs and behaviours, because;
- Secondly, the intervention primarily focussed on relationships, and on understanding and working to support the child in the context of their key relationships, including the broader professional network around them. An important part of this was having the same practitioner working with the child, parents and/or carers, and with key professionals, taking a relational approach to that work with children and families by;
- Thirdly, introducing play-based creative methods and activities to facilitate these relationships in a participative and trauma-informed way.

A focus on relationships was therefore at the core of the intervention in all cases, in one or more (or all) of the three following possible ways:

The relational bond between parent/carer and child. In a number of cases, the intervention involved support to build on the bonds between parents/carers and their children. This was primarily supported through engaging directly in play and arts, crafts, games and other activities together. It involved supporting nurturing touch, communication, affirmation of parenting, and creative activities around coping mechanisms for difficult emotions. This aspect of the work could involve or be structured by the principles from Theraplay and the PACE approaches, but not always. Parents involved in this form of support commented on the value of learning ways of playing and engaging with their children, of 'building a bond', and of the importance of seeing their child delight in playing. Two also reported the value of having their parenting skills affirmed. Some of the children said that doing these activities with their carer/parent and the practitioner was their favourite thing they did. A structured approach to this work was not always perceived as comfortable by foster carers.

Supporting the relationship between parent/carer and child. This work, rather than directing the focus of the intervention on the bond between parents/carers and child it focussed on supporting parents and carers in their 'emotional literacy', and in helping them to understand their child's behaviours in a trauma-informed way. It also directed support toward helping them to be curious about and make sense of the possible issues and needs of the child, to devise strategies to overcome some of the specific behavioural challenges and to address their wellbeing needs. This part of the intervention may incorporate aspects of PACE, particularly through supporting parents/carers to reflect on their own parenting experiences and learned patterns of managing behaviours. Parents and carers reported positively on this aspect of the intervention, and relayed how this had 'been the magic wand' and what had changed family life and their children's behaviour in a positive way.

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Building a relationship and connection with children. This involved one-to-one work between the practitioner and the child, and focussed primarily on building and modelling a positive trusting relationship with an adult. A key part of this support was the play and activity-based nature of the interactions, which could incorporate a number of the following: making slime, cooking, drawing, lego, jenga, drumming, role play, visiting places, talking in cafes, going to the park, the use of drama and other forms of embodied learning. Practitioners reported devising activities based on the interests of the individual children they were working with. In these one-to-one sessions the focus was on building trust and a sense of safety for the child, and could also include exploration of emotions and feelings and thoughts about other relationships, which could be parents, carers, siblings or friendships with peers. This part of the intervention may incorporate aspects of the TRM, and its emphasis on establishing relational safety and a secure base, prior to implementing a support plan to progress more therapeutic outcomes. Almost all the children used the word fun to describe their worker, and many used the words safe, and feeling comfortable. Some children struggled with aspects of the project (discussed in section 4.8) but regardless, they all reported enjoying playing and doing activities with their Gwella practitioner. Many relayed that their workers had 'helped them to feel better' and to feel happy, and they were not worried anymore about specific things. Some of the children expressed valuing that their worker did not make them talk about things they did not want to talk about, or do activities they did not like.

> *"This is like kind of advice for like other children when she sees them, don't be worried, she will help you and she will make you think, make you stop thinking about the bad things, make you think of happy things. Like what's your favourite thing and everything."*
> **Child, aged 9**

This aspect of the intervention is supported by a key message in the scoping review, on the importance of recognising the benefits of diverse individualised responses, and employing a non-prescriptive approach to intervention modalities.

This focus of the intervention with children, parents and carers was supported by the second project outcome and two principles of the intervention, detailed in section 2.2, which aimed to support children's relationships in the wider network of professionals around them. This focus on relationship and the relational context around the child suggests that while the Gwella approach maybe psychological in its framing, in practice it is primarily a social (relational) intervention.

5.5.4 Differences between the Gwella project and other support

The data from parents indicates there is something unique about the Gwella intervention which meant that practitioners were in a position to achieve better outcomes for children and families. While this was attributed directly by some to the focus of the intervention on supporting them in relation to the things that were important to them, it was also the case that they compared Gwella practitioners to social workers and remarked positively on the difference. This was in part, expressed through the responsive flexibility practitioners took in the arrangements of the intervention (i.e. arranging visits, responding to calls and text messages, flexibility about where to meet and for how long, and with rearranging when needed). However the data indicates that this difference was also in part down to practitioners not having to balance the legislative responsibility and care duty social workers have to manage alongside the more supportive aspects of their role.

Parents commented on understanding the important role social workers had to play in ensuring the safety of children, but when the focus for some parents has been on the risks they present, this has filtered down into their experiences of parenting and their confidence in their abilities to parent, while also leading to a mistrust and anxiety about relaying concerns and asking for help. This is evidenced in the following extracts:

Mother: *I think because like with social services when they come here obviously you know like they don't see us together, they obviously take me into a separate room to talk about things and then they take the kids into a separate room to talk about things because obviously they've got to see you know if we're not hiding things or you know they're a little bit more you know. Whereas you*

know [practitioner] you know with the project you know we're actually, me and [child] are actually sitting together and then [practitioner] is obviously then seeing how we bond together and you know stuff like that you know we're not pulled apart whereas social workers seem to like take the children upstairs and then me in the kitchen and it's very detached you know it's not you know they don't sit here with the kids and discuss things you know because I am very open with my children you know, anything that happens I am really open with them but you know it's just like...they separate it don't they and then it's like, you know and then they do, the kids do feel a certain way about it you know the kids don't like it.

Researcher: Right yeah. Do they say why they find that difficult when the social worker comes?

Mother: Yeah they just think, like they feel like they're trying to catch them out or catch me out or you know they feel that it's very, you know.

Researcher: Yeah yeah because you were saying that with [practitioner]you feel able to talk freely?

Mother: It's just because you know I don't want to like say the wrong thing and then they think that I'm not on board with the plan or whatever ... So I just feel like some things be misconstrued when you say them and like they view in a different way because you know obviously they've got a job to do as well isn't it, I'm not being you know negative towards them because you know it's great now all the kids are coming back but you know.

"Yeah the thing is with social services you know they're looking for the child's safety and things like that, in them days you didn't have emotional and things like that, if there was a problem then they would just take the children away to somebody else that can deal with that"
Father

The trust afforded to the Gwella practitioners may be possible in part because it is a voluntary service, and parents do not have to take part and there are no conditions that they do so, or consequences if they do not. This likely has some role in setting the nature of the support and the positive outcomes. For example, some parents commented that they were able to ask for support and advice, and to check if they were interacting well with their child, and ask for advice and if they were doing okay with their parenting, and this was something they did not feel able to do with statutory social workers in case it was taken as a marker of their inability to parent or to cope. This helped to facilitate a trusting relationship between practitioner and parent, in which parents could ask for support and receive advice.

Parents and carers also remarked on the different relationship the Gwella practitioner was able to build with their child than that observed with social workers. While this was in the main attributed to the lack of time and busy workloads of social workers, meaning they were unable to engage with children in a consistent or active way, this also indicates that the flexibility, consistency and non-directive engagement characterising the relationship between the practitioner and child is what was perceived as the difference between Gwella and social work support. This is indicated below:

"Yeah we don't see [social worker] that often, we don't do anything like that work with[social worker]. She just comes here, see how the kids are, she's here about five, ten minutes. You know what's he like, is he ok, yeah that's it, any problems? No problems. And then she's gone so that's all with [social worker]. Sometimes she'd take him out for breakfast and have a chat there but he doesn't like talking to people so, he is not a chatty person, he keeps everything to his self. But he was quite chatty with [practitioner], talk about music, where he'd been."
Kinship carer

Interestingly, three of the families reported a clear difference between the games and crafts that social workers had attempted with the child previously, and those undertaken with the practitioner. They felt that the activities incorporated into the support from the Gwella practitioner enabled their children to express and share their emotions in a way that the tools used by the social workers did not – as expressed below:

"I just feel, no they were good like in a way as well because their [social workers'] way of doing things is

pictures isn't it? It's like the pictures, worries, whatever then it's like who is in the happy home, who you didn't want in the home. But like I mean because [child] has done that so many times now that [child] needed this type of help because that to her was like well I've already told you, why do I have to keep doing do you know what I mean. But this type of work was completely different, it was about for her to express herself with her worries and whatever else."
Mother

This was also reiterated by four parents and carers in relation to previous therapeutic support their children had received. Two remarked that this support had not been something their children looked forward to doing, and all four indicated that there had been minimal change with some behaviours (such as bed-wetting, nightmares, lack of confidence, and aggressive disruptive behaviours). The 'success' of the Gwella intervention was therefore also understood in relation to the changes in such behaviours. This lends support to the uniqueness of the intervention, meaning it is not the same as child-counselling and therapy or 'direct' social work.

Ultimately, almost all the families involved, parents and kinship carers universally, relayed that the Gwella intervention was different from other services, because it 'worked'. As discussed in the following section on outcomes, parents and kinships carers saw significant changes in family life, in their own understanding of their children's behaviours and strategies to support them, and in their children's wellbeing. Families felt listened to, and saw change where there needed to see change. Many of the changes and impacts were reported as family and child specific, indicating that the flexible, responsive nature of the approach is what facilitated these.

5.6 Outcomes

5.6.1 Recorded outcomes

Gwella practitioners recorded progress against the following five outcomes for all children:

1. Access to support services;
2. Increased resilience;
3. Improved mental health and well-being;
4. Safe home/service environment;
5. Reduction in impact of trauma.

Each outcome is ranked on a five-point scale, with one being the 'best' score and five the 'worst'. Outcomes were recorded as a starting point at the beginning of work with children and then updated at roughly three-month intervals, with final outcomes recorded around the time of case closure.

The recorded outcomes are largely positive[17]. In all but two cases (N= 29), some improvement is recorded across at least some outcomes. In one of the remaining cases, no change is recorded, however this case ended early when the parent disengaged, so this is not representative of a full intervention year. In one case, an overall decline was recorded, however because this does not reflect the narrative recorded data for this case or in interview, this raises the question of whether the recording system's use of higher scores as worse outcomes has caused confusion for the practitioner when recording. Further detail is in appendix 1.

On average, service users improved across all outcomes:

- 'Access to support services' saw the smallest average improvement (average of +0.86) while 'Increased resilience' saw the largest (average of +1.62);
- The three outcomes with the highest rates of recorded improvement were: 'Reduction in impact of trauma' (N=26), 'Improved mental health and well-being' (N= 27), and 'Increased resilience' (N= 28);
- Fewer service users had recorded improvement in 'Improved mental health and well-being' (N= 19) and 'Access to support services' (N= 16; two cases were also missing data for this outcome). These two categories also had the highest rates of no change

[17] We note that there are cases in year one with one practitioner who reported and recorded positive outcomes, but this was not reflected in the interview with the parent/carers, who reported some negative experiences and/or a lack of positive outcomes. To what extent this is an issue of differing perspectives, and to what extent this is reflective of some positive change, is a subject for further analysis.

shown (N= 11 in both categories);

- In only five cases was no change recorded in 'Reduction in impact of trauma';
- 'Increased resilience' and 'Improved mental health and well-being' showed only three children with no change;
- The only outcomes that showed declines for any service users were 'Access to support services' (N= 2), 'Improved mental health and well-being' (N= 1), and 'Safe home/service environment' (N= 1).

5.6.2 Difficulties recording impact

In many of the practitioners interviews in the first year of the pilot they expressed a concern that they may not have been effecting change, and this was in part due to a difficulty with evidencing impact against the assessments, fixed outcomes and fixed dates to report against these (at three monthly intervals). This was similarly again raised in practitioners' exit interviews, when describing the difficulties evidencing in their recording the positive outcomes for children and families which may have been effected as a result of the intervention. In such cases, perhaps consequently, practitioners did not articulate the impacts of the intervention in the same terms as those expressed by parents particularly, and mitigated these by using words such as 'woolly', 'soft' or 'simplistic'.

This concern about relaying the impact of the intervention was also reported by an education professional who raised that on completing the outcomes form, it did not allow her to communicate the outcomes for one child as she saw them. As noted in section 4.7, this may be down to problems using standardised systems for specific interventions. More generally, evidencing positive change against universal outcomes may be particularly problematic for an intervention with a child-relational focussed approach ultimately offering unique and tailored support. In organisational and project delivery terms, establishing outcomes to report against for such an intervention is equally challenging.

This presents challenges for this evaluation, where we have limited numbers to report against, and where the outcomes for families are individualised. For the purposes of this evaluation it is important to note that the formal outcomes for the intervention and the improvements measured in individual cases do not encapsulate or relay the impact and outcomes reported by those involved in the evaluation. If we consider the focus on the needs of the unique child as essential to understanding the Gwella intervention, we should also acknowledge that unique child and family outcomes are desirable and inevitable, so we have attempted to include a sense throughout this evaluation of families own reports of transformative case experiences and in some cases life-changing improvements. The recorded outcomes also only capture change for children and families, not for associated professionals.

We report below those outcomes described by each participant group, and indicate where the same impacts were raised independently by and corroborated across these groups. We also note instances when impact was considered to be limited.

5.6.3 Reported impacts and outcomes – parents and kinship carers

The 17 parents and kinship carers involved in this evaluation were universal in their praise for the project and the changes that had occurred for them as a result of the work they and their child(ren) had been involved in with the practitioner, and the help and support received. The emphasis on the positive impact the project had made was expressed by all those in this participant group. While some of these impacts were child and family specific, other impacts and outcomes reported revolved around changes in their understanding of their children, changes in their parenting, their own wellbeing, and changes in their child's behaviour and wellbeing.

Of these 17 participants, when reporting on the impacts from the project, 15 spoke of having made a bond with their children, of feeling more confident in their ability to parent, and of understanding how to play and meet their children's needs. Three parents set the significance of this against having previously had their children removed from their care, and as a consequence having had high levels of anxiety and a lack of trust in their ability to parent before the intervention. This was mentioned as especially significant for one mother who had her child returned to her care during the intervention, and for whom the focus of the intervention was on supporting that transition and their relationships together. This mother was now in the process of having all

of her children returned home, and while this wider impact cannot be wholly attributed to Gwella, she credited her own confidence and the confidence of social services in her ability to parent to the support provided through the intervention and the positive transition with her child.

This participant group also marked significant improvements in their children's wellbeing and behaviours. Changes observed were varied, and generally specific to the child and their previous needs, such as: no longer having night terrors or nightmares; being settled at home; no longer expressing fear or being afraid of past trauma reoccurring; being engaged in play and interested in games; making friends; no longer being afraid of the dark and now being able sleep in their room on their own; being able to be alone in their bedrooms; having significantly improved concentration and attention; ability and confidence to express and verbalise their emotions – such as joy, happiness sadness, and their worries; gaining in confidence; having better self-esteem; being aware of their bodies in a positive way; a reduction in risk-taking behaviour; and significantly reduced concerns over harmful sexual behaviour; no longer being sent home from school; less anger and aggression. Two families said that the change was so transformative that they felt they had a different child. Examples of such changes and their significance are provided below:

> *"Well up until when was it? About a month again, [child] was still in my bed. He's in his own bedroom now. But it's just the little things like that are huge to me and [child]."*
> **Mother**

> *"Her enjoyment, she didn't enjoy things before. It was very hard to get her to be motivated or to do any games. To see her laugh I mean how she came on, progressed with that, [practitioner] and I were just amazed you know ... It's unique. This is unique and it's just what [child] needed, and just what I needed. Obviously at the right time. You know it couldn't have come at a better time because I was really at my wits end with what to do with [child]. And maybe this has just saved her from I don't know a downfall because she was so troubled and we can actually see that she's reasoning things through now because she had to do it with the games, she had to think, concentrate, take turns that was a big thing she wouldn't take turns but she learned that."*
> *Mother*

> *"I just think it's really good for like you know trust building and stuff and you know like and just getting that quality time together really. And just learning different ways of coping with [child's] emotions and [child] being able to cope with his emotions because before you know, like before he started any of this work you know [child] wouldn't cry you know he'd just be like whatever was happening, even if he wanted it to or not or anything he'd just you know, just sit back and distance himself and just be like well if it's going to happen it's going to happen or you know whatever like isn't it. But you know like doing the work with [practitioner] you know really helped [child] open up and be like you know no, I don't want to do that, no this shouldn't be happening, this should be. And you know he's cried now which none of us saw him cry at all you know."*
> **Mother**

As indicated above, for some families, a big change for parents was in their own understanding of trauma and its impact on their children's emotions and behaviours, and their own ability to understand and manage this for their children. All expressed this in some way, however for 12 participants they explained that this was hugely significant for them. They spoke of having a changed 'mindset' about responding to their child and understanding their behaviours, or having learned (or being in the process of learning) coping strategies for their children's behaviours and responding to their emotions, or that they were now able to see the perspective of their child and how to respond. As one father explained:

Dad: *I think it worked for me as well because obviously I then started treating him differently. As in rather than shouting at him and telling him off. So once [practitioner] explained that to me and I took it on board what she said and started you know because at the beginning I was like it went against everything I knew about normal life. But I've been using it now a year and it's been fine. It's worked rather than you know.*

Researcher:	*The games or just the way you talk?*
Dad:	*Well I mean our interaction now is completely, cuddles, kisses.*
Researcher:	*How do you describe what it is that they do then, what it is that you've learnt or?*
Dad:	*I don't know you know, it's strange. It sort of sneaks up on you. It's like...I don't know, it's like breaking down barriers I suppose. Yeah that's how I have seen it as. All I know is our relationship from when [practitioner] first came to when she left is a hundred times better than it was. And I don't know if that's a combination of, well it's a combination of me listening to what she's had to say and all the others and taking it on board, and doing it. And the [child] sort of yeah some of the interactions we had when she was here and then we'd obviously do a bit when she wasn't here, worked.*

All parents and kinship carers reported significant improvements in family life as a consequences of the changes described above, such as being able to go on family days out, to the shops, on a holiday. and they were able to enjoy spending family time together, and engage in craft activities and games together. One family described how there were less arguments, and one (separated) mother and father relayed that they were now able to communicate as partners about contact and had established shared routines for their child, and they were able to spend family time together with their child.

Six families reported a change in their involvement with social services because of professionals' change in perspective or confidence about their ability to parent, as a consequence of the intervention. Three families had children returned home to their care, and were maintaining this change, and there were no further concerns about the need for a Care Order for one family. These outcomes were credited to their practitioner advocating to social services on their behalf (about their ability to parent), or to their practitioner for supporting the family throughout this transition; and in some cases the intervention was described as the reason for the return home. Three families described that their cases with social services were now being closed because of the changes they had instigated through the project, and there were significantly reduced concerns and involvement for another one.

As noted above in section 5.2, while some of these changes while firmly expressed and significant, some concerns and anxieties were also expressed by some of the parents and kinship in relation to managing these changes after the end of the project. This was particularly so in the context of additional changes in associated support, and managing the change and the loss of key relationships for children, or instances when other changes (such as a change in school, or other significant family event) were occurring for children. This speaks less to the significance or success of the impact and more to a recognition of the social context for such impacts, and to the need to consider the step-down ongoing support that could be provided for families as part of the intervention.

5.6.4 Reported impacts and outcomes – foster carers

The six foster carer families involved in the evaluation relayed a mixed impression of the impacts from the project. In three cases they were ambivalent about attributing to the project the positive changes that may have occurred for the child in their care, indicating that these were likely because of a move in placement and as a result of becoming more settled. One of these did relay that one of the children in their care had become more spatially aware of themselves and the other had learned some calming strategies as a result of the project. One foster carer relayed that there had been no change arising from the project, and this was because the intervention was not right for their child, and that they were involved in too much provision which affected their child's experience of the project. This was corroborated by the child in their interview, and the practitioner involved relayed that the original referral had been in relation to a previous foster care placement and a concern about managing a transition to this new foster family.

In one instance the foster carer relayed that there had been positive change for the child, who now had calming strategies and had improved behaviour in school. The foster carer also relayed that the changes in the child's behaviour meant she was no longer concerned about whether they could maintain the placement. Only one

foster carer who had originally been involved in the project before the child's return to their parents care took part in the evaluation. This foster carer stressed the important role the project played in supporting the child and parents, and attributed the return home to the intervention, as she explains:

> *"I whole heart, hand on heart believe [Child] wouldn't have gone home without it, and he wouldn't have made it... 100%. He would not have stayed at home without this in place. And if this is how other children are with this project, this most probably keeps loads of families together. I reckon one of the best things that ever happened. I really believe [Child] wouldn't have made it without this. He is one of these cases that I had huge concerns about him going home without support and when I could see what it was doing and what was being put in place, that structure and the tools that were given from [practitioner] to [Child], he would not have coped without them. So and I can come home thinking he's going to be ok. But [practitioner] was quite natural. But she just listened, she was really attentive on everything, she listened to his concerns what his worries were. She made sure she went back and done, listened to all that [parents] worries were. She sort of put it together and put a plan from there. It wasn't just well you'll do this this and this, she knew that it had to be tenfold because this was the last chance that this little boy had of where he was staying. And without her, he, [Child] wouldn't have stayed, it wouldn't have got to this."*
> **Foster carer**

This was corroborated by the parents of the child, however, as noted above, there were some concerns after the end of the intervention from the parents about the child's behaviour and their need for ongoing support.

Two foster carers relayed disappointment with the project; as previously noted, this was in relation to the inconsistency in the support for the child. In both cases they stressed that from the work that was undertaken, they believed the project could have had a significant outcome for their child, but the intervention was not completed. They also said mentioned the important relationship that had been built with the practitioner, and the possibilities for this relationship to facilitate positive outcomes.

Four of the six foster carer families reported positively about the case formulation or 'trauma timeline' and how it had helped with understanding their child's needs and with having key professional relationships also understand the child's experience of trauma and their concerns; two specifically expressed this as a positive outcome. In an additional case, the foster carer relayed that the timeline had been helpful to remind her of the trauma her child had experienced, and she had learned of experiences that she had not known about (and felt she should have known about). This foster carer did not engage in the intervention seeing it as something positive for her foster child, and for her, a positive outcome was that her child no longer used her trauma as an excuse for her behaviours. This relays a different perspective on what trauma-informed might mean, and corroborates with some of the practitioners feedback that they felt they had not been able to make significant outcomes with some foster carers in that regards.

5.6.5 Reported impacts and outcomes – children

The children involved in the research gave positive responses about the intervention. The majority spoke of all the games and activities they liked to do, and of missing their worker. Seven of the children specifically said that their practitioner had helped them to feel calmer, or they liked them because they helped them to think or to feel differently about things, or they felt happier and they did not have worries anymore.

Drawing by child, aged 9

The drawing above shows a picture a child drew of herself and her worker. The child explained to the researcher

that she and her worker were holding hands and they had made it to the top of the steps together, to show that her worker had helped her. The child whispered to the researcher that her practitioner made her feel better now, because she had been able to talk to her practitioner about her mum and things that had happened with her dad, and this had helped her.

Some of the children explained how they had been able to talk about things that worried them with their worker, and they described activities they had learned which helped them to feel better when they were feeling worried or sad or angry. They described mood boxes, worry books, and other activities. As in the example below:

Researcher:	*So your unicorn book, was it a colouring book?*
Child:	*Yep it was like colouring book, it has like stars and castles and unicorns and things like that.*
Researcher:	*And how come [practitioner] gave you that, just as a present or?*
Child:	*Like the like she gave it to me because like I was sad and I had worries and things like that she gave it to me to stop having my worries. If I am sad I get to colour in my, and I bought a book just in case, if I'm happy I draw a happy one, if I'm sad if I draw a sad one. [...]*
Researcher:	*So you were going to say something else about [practitioner].*
Child:	*Me and [practitioner] up Daddy's we made like a bottle and then we put some things in and then when I am mad or like when I'm sad I shake it like that, shake shake shake.*

As noted previously however, one child said that although she had liked her worker and some of the activities she had been involved in, she did not think it had made any difference for her.

5.6.6 Reported impacts and outcomes – external agencies

Professionals from other agencies mainly spoke of positive outcomes for families, corroborating the impacts expressed by parents, carers and children.

Social workers spoke of positive outcomes including some children being able to return to parental care, having no more concerns over the need for care proceedings, and closing cases. They also reported that the intervention had contributed to the success of rehabilitation plans, whether this be a move back to parental care or to a new foster family. In these instances they reported that children were presenting as settled, secure in their life and placement, and had improved self-esteem. Parents were perceived to be attentive to their child's needs, that a bond had been built with their child(ren), and they had strategies to manage their children's behaviour in a crisis. Other impacts were that the intervention had made a difference for parents anxieties and ability to engage with professionals, and similarly that the intervention had helped with building parent's trust in professional agencies, which had then been positive in their own work with those families. These impacts were attributed to the activities engaged in, the duration and consistently of the contact and the relationship practitioners were able to form with parents and children. As two social workers explained, below:

> *"And mum as I said, she was really difficult to sort of express any emotions, showing emotion was always to her a sign of weakness whereas now you know she will go and hug the children, they do enjoy doing activities together. She has really learnt how to appreciate family time and just sort of basic things like cooking together and being able to talk to each other. And you can see the children have really appreciated that and you know they're thriving on it now and we're actually looking to close the case to social services."*
> **Social worker**

Researcher:	*Ok. And yeah...who would you say in the family has benefited most, if relevant?*
Social worker:	*I would say the parents and the children, I think it's equal definitely. Probably the parents more so.*
Researcher:	*And what do you think are the key reasons for that in terms of Gwella or [practitioner]'s work specifically?*
Social worker:	*I just think it's the intensive work they've been able to do and getting into the family home and just being open and honest and saying these are the goals I would like to*

achieve, this is what we're going to do and this is how we're going to do it. I think just getting into the family home, building that relationship, building the trust and the rapport with the family, I think it's just been hugely beneficial. And plus, linking with other professionals.

Social worker: No I just, I can't praise it enough. I think it's been, and we have seen that huge turnaround that this time last year nobody would ever have predicted. It's just amazing, I think it really is beneficial

Two social workers reported that the project did not have positive outcomes for two families, and could have had a negative outcome, but this was understood to be wholly due to the absences and disruption in the intervention experienced by these families.

As considered previously, all social workers who took part in the evaluation relayed positive outcomes from having been involved in the case formulation work, stating that this had increased their understanding of trauma, that this had led to a change in thinking either through giving perspective on a specific case, or more broadly though an improvement in their general practice:

> *"sometimes in terms of our involvement you know we move in with families when they're in crisis situations and a lot of it can get lost because you're almost trying to work with the families to overcome the issues right there. But having that understanding of you know why we have got to this point with [child] you know what were the repeated moments of trauma that he'd encountered and the impact you know on his development you know that was really interesting as well yes I enjoyed that. Certainly you know I involve it in my practice now."*
> **Social worker**

Education professionals involved in the evaluation who were involved in case formulation meetings also reported that this had changed their understanding of a specific child's behaviours. They also reported positively about children's improved classroom behaviour, less need for in-school support services, better academic and social performance, increased trust, and children expressing their needs verbally, and no further bullying or aggression in school. They attributed these changes in the main, to the intervention's focus on work with parents and in the family home:

> *"I think the outcome is that we have a happier family. We have a family that hasn't got as many arguments, as much disruption, we haven't got the police being called you know the children aren't seeing violence. And just the biggest outcome is happier children, happier homes, happier parents. And parents who are ready to parent and not just argue with each other, they're seeing what actually is important and the importance is the child. So I'd say that's the biggest outcome is that how we've turned, well the Gwella project and everybody else involved, we've seen this family completely turn around. So I'd say that's the biggest outcome is happier children, happier home"*
> **Educational professional**

In one case, two education professionals involved reported no change in the child's behaviour and relayed that the child was being more disruptive in school after having met with the practitioner.

5.6.7 Summary of outcomes

The above findings indicate some themes that could be incorporated into the existing five outcomes in planning for a future project. Improved understanding of trauma – for parents, carers and professionals; positive changes in family life; improved family relationships; settled transitions; reported improvements from external professionals – case closure or reduced concerns, positive school engagement. While not reported directly as an outcome by participants, given the emphasis by almost all those involved in the evaluation on the importance of the trusting relationship between the practitioner and the parents, carers and child, and on the skill and the time required for the practitioner to develop and build that trust, these relationships could themselves feature as a key outcome. Particularly so for interim reporting, given the emphasis by all on the importance of the 12 month period for facilitating impact.

5.7 Two case studies

The following two case studies provide examples of the intervention in practice, drawing attention to aspects of organisation, implementation, and delivery, and their connection to outcomes. In the first case, the experience was very positive with very positive outcomes, whereas the second case draws attention to the ways in which organisational challenges and a rigid interpretation of the approach can contribute to a less positive experience and outcomes for children and families.

Case study #1: *The Grant family. Lucy is seven years old and was referred to Gwella because of trauma relating to familial substance misuse and witnessing domestic violence, as well as witnessing challenging behaviour from her older brother. She was having trouble dealing with her emotions and she was having night terrors. Lucy was living with her father and had limited contact with her mother. Her mother and father were not communicating well. The Gwella project worker was meeting with Lucy and with her father fortnightly, on alternate weeks. The focus in the worker's sessions with Lucy's father was on understanding ways to support Lucy's emotional needs. The focus in sessions with Lucy was on helping her understand her emotions and become more confident in handling things she found difficult. Some sessions they did all together and engaged in creative play activities. Lucy's mother later became involved in some of the sessions with the practitioner.*

Involvement with the project ended after 12 months, which was the original end date for the planned Gwella intervention for Lucy. At the end of this period, Lucy was no longer experiencing night terrors, and her parents reported her confidence and emotional stability had improved greatly. School contacts also reported that Lucy's behaviour in school was much better and that she was no longer discussing traumatic events from her past as though they were still happening. Lucy's Gwella worker also recorded improvements to recorded outcomes for Lucy, including a safer home environment (+2 points) and reduction in impact of trauma (+2 points).

In interview, the parents highlighted that with the various difficulties the family had experienced, there were a number of professionals involved in supporting them, but that while many of these professionals were working with a specific family member (such as the older brother), Lucy had not previously had any dedicated support. They also felt that previously they had not received support to help them understand how to help their children. The parents spoke positively of the impact that the relationship with the Gwella practitioner was able to have for Lucy because she was able to feel more individually supported and this gave her an opportunity to open up to someone about her feelings and experiences in a way that she had not been previously able. Lucy's mother and father both reported feeling confident to be able to play games and have fun with Lucy, and this would help her with her emotions. Both parents explained that the Gwella practitioner had helped them to understand how to build a connection with Lucy and how to help her explore emotions and feelings.

In her interview about the research, Lucy relayed she liked when her Gwella worker had helped her with ways she could express her anger. She said that it made her feel less angry when she used the things (tools) they had made together. She said that she had lots of fun when they played together, and she liked her worker because she was fun, kind, and had a beautiful smile. Lucy drew a picture for the researcher, which showed her identifying the difference between things that were sad and things that she worried about, alongside the emotions 'happy', 'like', and her favourite things. She also said that she does not always like to think about the project worker now because she misses her and it makes her sad that she can no longer see her.

Case study #2: *The Morris family. Olivia is twelve years old and was referred to Gwella because of significant trauma from a neglectful and physically abusive home environment, followed by a foster placement which was also neglectful. Her new foster carers were also concerned about her confidence in social situations with peers and aggressive behaviour, along with vulnerability to future exploitation. Olivia's involvement with the project lasted almost 8 months, at which point Olivia's foster carers chose to decline further involvement. They reported that engagement with the Gwella worker was inconsistent because of cancellations. Some of the cancellations were due to scheduling conflicts for the family, and some were due to weather conditions, but the significant majority of cancellations were due to practitioner illness. Olivia's foster carers expressed disappointment that there had not been provision for sickness cover within the project.*

When Olivia's foster carers were offered a new Gwella worker, after a period of absence of the original worker, they declined because of their concerns about the short time remaining with the project and the difficulty they felt Olivia had experienced with the project up to that point. While the foster carers did say that Olivia liked the Gwella worker and responded positively to her at first, they reported that later, Olivia resisted engagement sometimes. Her carers felt this was because of the impact of the cancellations and inconsistency of the sessions.

Olivia's foster carers did speak very highly of some of the work that was done, particularly the trauma timeline produced at the start of work (in the case formulation meeting), and the last session done with Olivia which focussed on bullying and empathy. They referred to Olivia's last session as a 'breakthrough' for her and expressed regret that the work was ended at this point due to the Gwella worker's absence and then later departure. However, they also expressed disappointment that the activities had not seemed designed to respond to Olivia's needs, and they felt that the project had not been realised as the therapeutic service they had hoped for. The foster carers were very positive about the concept and structure of the Gwella intervention, but said that there needed to be inbuilt staff resilience to cope with unforeseen circumstances like illness.

Ultimately, the foster carers felt that Olivia's involvement with the Gwella project had not helped her, and although they did not feel it had made things worse, they expressed that they thought things could have been better for her by now if the intervention had gone differently. This both confirmed that they were positive about the idea of Gwella and the possibilities it could achieve, but that the delivery and processes form a key part of its success. It was decided in light of these experiences that involving Olivia in an interview would not be in her best interest.

Section 6. What is the Gwella intervention, and how can it be delivered effectively?

The 'process' evaluation aimed to present a detailed outline of the scope and organisational aspects of Gwella in order to inform possible future replication or expansion in Wales or nationally. We aimed to identify how the intervention and approach was realised in practice, and explore organisational issues relating to its implementation in order to identify both effective and ineffective practice, and any obstacles. We also sought to identify those methods and strategies found to 'work best' in project delivery, to ensure that lessons can be learnt and to identify potential strategies which can avoid recurrent problems and/or ameliorate their impact.

6.1 The Gwella intervention in practice

As stated in the introduction, Gwella was a unique approach and the project to deliver it was a pilot, so there was no prescriptive manual for the intervention. The following brings together the analysis to detail the features of the intervention in practice.

The Gwella approach was a trauma-informed, relational and play-based approach to working with children and families. The uniqueness of the approach is its central focus on understanding and being led by the needs of parents, children and carers, and its flexibility to draw on a range of established techniques and methods (such as the TRM, Theraplay, PACE, among others). This enabled practitioners to be responsive to the varied, and family specific nature of concerns, and work with parents, carers and children to identify areas of support that were important to them.

The flexibility within the delivery of the intervention made allowances for working around the potential contradictions between those methods and approaches within the principles of the Gwella approach, and this flexibility was viewed as a key strength of the intervention.

There were varied practices amongst the practitioners in terms of how the intervention was employed with children, parents and carers, and the activities and tools utilised.

From the data it was possible to deduce that there are three key aspects directing the delivery of the intervention in all cases:

1. The intervention was 'trauma-informed', meaning a recognition of the specific trauma experienced by a child, the needs that may be present or exacerbated as a result of the trauma experienced, and the impacts such trauma may have on their behaviours. The intervention in this regard did not focus on the trauma itself, and it also allowed for an understanding that there may be a range of reasons behind those needs and behaviours;
2. The intervention primarily focussed on relationships, and on understanding and working to support the child in the context of their key relationships, including the broader professional network around them;
3. The intervention incorporated play-based creative methods and activities to facilitate relational working in a participative and trauma-informed way.

A focus on relationships was therefore at the core of the intervention in all cases, in one or more (or all) of the three following possible ways:

- *The relational bond between parent/carer and child:* supporting parents/carers and children to build on their relational bond and connection;
- *Supporting the relationship between parent/carer and child:* focussing on supporting parents and carers in their 'emotional literacy', and in helping them to understand and plan strategies to respond to their child's behaviours in a trauma-informed way;
- *Building a relationship and connection with children*: one-to-one work between the practitioner and child, focussing primarily on building and modelling a positive trusting relationship with an adult. A key part of this support was the play and activity-based nature of the interactions.

Alongside the above was work to support:

- *Relationships in the system around the child:* supporting children's relationships in and across the wider network of professionals around them.

6.2 The framing of the intervention

The psychological framing of the approach is potentially problematic, operating in a social care context by social care professionals. The intervention's primary focus on relationships and the relational context around the child suggests that, in practice, Gwella is primarily a social (relational) intervention. If the assumption among external professionals is that the intervention is a trauma-led (psychological/ counselling) intervention, this has the potential to undermine the professional expertise of practitioners, and misrepresent the intervention.

Ultimately, the psychological framing may not be helpful for describing what the intervention is and how it works in practice. We suggest that the cross-overs between social and psychological theories may be helpful here, and complimentary languages such as relational and dialogical approaches, along with co-production and children's rights, could be embedded within a reframing of the approach to better reflect the intervention.

6.3 A consideration of the principles behind the Gwella approach

The below provides a consideration of the ways the principles set out in the Gwella approach featured in the data, in terms of the way they informed practice and were realised in the delivery of the intervention.

Trauma Recovery Model

The data suggests that the TRM model was used primarily for directing attention to the specific needs of children, and the ways in which these needs may be exacerbated by the trauma experienced, and underpin behaviours. Not all practitioners engaged with the TRM in terms of assessment or directly within their workplan with some of their cases.

The emphasis of the TRM on establishing relational safety and a secure base prior to implementing a support plan to progress additional (therapeutic) outcomes, provides a helpful way of framing the purpose of the play-based and one-to-one work, and for monitoring/evidencing ongoing progress.

How much Gwella's benefit was associated with a focus on childhood trauma and development was mixed. Some participants appeared to simply value improvements from better understanding of a child or family's perspective, circumstances or current issues. There is a long tradition in social work around the value of network and multi-agency guidance, separate to a trauma orientation. This is often driven by other models such as child rights or dialogical approaches, and at least one Gwella practitioner raised the importance of holding other perspectives as important outside of a trauma focus.

Multi agency case formulation

The case formulation was highly valued, almost universally, by participants who took part in this process. The identification of trauma and traumatic events for individual children was important for understanding children's needs, and informing practice in a range of contexts in order to respond in a trauma-informed way. The case formulations were also a mechanism for establishing support for the project. There were however concerns about the time-commitments needed for travelling to and attending these meetings. There were also logistical challenges for arranging these.

The 'case formulation approach' is informed by clinical psychotherapy and child development theory, however it shares similarities to the 'enhanced case management timeline' tool utilised within support approaches for the YOS, and also event timelines utilised within social research techniques as a tool for marking specific events and the meanings such events may have for participants. Given the challenges with accessing specialist consultation, particularly if the project is expanded, it may be possible to adapt this process to the expertise of Gwella practitioners, so that the process is not confined to clinical expertise. This would need careful consideration, and also attention given to whether some of the support from external professionals was gained through this specialist input.

Relational based play

The intervention clearly engages with relational play, in a number of ways. A key focus of practitioners' work was the play and activity-based nature of the interactions, which incorporated a number of creative activities, music and

drama techniques, based on the interests of the individual children they were working with. The specific reference to Theraplay within the approach may be unhelpful, and does not reflect the diverse individualised responses and non-prescriptive approach to intervention modalities employed by practitioners.

Integrating with existing plans

This was an important part of the intervention from the perspective of parents, carers and external professionals. When the intervention worked well, Gwella can act as a helpful point of contact for all involved (including families) providing an informed perspective on behalf of families and external professionals. Another indication that the intervention worked well and complimented support is that there were several families for whom by the end of the intervention their case became closed to social services and other agencies. This aspect of the intervention is considered more fully in relation to outcome in section 7.

PACE approach for primary carer

Practitioners employed the PACE approach in a number of their cases, but not all – notably this was less likely to inform the work with foster carers. As indicated in the analysis, practitioners were flexible in their delivery of the approach drawing on the PACE principles where useful and appropriate, even if not directly in their work with parents and foster carers.

Supporting healthy child development

Almost all participants spoke about and evidenced their understanding of the effects of traumatic experiences on children's behaviours, as well as evidencing an understanding of how to recognise what may have been experienced as traumatic. From the data it suggests that regardless of the theory behind the intervention, in its delivery it aided an understanding of the impact of trauma on *children's behaviours and their emotions.* This does not specifically relate to and therefore require an understanding of child and/or brain development for delivery of the intervention, or to evidence this understanding as an outcome amongst families, carers and external professionals.

6.4 Key messages from the process evaluation

In addition to the above considerations for the Gwella approach and the intervention in practice, the following details further key messages and considerations from the evaluation in relation to organisational planning and project delivery.

The relationship between the practitioner and children, carers or parents

A trusting relationship between the practitioner and the parents, carers and child, is key for successful delivery of the intervention and achieving outcomes. Parents and carers recognised two qualities of what they felt characterised an effective professional: the ability to craft a positive relationship; and relevant skills and expertise in understanding trauma, and practising child and needs-focussed support which could be exercised respectfully.

Consistency and the consequences of staff absences

Consistency in the relationship was also key to the perceived success or failure of the project. This is particularly important for ensuring that the relationships formed do not mirror previous trauma and rejection. The consequences of disruption through practitioner absences and giving notice were noted as hugely significant by all involved. This indicates that organisation of provision itself needs to be trauma-informed and allow for consistency and stability.

Flexibility with the intervention

A key strength of the approach is its central focus on understanding and being led by the needs of parents, children and carers, and its flexibility to draw on a range of established techniques and methods (such as the TRM, Theraplay, PACE, among others). This enabled practitioners to be responsive to the varied, and family specific nature of concerns, and work with parents, carers and children to identify areas of support that were important to them.

Using modalities more flexibly and eclectically, was in keeping with being responsive to unique family situations. Practitioners rigidly followed a technique and being method-led (rather than needs-led), informed a less positive experience of the intervention and whether it was suitable. Work with foster carers required an increased emphasis

on flexibility to depart from elements of the approach. Foster carers were more likely to appreciate and express support for direct work undertaken with children and for work which developed their knowledge about the child's behaviours and needs.

Duration

The findings support the 12 months of provision for the delivery of the intervention. The views of participants and the reported experiences of service withdrawal amongst children and parents indicate the need to embed these 12 months within a period of tapered support.

The analysis suggests that the duration of the intervention is crucial for the immediate and long-term success of the intervention and outcomes for families in three ways;

- firstly to build the necessary trust that is vital to facilitate practitioners' ability to engage, appropriately assess, and plan support with parents and children;
- secondly to facilitate step-down endings that provide some level of control for children and parents; and, connectedly;
- thirdly, to ensure that the intervention is withdrawn according to an assessment of the needs and situation of the families, rather than being driven by organisational set-up and funding limitations.

The extent to which the project has the ability and resources to facilitate all three considerations will also determine the extent to which it can be 'trauma-informed' in its organisational practice and delivery. The challenges and negative experiences associated with exiting from the program ultimately raise the question of how this echoes the child's experience of past relational losses, and whether an approach can provide the child with some level of control over the exit process.

Caseloads and flexible support arrangements with families

Consideration should be given toward the extent to which families can be impacted by seemingly innocuous professional-led logistical arrangements. Relational working involves the recognition of how work practices will be experienced and may impact on children, parents and carers. These can help to facilitate trust and their positive engagement with the practitioner.

The flexible approach to working with parents, carers and children was significant in shaping the working relationship which was itself crucial to the success of the intervention. The very broad diversity of arrangements facilitated the bespoke intentions of the intervention.

It is important that a child-centred approach is adopted throughout all aspects of the organisation of the project, if the aim is to be trauma-informed and child-focussed.

Key to enabling such an approach was the caseloads of practitioners. Practitioners reported that their caseloads afforded the ability to work flexibility with their arrangements, and with families and children in sessions, such as extending these or finishing earlier and arranging to visit again on a more suitable date. This flexibility also helped to support consistency with weekly visits.

Multi-agency working and the trauma-informed network around the child

Given that multi-agency partnership working plays a key role in the intervention, the findings speak to a need to consider how to build a robust and resilient system of co-operation among involved professionals. Involvement with social services and open communication with social workers involved with families is key in terms of facilitating practitioners ability to effect practice and existing provision, and influence the network around the child.

The number of professionals involved is less important for the success of the intervention. A salient point is whether practitioners are able to work with the relevant agencies and identified professionals for whom there is significant meaning or potential impact for the case.

Consideration should be given to involving children's extended family members and other key relationships in the case formulation or work to facilitate a trauma-informed network. While only suggested by one participant in the evaluation, it does raise the important point about who is recognised as being part of the trauma-informed network around the child, and the tendency within social care practice to focus on systems and

professional relationships. This would reflect the relational ethos of the approach.

Support, supervision and training

While it is not uncommon for regular supervision to be a challenge in busy social care environments, the importance of support through supervision for the approach needs to be emphasised. There are emotional demands of the role, the approach is about transformation which entails a level of monitoring, while the multi-skillset aspect of the approach, in which practitioners are expected to be competent across several specialised methods and approaches, all need to be supported by regular supervision and contact with the team, particularly so given the nature of remote working. The model supported through the findings is one of regular individual supervision, a pairing system for more informal peer support, with regular group supervision and team meetings as a more formalised mechanism of peer support.

Clinical expertise is essential to the intervention for facilitating an understanding of trauma and talking through the practitioners' plans for work. Practitioners were more confident in their role when they received clinical supervision in a form less directed by specific interventions models and approaches, rather than for consultation on the specific techniques and models that form part of the overall Gwella approach.

The flexibility of the intervention encouraged an active culture of seeking new knowledge and skills, which were actively integrated into the flexible delivery of the intervention. This should be supported. Embedding time within practitioners workplans for recording as a reflexive activity, could support this learning environment, while also promoting this as a meaningful use of time for practitioners.

Training in the Theraplay, the TRM and DDP methods is an important part of developing the skillset of Gwella practitioners, but the level of training and whether practitioners require ongoing support is dependent on the extent to which practitioners assess the relevance of these methods in their workplan with each child and their family.

Training and staff development is an important aspect of the organisation of the project. This has implications for staff turnover and induction; which also connects to the wider funding context. The significant investment in training, and the development of a rich skillset with exposure to specialised techniques, as well as creative, relational and play-based work, indicates that this pilot established a highly skilled workforce, and to lose that human capital through funding related turnover is significant.

Funding context and associated pressures

We note that the wider context of time-bounded funding had implications for the implementation and delivery of the project. Pressures arising through funding and reporting arrangements are not unique to the Gwella project but are notable, due to their particularity to short-term funded projects, more so when these are innovative and complex, aim to be relational and child-centred, and are designed to work with existing provision and external agencies so need time to 'bed-in'. Some negative impacts on child, family and practitioner experiences from organisational factors, such as workers breaking off relationships with children early due to funding arrangements and short term employment contracts, demonstrate how aims to be relational and child-centred can sit in tension with organisational arrangements. How organisations and commissioners consider and mitigate impacts arising from these kinds of conflicts is a key challenge.

Section 7. What are the outcomes from the Gwella intervention for children and families, and what is the 'added value' of the project?

The outcomes focus of the evaluation aimed to consider progress against project established outcomes recorded through Barnardo's casefile system and to detail the impact of the Gwella intervention on outcomes for children and families by understanding and examining these from the perspectives of children, families and carers, and those involved in key areas of their family life as well as Gwella practitioners. This part of the evaluation also considered why and how Gwella made these changes, and consider any comparisons to other supports or interventions (where service users have previous experience of similar service supports).

7.1 Key findings: outcomes

The recorded outcomes for cases are largely positive. In all but two cases (N= 29), some improvement is recorded across at least some of the five outcomes: Access to support services; Increased resilience; Improved mental health and well-being; Safe home/service environment; Reduction in impact of trauma.

Evidencing positive change against universal outcomes may be particularly problematic for an intervention with a child-relational focussed approach ultimately offering unique and tailored support. In organisational and project delivery terms, establishing outcomes to report against for such an intervention is equally challenging.

The 17 parents and kinship carers involved in this evaluation were universal in their praise for the project and the changes that had occurred for them as a result of the intervention. While some of these impacts were child and family specific, other impacts and outcomes reported revolved around changes in their understanding of their children, changes in their parenting, their own wellbeing, and changes in their child's behaviour and wellbeing.

The children involved in the research gave positive responses about the intervention. Seven of the children specifically said that their practitioner had helped them to feel calmer, or they liked them because they helped them to think or to feel differently about things, or they felt happier and they did not have worries anymore.

The outcomes relayed by participants indicate the following themes which could be incorporated into the existing five outcomes in planning for a future project:

- Improved understanding of trauma: for parents, carers and professionals;
- Positive changes in family life; Improved family relationships;
- Settled transitions;
- Reported improvements from external professionals: such as case closure or reduced concerns; and positive school engagement;
- The importance of developing a trusting relationship between the practitioner and the parents, carers and child to achieve outcomes means that these relationships could be a key outcome. Particularly so for interim reporting, given the emphasis by all on the importance of the 12 month period for facilitating and evidencing impacts.

Professionals from other agencies mainly spoke of positive outcomes for families, corroborating the impacts expressed by parents and children shared:

- These impacts were attributed to the activities engaged in, the duration and consistently of the contact and the relationship practitioners were able to form with parents and children;
- Two social workers reported that the project did not have positive outcomes for two families, and could have had a negative outcome, but this was understood to be wholly due to the absences and disruption in the intervention experienced by these families;
- Some also referred to a reduced workload with a specific child as a consequence of the project, because they were no longer engaged in constant crisis management. This suggests possibilities for future evaluation of cost savings, which might offset costs related to Gwella.

The case formulation or trauma-timeline work undertaken with professionals and carers was an important mechanism for gaining professionals' commitments to the intervention and for facilitating an understanding of what it means to be trauma informed:

- All social workers who took part in the evaluation relayed positive outcomes from having been involved in the case formulation work, stating that this had increased their understanding of trauma, that this had led to a change in thinking either through giving perspective on a specific case, or more broadly though an improvement in their general practice;
- Education professionals with experiences of the case formulation meetings also reported that this had changed their understanding of a specific child's behaviours;

- There was a mixed impression of the impacts from the project among foster carers, however the majority of foster carer families involved in the evaluation reported positively about the case formulation, emphasising that this had helped with understanding their child's needs.

All participants gave an important emphasis on the trusting relationship between the practitioner and the parents, carers and child, for achieving outcomes. Other factors to note are:

- The skill and social care expertise of practitioners;
- The duration of the intervention;
- Small caseloads;
- Independence from social services;
- The flexibility to draw on different techniques and work across or focus on a particular relational aspect of the intervention;
- The flexibility to work across practice boundaries e.g. edge of care, restorations to parents, foster care, child protection

Given the importance of the role of the practitioner in project delivery and outcomes, we also note that peer support, line management and psychological supervision have an important role to play in the successful delivery of the intervention. We also note the importance of facilitating a supportive creative learning culture, and access to training.

While outcomes were firmly expressed and significant, there were some concerns and anxieties in relation to managing these changes after the end of the intervention. This was particularly so in the context of additional changes in associated support, and managing the change and the loss of key relationships for children, or instances when other changes (such as a change in school, or other significant family event) were occurring for children. This speaks less to the significance or success of the impact and more to a recognition of the social context for such impacts, and to the need to consider the step-down ongoing support that could be provided for families as part of the duration of the intervention.

7.2 How has Gwella 'added value' to the system around the child?

To conclude, we consider the ways in which Gwella provided 'added value' as a project. The evaluation identified three key things the Gwella intervention did to enhance performance of the system around the child:

- First, it provided guidance to external professionals by leading a 'case formulation' meeting with a focus on trauma, held at the outset, to share knowledge of a child's circumstances with reference to the potential impacts of trauma on their behaviours and the possible wellbeing needs arising in connection to the experiences of such trauma. These case formulation meetings were highly regarded by participants.
- Second, Gwella practitioners supported external professionals ongoing work, providing guidance through contacts and meetings. This ongoing engagement was highly valued by those external professionals who had regular contact with practitioners, but was less notable where contact was minimal. There was no clear pattern to which external professionals had strongest engagement, although it appeared that the external professionals own interest and commitment was a key factor. A second factor appears to have been the Gwella practice location, with stronger engagement where work was scheduled in a professional's location, such as a school. The Gwella practitioner's strong knowledge of the child and family gained through an ongoing (and non-threatening relationship) allowed them to provide important guidance to support external professionals' work.
- Third, Gwella practitioners added value in the system through the 'spin-off' effects of their ongoing direct work with children and families. For example, parents who had children restored to their care or were at the edge of care, reported how their confidence and family dynamics were improved by involvement with the Gwella practitioner, although also highlighting a level of anxiety over the end of the intervention, given the lack of that relational practice elsewhere.

Primarily, external professionals described Gwella in terms of how the relationship between the Gwella practitioner and the child or family provided them with better knowledge and confidence about that context. It was notable that Gwella practitioners' roles contrasted strongly with those of external professionals who appeared to generally have limited time and scope to build a relationship with an individual child or family. Ultimately, the success of the Gwella practitioners in this area was due to a mixture of factors: a strong positive response to the initial trauma-focussed case formulation; added value experienced from practitioners ongoing multi or cross agency engagement; and a spin-off impact for families in the system.

As discussed above, families reported a change in their involvement with social services because of professionals' change in perspective or confidence about their ability to parent as a consequence of the intervention. Three families had children returned home to their care, and were maintaining this change, and there were no further concerns about the need for a Care Order for one family. These outcomes were credited to their practitioner advocating to social services on their behalf (about their ability to parent), or to their practitioner for supporting the family throughout this transition; and in some cases the intervention was described as the reason for the return home. Three families described that their cases with social services were now being closed because of the changes they had instigated as a result of the intervention, and there were significantly reduced concerns and involvement for another one.

Gwella practitioners were in a unique position to achieve outcomes for children and families due to the trust afforded to the practitioners by the children, parents and carers involved. The flexibility, consistency and non-directive engagement characterising the relationship between the practitioner and parents, children, and carers was perceived as the difference between Gwella and other supports and social care involvement. The voluntary and independent nature of the service likely has some role in setting the nature of the relationship between practitioners and families, and the positive outcomes achieved. The uniqueness of the intervention was also indicated by the reported clear differences between the creative activities engaged by the intervention and similar methods employed by social workers.

Final comments

All the parents and kinship carers involved in the evaluation reported that they were very pleased to have taken part in the project. Foster carers also in the main reported positively about the intervention, even if they later felt that the initial expectations were disappointed and they declined further involvement, or when they also reported that they felt the service was not appropriate for their foster child and their circumstances. We had a relatively low take-up of involvement in the evaluation from professionals in partner agencies, but those who did participate were almost universally enthusiastic about the prospect of future involvement with Gwella. External professionals involved in the evaluation remarked on the need for the project, and its contribution to the work undertaken with families. The only exceptions to this were where professionals raised concerns about their experience of implementation (e.g., about the time taken for the referral process, or about resiliency of the Gwella team in relation to staff absences) but reiterated their overall positive impression of the intervention itself and the potential benefits for children and families.

Appendix 1: Recorded outcomes

The table represents improvement as positive numbers, decline as negative numbers, and no change as zero[18].

Table: Rates of improvement from first to final recorded outcomes, for each child

Age	Services	Resilience	Mental Health	Environment	Trauma	Average
8	0	+1	+2	0	+1	**+1**
10	+1	+1	+1	0	0	**+1**
9	0	+1	+1	0	+1	**+1**
6	0	0	0	0	0	**0**
7	0	+1	+1	0	0	**+0**
11	+1	+1	+2	+1	+2	**+1**
9	+2	+2	+2	0	+2	**+2**
9	+2	+2	+1	+1	+1	**+1**
8	0	+3	+2	+2	+3	**+2**
6	0	+2	+2	+2	+2	**+2**
8	+1	+2	+1	+1	0	**+1**
11	-1	+1	0	+2	+2	**+1**
7	+3	+2	+2	+3	+2	**+2**
6	+3	+3	+3	+4	+2	**+3**
10	-3	0	0	-4	+1	**-1**
9	+1	+2	+1	+1	+2	**+1**
9	0	+2	+2	+2	+2	**+2**
7	0	+2	+1	+1	+1	**+1**
9	Missing	+2	+2	+2	+2	**+2**
11	Missing	+2	+2	+1	+2	**+2**
5	+1	+1	-1	+2	+2	**+1**
10	+3	+2	+1	0	+1	**+1**
10	+2	+2	+2	0	+1	**+1**
8	+4	+4	+4	0	+3	**+3**
9	+1	+2	+2	+2	+1	**+2**
7	0	+1	+2	+1	0	**+1**
11	+1	+2	+2	+2	+1	**+2**
9	+1	0	+1	+1	+1	**+1**
11	0	+1	+1	0	+1	**+1**
7	0	+2	+1	0	+1	**+1**
8	+2	+2	+3	+3	+3	**+3**
	+1	**+2**	**+1**	**+1**	**+1**	**+1**

[18] For the sake of clarity although lower numbers are better on the Barnardo's scale, the table represents the difference as a positive number to show improvement and a negative number to show decline.