

Preventing Family Breakdown Team

A guide to how we work with families

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# **1. Background to the Preventing Family Breakdown Team**

The PFBT is an intensive, evidence-based team within Derbyshire Childrens Services, firmly rooted in Derbyshire’s “Stronger Families, Safer Children” operating model. This is a strengths-based model that attends to risks and worries in a balanced way. It is child focused and rooted in evidence-based practice. The SFSC model and the three key approaches (systemic, person centred and social pedagogy) equip practitioners, Managers and partner agencies with ‘tools’ to support good practice. However, the model is more than just a ‘toolkit’ at its core is a value set and a commitment to a way of ‘thinking, being and doing’ that encourages all to be respectful, inclusive, transparent and curious; while ensuring that children, young people and families are kept safe, free from harm and able to achieve their full potential.

The service works with a small number of families at any one time to enable us to work more intensively with those families. We aim to support families for between three to six months, although the actual length of support varies depending on the complexity of the family system, their circumstances and need. The purpose of the work is to identify with families what the shared aims of an intervention will be and what needs to happen to create sustainable change. Our work is about engaging with the whole system around the family and working with wider family members to pull in the resources that are already available.

The PFBT is founded on the idea that most families want to stay together but can’t work things out for themselves. The team members all share a similar outlook and approach to the work undertaken with families, including a fundamental commitment to keeping children safely with their families wherever possible and the belief that judgements made about families must always be made within a context of emotional intelligence and empathy. We recognise that the family are the experts in their own situation and therefore we collaborate with the family during each stage of the model.

In the PFBT we invest time and effort into building a relationship with families and getting them to “buy in” to our interventions. This can mean that at the beginning of our work we try to demonstrate our usefulness to a family and support them in ways they find helpful. For example, if the family are facing being fined for their child’s non-school attendance, us having a conversation with school about putting this on hold for a few months whilst we intervene may be well received by the family. It is important to focus on the quality of the relationship and notice if/when we have the families trust so that conversations are more genuine, open and agreeable to challenge from both sides.

# **2. Team structure**

The team consists of:

* Team Manager
* Clinical Psychologist
* Practice Supervisor
* 3 FTE Social Workers
* 2 Family Practitioners
* Team Coordinator

# **3. Referrals**

3.1 The PFBT accepts referrals from Locality Social work Teams across Derbyshire Children’s Services for families where there is a child aged between 10 and 17 who

* is identified as at risk of coming into care now or within next 6 months

Or

* is a Looked After Child and is identified as being able to return home with intensive intervention and support

All required assessments need to have been completed prior to referring to the PFBT so that we can be assured that the Locality Social Worker and their Manager are confident that the level of risk is manageable and that the child(ren) remaining at home is in their best interest.

It is vital that families consent to a referral to the PFBT as we are a voluntary intervention service. Information leaflets are available to support other professionals to explain about the PFBT to families, what we offer and what is expected of them (see appendix 13.3).

When making a referral to the PFBT Locality Social Workers should ensure that the case file of the child(ren) is up to date. The referral needs to reflect current worries and concerns regarding the family and should be concise. The latest assessments, chronology, care plans and case notes will be read in conjunction with the referrals so there is no need to duplicate significant amounts of information.

Once the PFBT have received the referral the Team Manager/Practice Supervisor will check the referral meets the basic criteria and consider the team’s capacity before feeding back to the referrer regarding likelihood of when the team are likely to be able to accept new cases. The PFBT do not hold a waiting list as the nature of our work means that the family require intervention/support in the immediate future and often if other agencies or services hear that a referral has been made to us then they step back. The decision on which cases we accept will be based on the level of risk of breakdown (i.e. the risk of the child or children coming into care) and the level of capacity for change in the family.

# **4. Matching process**

When the referral is received the Team Manager and/or Practice Supervisor will read the referral and review the case file. The purpose of this is to begin to explore if the family meet our more subtle matching criteria. With the PFBT being such a small team and having such limited capacity we need to make efforts to ensure that we are working with the families that we are likely to have the most success with. These include families who are committed to staying together and are aware that we are an intervention-based service who will expect them to engage in weekly therapeutic intervention sessions.

The Team Manager and/or the Practice Supervisor will undertake a Matching Assessment Visit (MAV) to the family so they can test out the family’s commitment to staying together and how open they are to engage with intensive changed based work. It is important that we establish what the family know about the PFBT, clarify any misunderstandings and fill in any gaps in their knowledge about our service to ensure that we have informed consent.

During the MAV we use solution focused questions to examine what the family want to change, what they think will happen if we work with them and don’t work with them and explore what their hopes are for their family. Analysis of PFBT historic cases has shown that successful outcomes are much more likely where there is commitment to rebuilding the parent –child relationship and this is also explored in the MAV.

# **5. Working relationship between PFBT and Locality Social Work Teams**

The PFBT work alongside the Locality Social Work Teams providing a tailored package of support to families around specific behavioural difficulties they are experiencing. We initially take all cases on with a three-month period in order to test out the family’s commitment to working towards staying together, as well as their willingness and ability to engage with our model.

Safeguarding responsibilities will remain with the Locality Team throughout the PFBT involvement. PFBT workers will ensure that all contact with families is recorded on Mosaic in a timely manner and case note alerts are added to the allocated Social Worker when necessary. Serious safeguarding concerns will be shared immediately with the allocated Social Worker, Duty Worker or Team Manager as appropriate. Whilst often PFBT workers may be part of the response to these concerns, the responsibility for action remains with the Locality Team.

It is important that the allocated Social Worker remains actively involved with the family, undertaking their statutory responsibilities (e.g. chairing meetings, writing child’s plans, undertaking statutory visits to children etc.). This is also important as if the PFBT intervention is not successful or the family change their minds about working with us then the allocated Social Worker needs to resume work with the family. The allocated Social Worker is also expected to engage in the PFBT work. This will vary from case to case, but a joint working approach can be beneficial to all involved. If the Locality Social Workers have a clear understanding of how change was achieved, then they are more able to support families through their sustainability period and beyond or continue any work not completed with the PFBT.

Joint supervision between the PFBT and the Locality Team is often useful. Allocated Social Workers and their Practice Supervisors can attend the PFBT Unit Meeting as this is our primary source of supervision. This often works well as it allows the Locality Social Workers to engage in the reflective discussion which supports a collaborative approach to the family and allows a greater understanding of the ongoing work. If preferred the PFBT Worker and Team Manager can attend supervision in the Locality Team periodically on a case by case basis.

There are times where the PFBT Social Workers may be able to chair meetings and undertake statutory visits to children, but these need to be carefully considered. The rationale must be clearly understood by all involved and this must not distract away from the therapeutic relationship that the team have built with the family. These decisions need to be agreed between the Locality Team Manager and the PFBT Manager.

# **6. Safety Plans**

The families we work with will often have the same crises repeating again and again that lead them to call emergency services, Out Of Hours and/or request their child is accommodated. Professionals often invest lots of time and energy in dealing with these crises and still little progress is made on working out how to stop it happening. It also can mean that parents become deskilled in managing situations. If their first response is to call for a professional like the Police or a Social Worker to get involved it can mean their position of authority in the home is undermined, especially when this happens on a regular basis. A Safety Plan is a short-term solution to manage the situation – it is not an intervention. It is simply there to keep everyone safe whilst work is completed with the family to firstly understand the problem and then make changes.

When a family is experiencing regular crises the PFBT will ensure that a clear written plan is completed with the family in the early stages of our work. This ensures that everyone in the system knows what is expected of them in the crisis and responding consistently and predictably can often help reduce the intensity of each crisis. See appendix 13.1 for guidance and examples.

# **7. The “FAMILY” Model**

The FAMILY Model which the PFBT follow is a six-stage model:

* 1. Finding Out
	2. Agree Goals
	3. Map it out
	4. Intervention
	5. Look for difference
	6. over to You!

# **7.1 Finding Out**

The first stage of the model is our assessment period. This is where we find out about the presenting problems, resources within the family and the family’s aims for our intervention. We do this using various assessment tools (FIDO, Genograms, Timelines) which are outlined here as well as consulting all family members, other people as identified by the family and all professionals involved (Stakeholder Aims).

# **Fig. 1. The FIDO**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Problem** | **Frequency** | **Intensity** | **Duration** | **Onset**  |  |
| What behaviours do the family see that they would like to change? | How often the problem occurs:DailyWeeklyMonthlyIf daily - how many times a day? | Is it causing injury?How bad does it get?What’s the worst outcome?How long does the episode last for?  | How long has this problem been going on for?When did you first notice it?  | What things were happening when the behaviour first started?What are the potential triggers for this starting?Think about big changes in the individual, the family, circumstances etc.  |

It’s important that we establish clearly what is happening for our families at the beginning of our work with them and the FIDO gives us this baseline. If information is vague it leads to people subjectively interpreting it. The FIDO is the basis for the FAMILY model; if we don’t get this right it can hinder the rest of the work with the family, as it impacts on our ability to assess the seriousness of what’s happening, our ability to see patterns and our ability to accurately notice progress or lack of.

Problem – here we need to concentrate on the behaviours that are leading the family to feeling they are at risk of breaking down. These need to be recent and relevant to the referral to the PFBT. We need to keep thinking safety first – if there is violence and aggression in the home or children going missing these need to feature on the FIDO. Sometimes families want to list everything that their child does that annoys them. We need to listen to them but ultimately, we need to take control of this and ensure that we only record the key behaviours or it can become overwhelming.

Frequency - how many times a day, days a week is this happening? This needs to be specific e.g. “at least 3 times per day” or “once per fortnight”. We do not accept “all the time”, “often”, “when she’s angry” instead we use these as conversation starters and explain the importance of understanding this now.

Intensity - it is important that we are clear what families mean when they say “aggression” or “meltdown”. Ask the family to explain in detail and give examples. What exactly happens and how bad it is? What is the impact? Consider asking about how long the incident lasts and how they are resolved now.

Duration – how long has this been happening? We don’t accept answers like “ages” or “always” but instead try to pinpoint a period of time e.g. since Christmas or since he started secondary school. If families insist that things have been happening forever, we try to establish when things became worse or unmanageable.

Onset – was there anything that happened about the same time as the behaviour started? What could have triggered it? Think about changes, new babies, house moves, deaths, losses, school moves, adolescence etc.

**Genograms**

The genogram has been established as a practical framework for understanding family relationships and patterns (McGoldrick et al, 2008). They are useful as they provide a quick visual picture of the complexity of a family and are particularly good to help clarify complex relationships, to indicate gaps in knowledge and to make visible intergenerational issues and patterns. A genogram helps us establish a systemic perspective and give us an understanding of the current family context, the strength of relationships within the family and with their wider system. A genogram is a practical way of engaging with the whole family; often a genogram will be completed over more than one session to allow different people to contribute and allow for the in-depth discussion that goes alongside e.g. exploring why certain members don’t have contact and the possible sense of loss, even trauma, linked to this.

As they can be powerful in raising painful and sometimes suppressed memories it is important to explain to the family what a genogram is and what it is likely to raise. Some of the ‘recognised’ symbols used can have a considerable but unintentional impact. For example, the use of X to symbolise the death of a family member may be very hurtful. Family members should be asked what symbols they would wish to use.

Genograms are often messy and can be intimidating especially if you’re working with a large family. However, once the process is completed a neat version should be produced. It is important to ensure that you develop a ‘key’; always make sure you have clearly coded your genogram and explained what the symbols and lines represent. This is especially important if a child, young person or family have created their own unique symbols.

Generally, there are some ‘standard’ rules to genograms:

1. In a genogram, the male is represented by a square and the female by a circle

2. The male is always at the left of the family and the female is always at the right of the family.

3. The oldest child is always at the left of his family, the youngest child is always at the right of his family

The PFBT use genograms to work out who is in the system, who is likely to have resources to offer the family and to help the family see the strengths in their system. It is also useful to refer to when discussing stakeholders with the family as we are therefore in a position to ask about specific family members with some knowledge of the quality of relationships and any losses they have experienced.

**Timelines**

A timeline is a useful, succinct way to record significant events in a child, young person or family’s life from their viewpoint, showing their ‘journey’ through their life to date. This is a useful tool to greater understand the family and the events they deem to be important. It is important to include critical life events such as births, deaths, marriages, house moves, school moves, separations, new partners, as well important holidays or anything the family tell you is important. The finished article is only part of how the timeline is useful; critical life events in a family will have had a “ripple effect” throughout the system impacting on different family members in different ways. The timeline is a way of exploring this as the conversation can flow naturally to questions about who was most impacted by this death or how did the children feel when a new partner moved in.

It is useful to refer back to the FIDO and ask the family to consider where they would plot the problem behaviours they have mentioned in the timeline. Sometimes this can be a powerful intervention in itself as often families themselves can begin to see links between key events and difficulties in family life. This can be an insightful but also difficult process for a family to complete and should be handled sensitively.

**Stakeholder Aims**

During the Finding Out stage the PFBT will contact approximately five stakeholders as identified by the family and with their consent. This is to ensure that we know what the important people to the family want to see change and to gather their hopes and aims for the intervention. The evidence base for the model suggests that if we have goals that all stakeholder have bought into they are more likely to succeed.

We are not contacting stakeholders to share information but to gather their views on what is going on for the family, how they got to the crisis they are in and what they think will help the family get back on track. It is also good to explore what support the stakeholders currently offer the family or offered them in the past and why things have changed if they have. For example, we often hear of extended family that had children to stay at the weekend when they were small but report they’ve grown out of this – this could be support that could be put back in place if everyone (including the child) is in agreement with.

Stakeholders usually include:

* parents
* children
* grandparents
* any other carers (e.g. foster carers, residential staff)
* aunts and uncles
* family friends
* neighbours
* the Locality Social Worker
* School
* Any other professionals working with the family (e.g. CAMHS, YOS, Adoption Support Social Worker etc.).

It’s often best to explore what the stakeholder already knows about the PFBT and our involvement with the family and be guided by them. If the stakeholder says they know nothing we should explain a little bit about the PFBT, our model and why we are calling.

Some conversation prompts for the stakeholder interviews:

* How well do you know the family?
* How involved have you been in the past?
* What needs to be done to help?
* What would things be like if we did something really helpful?
* What would be the first thing you would see change if things were better?
* Where would you like to see this family in six months?
* What support have you been able to offer in the past?

Often wider family members and friends feel valued and included when contacted by PFBT as they feel they have a lot of knowledge about a family. However, occasionally we may speak to a stakeholder who either insists that they have nothing to share, don’t want to talk to us or push back that we should be asking someone else. We need to respect their wishes but sometimes this is an avenue for further discussion and by being curious as to why they feel like that when the family have put them forward could start another conversation.

Some conversation prompts if things are difficult:

* The family say that you know them really well and would be a helpful person to talk to…
* We are not experts, but we are trying to help the family work things out themselves…
* So, you’re not worried about the family or X (the referral behaviour?)

**Systemic Strengths and Needs Assessment**

We use this tool to assess what is going on across the whole system for the child and the family. It encourages us to look for systemic hypotheses about what is happening and shows where our efforts are best focused. It also forces parents to think about positives, no matter how hard it may be, and recognise what strengths they and the system around them have. It also helps us work out what resources the family have and where change can be created. It is best completed with the whole family (either together or individually depending on circumstances) on a big piece of paper so they can see the whole system as you record their thoughts.

# Fig. 2 Systemic Strengths and Needs Assessment template

|  |  |
| --- | --- |
| **Strengths** | **Needs** |
| Individual:  | Individual |
| Family:  | Family:  |
| School:  | School:  |
| Peers:  | Peers:  |
| Community:  | Community:  |

Once we have completed this stage of the model, we need to then present the family at a Unit meeting. This is to ensure that the whole PFBT are aware of the family and can engage meaningfully in reflection and advise on the ongoing work. We also gain team and manager oversight regarding the direction of the case and later agree the goals with the team.

At the point of case allocation, a date will be set for the family to be presented to the team with the allocated PFBT worker. This should be four weeks from date of allocation. The reason for this is to ensure that we are on track with Finding Out and haven’t slipped into intervention. Ideally at this point the allocated PFBT worker(s) should have completed most, if not all, of the Finding Out work.

# **7.2 Agree Goals**

The second stage of the model is all about agreeing the goals that the PFBT will support the family to achieve. Goals are important as this is how we measure the progress, or not, of work and tell us when it is time for us to move on with the model. Goals also ensure that everyone in the system is aware of what the family are trying to change. It is important that the goals are designed collaboratively with the family and fit with as many stakeholders aims as possible because evidence tells us that the more “buy in” we have from the system, the greater the chance of achieving our goals. This is because often the family is being supported by the stakeholders to achieve the goals, but it also helps to avoid the situation where our goals are being sabotaged or undermined by those around the family.

When we are thinking about what a family’s goals should be we always start with stakeholder aims. We need to consider what the family and their key supporters have said but we also need to think about what core Children’s Services business is and find goals which everyone can agree are the most important.

Goals need to be ambitious for a family, for example a parent might say they want their relationship with their child to improve but with prompting they may say they want their relationship to be good. This is what we would work towards. The way we create big change for families is to think about the future and work backwards. We often say to families “paint me a picture of what you want your life to be like” to encourage them to speak freely and in as much detail as possible. It doesn’t matter if they don’t believe that these things can happen at this stage. We are simply trying to work out what their hopes are. The goals that families choose are often very simple and very similar across the families we work with and usually focus the family’s safety and happiness.

Once we have agreed a goal with a family, we then need to decide how we will measure the progress towards this goal – what would we see happening or not happening if this goal was being achieved? We call these “As Evidenced By” (AEB) and these are the parts that are individual to every family that we work with. We need evidence that is measurable and clear, not open to interpretation so we look for what observable behaviour would stop, start or change. It is important that we don’t use words like “more” or “less” as the measure but work with the family to find a number everyone can agree on. To do this, we refer to the FIDO. If the family want less aggression at home, we would look at the FIDO and remind ourselves how often this is happening, discuss with the family what they would see as realistic progress and agree our AEB from there. So, if aggression is physical and towards parents daily, we would encourage them to see progress as 1 or 2 incidents per week. This isn’t about us saying this is ok but that it would be more manageable for parents.

Checklist for Goal Setting:

√ Do the goals have multiple buy-in?

√ Are the goals clear – could they be interpreted differently by different people?

√ Are the goals achievable in our timescales?

√ Are the goals measurable?

# **7.3 Map it out**

The third stage of the model is where we begin to try to understand the behaviour we are trying to change, and we do this by mapping. Maps are completed collaboratively with the whole family if possible, sometimes together but depends on the circumstances. This is the beginning of showing the family ways to problem-solve and encouraging them to think about their system and ways to create sustainable change.

Mapping is a three-stage process:

**Stage 1 - choose an example problem**

We choose a goal to start with by asking the family which is their priority goal. We ask the family which of the issues is having the greatest impact on them and leading the family to the point of breaking down. Usually this is the goal that is linked to safety so we need to work on this one first, but it doesn’t mean we can’t achieve progress in other areas too. For example, if we start addressing a child’s aggression towards parents, carers or siblings, (the family’s first goal) we usually see improvements in relationships which could be the family’s second goal. Once we have agreed with the family which goal is the priority, we ask them for a specific and recent behavioural/observable example of the target problem. We need recent examples of the behaviour occurring for this process to be useful.

**Stage 2 – mapping out possible contributing factors**

To begin a map, we write the identified example in the centre of the page (see Fig 3.) and then write down anything that may have contributed to this problem behaviour occurring. Here we are generating multiple, systemic hypotheses about the causes of this behaviour and to do this we use information from the family, the referral, the case file, our experience of this family and other families, discussion with PFBT colleagues and information from research and academic literature. We gather as much information as possible by asking everyone involved why they think this behaviour occurred, by spending time with the family observing their interactions and also by collecting sequences of key events (see section 9.1 & appendix 13.2 for further details of sequences).

Once we have gathered all this information, we create the map (Fig. 3.) by writing down the contributing factors around the problem behaviour showing them leading **towards** (arrow facing in)the behaviour that needs changing. We analyse this information considering if each factor actually could **lead** to the behaviour or is it background information.

**Stage 3 – Deciding what to target**

Our interventions are generated from the map. We work through the contributing factors to consider if changing/removing these impacts on the behaviour. It is a process of elimination so we need to decide which factor on the map we will target first. We do this by thinking about what the most powerful factor is and discussing with the family if they think this behaviour would still have occurred if this factor was not present. If there are a few powerful factors, we do this for each one. We then look for the most powerful factor that is easiest to change and which is most immediately connected to the behaviour before finally considering which of the factors gets the most buy-in from the family. If they don’t believe that the factor impacts on the behaviour, they are not likely to work hard on changing it. Once we have agreed what we will target we can begin thinking about intervention.

# Fig. 3. Map template



# **7.4 Intervention**

The FAMILY model is not about bringing in lots of resources, it assumes that the family have the resources, skills and abilities within their system that can be used to bring about change. Therefore, our interventions need to be about utilising existing resources with the family. When considering interventions, it is important that we are primarily looking for ideas that involve people in the family and/or system doing something different, ideally every day. We need to be clear with families that we believe they find their own solutions to problems and that we are just there for ideas, support and coaching. All our intervention plans are bespoke because we look at the unique experiences of each family and for each behaviour, we assess what is causing and maintaining it to look for opportunities to do something different.

Some examples of interventions:

|  |  |
| --- | --- |
| **Direct therapy:** | Direct work with children, young people or parents using psychological models as suggested by formulation. These interventions are led by either the clinical psychologist for the IAPT therapist but can involve other members of the team e.g. Cognitive behavioural therapy – increasing awareness of thoughts, feelings behaviours and repeating patterns. Use of graded exposure, thought challenging, relaxation tools, motivational interviewing among others. Other models are available as per formulation and these will also be the responsibility of clinician or IAPT therapist with support.Motivational and changed based direct support can be provided by any member of the team. Personalised goal setting can help to assess motivation for change as well as provide a framework for the support needed. |
| **Family therapy, attachment and Relational approaches** | Formal therapy is led by the clinical psychologist and involves employment of systemic methods. It can be provided using multiple members of the team. Families are provided with an opportunity to sit together and talk openly about current thoughts and feelings. These are shared in a safe and protective way to ensure communication remains productive. The team takes responsibility for directing open questions designed to encourage reflexivity in family members and to open up dialogues and new ways of thinking about current problems. Ideally a shift from problem focused thinking to solution focused thinking is provided.Informal therapy can involve support from the team to encourage the family into a more solution focused attitude. Encouraging frequent and constructive communication can be very helpful. This approach may simply involve generating practical solutions for issues that cause difficulties in the family’s relationships.Therapeutic conversations are used throughout our work.  |
| **Community intervention** | Recruitment and active engagement of others to target behaviours deemed to be of high risk such as drug and alcohol abuse or CRE. This may include us working with neighbours, friends, family and community services e.g. local police, local shop keepers, fast food outlets etc. to monitor and manage risks.  |
| **Consistent parenting and reinforcement approaches** | Supporting parents to apply clear boundaries within their family. To ensure that young people are being given clear messages about what they can expect and therefore making their experiences at home more predictable and less stressful/ unstable. This might include setting up rotas, family rules and even the use of regular family meetings to discuss recent events. Non-Violent Resistance (NVR) training for parents which supports them to regain authority using ‘peaceful protest’ against challenging, aggressive behaviour.Token economy. Rewards are given on a regular, at least daily basis for target ‘behaviours.’ Tokens accumulate and can be traded for physical rewards including money.Positive reinforcement through verbal feedback. Immediate feedback must be provided directly related to the ‘desired’ behaviour so that this becomes reinforced. Examples including rewarding times of calm by saying ‘we’ve had such a lovely day today; I’ve really enjoyed spending time with you’.Negative punishment. Loss of certain items or privileges when undesirable behaviour takes place. Essentially creating a negative consequence for actions for example losing access to mobile phone. Applying extinction procedure – use of ABC charts to determine the function of a behaviour and removing the desired outcome. E.g. shouting occurs to gain affection. Affection is not given following shouting but is provided at all other times. |
| **Education, information and reframing**  | Providing families with important and useful information regarding specific factors that may be contributing to the family’s current difficulties. Examples include providing parents with clear information about a diagnosis that impacts upon the young person or giving advice and information on money management.We work with parents to reframe what they see as their family’s pitfalls and issues are e.g. parents are often devoted to slippery-slope logic—"If I let this one go, I lose control, and my child will become a barbarian"—but that's typically the opposite of what happens. We support them to see that if they go to war over every minor thing and they may lose both the minor and the major battles. We provide families with a greater understanding of their child’s behaviour and what they gain from it. We help them understand the cycle of maintenance, and more importantly, how they can influence this and change their child’s behaviour. By increasing parental understanding, we hope to increase empathy for the child.  |
| **Practical support** | To create actual changes in the family home by engaging directly in practical solutions. This may be carried out by members of the team in the first instance as a means to an end. This may involve helping the family to organise their home/ environment to make it more conducive to family life e.g. decorating the dining room to encourage the family to have meals together every day and so improve communication and relationships.Practical solutions should in no way create dependency upon services, they should be time limited and follow clearly from the maps/ formulation created. |

# **7.5 Look for difference**

By tracking the family’s progress towards meeting the goals each week we are “Looking for difference” but this stage in the model refers to the stage where post-intervention we pause and consider whether our intervention has created change within the family. This is not necessarily a lengthy stage and is mostly just done through conversation and discussion.

If everyone agrees that things are changing for the better, then we can continue with the model. If all goals are being met, and the family are reporting they are not at risk of breakdown any longer then we move on with the model. If we have other goals to move on to then we go back round the model (see Fig. 4) and start the mapping process again for the new goal.

Sometimes families bring these discussions to the table by saying how different life is for them for various reasons and this can lead naturally into the next stage – Sustainability.

If we can see things have improved but the family report, they can’t see this then sometimes it is useful to do a “then and now” comparison of behaviours. Here, the original FIDO will be incredibly useful alongside with the goals we’ve tracked. This can be our evidence for the family for moving to the next stage and beginning to talk about closure.

If things are not changing for the better, we need to consider:

1. We weren’t actually able to change the factor we chose with the intervention, and we need to come up with a new intervention for the same factor
2. The factor we chose wasn’t actually very “amenable to change” and we need to choose an alternative factor
3. Even though we did change the factor it didn’t change the underlying problem, indicating it wasn’t that powerful after all.

If we aren’t making progress, we can consider starting at any point in the model again. It is always worth revisiting the Finding Out (especially the FIDO) with the family to consider if things have changed or if things were not fully discussed initially.

# Fig. 4. Going back round the FAMILY Model

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# **7.6 over to You! (Sustainability)**

The key principle for all our work is that it is sustainable without us. As soon as we start to see evidence that something is working, we change our thinking from “how can we create change for this family” to “how do the family keep these improvements going”.

This is an important part of our work with a family and should not be an afterthought once we are preparing to close. This should start when we have been meeting a goal for 2-3 weeks and can be on-going whilst work is still going on.

Sustainability planning is different for all families, the most important thing is that it is useful and easily understood/accessible for the family.

It should include:

* What the issue is we’re talking about
* What created the change
* Steps to keep going
* What might go wrong and how to overcome them

We start by doing a positive map (see Fig. 5) with the family and we need to think broadly when doing this. As well as considering individual and family factors we need to think about peers, environment, community and neighbourhood factors.

Once we have done the map, we need to look at each factor with the family and highlight the most important ones. From this, pick one and work out with the family exactly what the steps are to keep this going. Repeat with all key factors to see if they overlap or combine.

For example, in the positive map for Tommy coming home on time for 3 weeks (Fig. 5) one important contributing factor is that Gran is setting clear expectations and calling Police when he does not return.

The steps to keep going are:

* Gran to set a curfew time with Tommy every time he goes out
* If Tommy is late, Gran should give Tommy a 30-minute warning before taking any action on the Safety Plan
* Gran to be consistent in calling the Police if Tommy doesn’t return and is not in contact as agreed.

The “what if’s …”

Once we’ve got the steps to keeping a factor going we look at them with the family and think about what the “what if’s” are for those steps. The “what if’s” are the things that might go wrong or might prevent these steps from being completed. We then come up with ideas with the family of how to manage the ‘what if’s’ - ideally the family will have their own ideas but don’t worry if they don’t we ask the PFBT or other people who know the family well (with consent). We often go back to the stakeholders or other agencies who are heavily involved with the family and sometimes we complete this in a Core Group or CIN meeting which helps everyone feel part of the plan.

The “what if’s…” for Tommy

* Tommy goes out without warning. Gran to text to remind him of his curfew
* Gran has no credit. Nip next door and ask Julie to text Tommy.
* Tommy goes out without his phone. Use social media to contact his friends to let them know he needs to be home on time.
* Police don’t respond. Contact the local safer neighbourhood PCSO 123 Dave Turner on 07xxxxxxxx the next day to discuss.

# Fig 5. Positive map – Tommy coming home on time for three weeks.

Gran has been praising and rewarding Tommy when he is home on time.

Gran is setting clear expectations for Tommy and consistently calling the police when he is missing.

Gran and Tommy are getting on better so there are less rows at home

Tommy is keeping in contact by phone

Gran is more aware of Tommy’s vulnerabilities and feels less judged by the neighbours as they know what’s going on.

Gran is acting pleased that Tommy is home – even if she is annoyed he’s late!

Gran and Tommy do stuff together now at home

**The Sustainability Plan**

Once we have got all that knowledge, we need to write up the steps and the “what if’s” as the family’s guide to how to keep things going, what could go wrong and what to do if it does. We do this in the format that suits the family best and although we know the family as we’ve worked with them a while by this point it’s always best to ask them. It is often useful to show the family some examples and ask what they think will work for them. What is important is that whichever method or style we choose, it is easily understood by each key person in the family. This can mean that at times we may have to write the same information in different styles for different family members. Sometimes we write a “mini plan” for the young person, especially if they’ve been a big part of the intervention.

**Using the Sustainability Plan**

Once we’ve written the plan, we need to support the family to explain it to anyone who is named in it and anyone who will be an important part of supporting parent/carers using it. We explain to the family that now they have the plan they need to have a go at things themselves – this is the **over to You!** phase. The idea here is that this is the time to test it out and we are still around to adjust the plan if we need to.

If there are problems with the plan during this time it’s important, we keep positive, explain to the family that it’s good that it’s happened in this testing out time and that now it’s shown us the holes we can address them. We tweak the plan and carry on!

We usually have a period of 4 weeks of being in sustainability before we close. However, there are times when this can be extended. If there are lots of incidents during the testing period, then we keep tweaking the plan – but we need to try not to go back into intervention. At this point we need to ensure that the Locality Social Worker is fully on board and talk to them about signposting to other agencies or voluntary sector organisations if additional support is needed.

# **8. Closing cases**

The PFBT are a short-term intervention service; the aim is to complete interventions with families within six months. The PFBT will not have solved all the family’s difficulties but we aim to leave the family at a point where they are not in crisis and feel more able to manage their children’s behaviour. It is hoped that the family will have safe responses to worrying behaviours and the skills to respond themselves as a family as well as a meaningful Sustainability Plan that they feel confident in using. Finding the ‘right time’ to close a family to the PFBT can be difficult but the decision needs to be based on progress that has been made on the behaviours we have targeted.

Once the PFBT and the Locality Social Worker have agreed that it is time for PFBT to close it is important to set a date and stick to it. This way it focuses everyone’s mind to use the Sustainability Plan rather than relying on the PFBT. It is good practice to agree this date with the family but understandably some families are anxious and want services to continue so this is not always possible. The PFBT will always work with a family to try to reach agreement and this can sometimes involve us offering additional time limited support (e.g. a weekly phone call, a longer period of sustainability). However, this needs to be carefully considered and agreed with the PFBT Manager. Closure to the PFBT is a celebration – the family will have worked hard to get to this point and this should be acknowledge by all involved.

It may be that the PFBT close before all the goals that were agreed at the beginning are achieved. This may be because the goals weren’t the right ones (i.e. the family had other priorities, things changed over the course of our work) or because the priority goal (e.g. around safety) has been met and impacted positively on other areas of family life so the family are no longer at risk of breaking down. The PFBT work hard to avoid service dependency with families and therefore the decision to close may be brought forward if necessary (see section 8 for more details on closing cases).

In cases where we believe our interventions have been successful all of our completed documents will be uploaded to Mosaic including the Sustainability Plan alongside a closure summary case note. In cases where our interventions have not been successful a closure summary will be completed detailing what work the team attempted, what the barriers appeared to be and suggestions for future work for the Locality Social Work Team.

# **9. Other tools**

# **9.1 Sequencing**

For us to fully understand the problem behaviour that the family are concerned about it is often useful to examine in detail an example of the behaviour and the context in which it occurred. We try to establish “the whole story” about what happened and write it down in the sequence that things occurred. We call this sequencing an event.

When undertaking a sequence, we try to ensure that we record each step of the incident one after the other by asking “and then what”. We ensure the sequence starts before the incident occurred and continues after. It’s important to establish what people were thinking and feeling at key points of the incident. Sequences are better if they are completed with more than one person – either together or separately – to ensure as accurate as recollection as possible. Often people, especially adults, may find this uncomfortable as it involves analysing exactly what was said and done by each person. We explain to them the importance of the step by step process and stress that it’s not about proportioning blame (although a sequence can raise safeguarding concerns) but about understanding everyone’s role in an incident.

**How do we use sequences?**

* A sequence could give us additional contributing factors for the maps.
* Drawing it out visually is another aid to helping families see actions as part of a set of interactions, rather than solely the action of the child.
* It helps us monitor if Safety Plans are being adhered to
* It can inform interventions
* It can help us understand how the family interacts
* It can show us where the escalation is coming from and what type of escalation is occurring.

# **9.2 Formulations**

**What is a formulation?**

There is no universally agreed definition of formulation as each profession which uses formulations does so differently with different emphases depending on their function (Division of Clinical Psychology, 2011). However, Eells defined case formulation as “a hypothesis about the causes, precipitants and maintaining influences of personal psychological, interpersonal and behavioural problems [which] helps organise information about a person and serves as a blueprint guiding treatment” (Eells, 2007: 4). This definition seems to fit well with how they are used in the PFBT. A formulation can support us to develop hypotheses about what has caused, and what is maintaining the problems our families are experiencing.

Formulations are rooted in psychological theory, particularly Cognitive Behavioural Therapy. They focus on the interaction of thoughts, feelings and behaviours as well as including other factors such as organic conditions or diagnoses and the family’s history/functioning to help us understand a person and their behaviours.

**When would we do a formulation?**

The main purpose of a formulation is to help inform the intervention plan. However, it has many other purposes, such as identifying gaps in knowledge about a family/person, generating new ways of thinking about a family using the experience and expertise of the team, helping understand and manage risk and understanding lack of progress/troubleshooting.

A case formulation can also be used to help other people (e.g. family members or other agencies) gain greater empathy for a young person or parent, and help the young person feel understood.

Formulations are not part of the FAMILY model utilised by the PFBT but they can be useful to add to the understanding of the family. They would therefore be done after the Finding Out stage as we need a certain amount of knowledge about the family for a formulation to be useful.

We often do a formulation, alongside maps, to help us understand the factors contributing to and maintaining the problem(s). They can be useful if we are stuck as a team to identify an intervention or understand a family’s functioning.

We may do a formulation for a specific purpose such as helping a school understand why a child is struggling to attend or behaves how they do or to help parents understand their child and their behaviours. Both of these can be really powerful because if we can change the perspective of the adults around the child, often they are more able and willing to make changes to how they interact with the child, this in turn can create changes in the child’s behaviour.

**How to do a formulation**

The template we use has two questions at the beginning of the form which give the predisposing factors (historical factors) and precipitating factors (recent triggers). It is probably useful to have the family’s timeline to hand when completing this as some of these significant factors will no doubt overlap.

The predisposing factors are historical factors which made the individual vulnerable to the problem. Here you need to include the family’s background in relation to life history, events, social identity, culture, belief systems etc. In particular, think about things that happened in the past (e.g. early trauma, physical and mental health difficulties).

The precipitating factors are the recent triggers for the current situation or problem. These may be physical, psychological or social. Think about the final straw and what has happened recently (e.g. loss of job, bereavement, school exclusion, drug use, new friendships, diagnosis etc.).

The third section of the form is perpetuating factors (the maintenance cycle – see Fig. 6). Here we need to think about individual and systemic factors that maintain the current situation/behaviour. Think about how it feels to be the person that you are formulating for; we really need to try to see the world from their eyes. You can start anywhere in the cycle but try to follow it through for each idea. For example if we start with thinking about a child who is feeling anxious about school then think about the behaviour that people see (often school refusal) and then consider the reactions that the child experiences (often negative, detentions or isolation when they return) and then consider how this feeds into the cycle again.

**Things to consider…**

Although good practice says that formulations should be completed collaboratively with the families and young people we are working with, there are times when we would undertake formulations as a team. This is often because we are stuck or struggling in our work. Whilst it is often useful to get a family’s feedback on our formulation, it is not always helpful to share with the family what we have written in its entirety. It may be that once we have completed a formulation as a team you can then attempt the formulation with the child and/or parent to see if they come up with similar ideas. Ideally you would then have one working formulation. However, if this is not possible it is also ok to have two working documents.

However, if we are sharing a formulation about a family with other agencies then **consent must be sought** and so it is important to be aware of what we are writing and how this may be interpreted by our families. Completed formulations should always be shared face to face with the family to ensure they understand what we’ve written and can ask questions or challenge us. We must also ensure that we use accessible, everyday language to support everybody to understand what we’ve written.

A formulation does not always lead to an intervention – developing the formulation may be an intervention in itself “a good formulation can be a powerful systemic intervention” (Kennedy et al., 2003) or it may just add to our understanding of the family.

We should call our formulations “formulation **with** …” or “formulation **for** ...” rather than “formulation **of**…” – this way we make sure it’s obvious if this was completed collaboratively and that it is of benefit to the person that it is written about.

# Figure 6 The maintenance cycle



# **10. Unit meetings**

The PFBT undertake supervision as a team and record this using a Unit Plan (see appendix 13.3). This directs the work with the families, provides case supervision for the involved workers and management oversight of the plan for the child(ren). This supervision should take place every two weeks for each family. It is important that the Unit Plans are uploaded to Mosaic as soon as completed so that Locality Social Workers are aware of our current involvement with the family and the rationale for our decision making. It can be useful to invite the allocated Social Worker and/or Practice Supervisor to the Unit meeting at intervals. This can be particularly useful if we think things are not progressing, there are risks we want to discuss, we are thinking of closing or if joint supervision is required.

Our unit meetings are held weekly and usually last a full day. Where possible all team members should be office based on this day to ensure that as many people as possible are available for reflective discussions. During this reflective discussion it is important that everyone participates and stays focused, even if they don’t know the family. One of the unique elements of the PFBT is that each team member has some knowledge and understanding of each of the families we are supporting. This ensures that unit meetings, reflections and team consultations (see section 10) are timely as detailed information does not need to be repeated and useful for the allocated worker as relevant suggestions can be made as well as other workers being able to provide meaningful support to families if the allocated worker is not available.

During the meeting one person on rotation should take the role of “devil’s advocate” – their role is to challenge the team and provide an alternative view, even if they agree with what is being said. This helps us generate multiple hypotheses about a case as we progress with our work. A hypothesis is a statement of ideas which connect people and behaviour and contains an offering of an explanation why something might be so. We should always aim to prove a hypothesis wrong, not right as once we think we have it ‘right’ we stop searching and we stop being curious.

Time is often an issue during the unit meeting so 30-minute time slots have been allocated to each family to try to ensure that there is time to discuss all the families planned for the day. However, to ensure that this is effective all team members need to ensure that they are using the meetings efficiently. This means coming to the meetings prepared, with information regarding the progress on goals and an idea of what they would like to get out of the meeting. The team members also need the confidence to challenge others; it is easy for discussions to be drawn out or for people to start “story-telling” out of frustration, excitement or exacerbation. In order to keep to time some discussions need to take place out of the Unit meeting (see appendix 11.2).

# **11. Consultations**

**11.1 Consultations with other professionals**

The PFBT offer consultations to support work with the children and families across Derbyshire. This service is offered to colleagues in Locality Teams either face to face or by skype/telephone and we also aim to hold monthly drop in sessions in each Locality. Consultations can be requested about any child or family – they do not have to meet our referral criteria.

We appreciate that workers can become anxious when families are in crisis or demanding that their children are accommodated. Where possible we try to undertake consultations at short notice. We also find that our consultations are more useful when we have had time to review the case file as we have a greater understanding of the family.

**What could a consultation with the PFBT include?**

* A reflective space to talk about challenges experienced when supporting the family
* Discussion regarding barriers to working with the family and suggest potential alternative approaches
* Support to consider more systemic hypotheses about what could be impacting on the family
* Suggestions of alternative assessment tools to understand more about the family function and the children’s behaviour
* Support to look at what could be contributing to the behaviours the family are experiencing
* Provide ideas of things to try with the family or to encourage the family to try doing differently themselves
* Support with specific pieces of work e.g. safety planning, interventions identified as appropriate by the Social Worker from their assessment (e.g. relationship rebuilding, de-escalation work), work to support the family sustain positive changes made during social work interventions
* Signposting to community resources
* Discussion regarding the FAMILY Model we use, our referral criteria and what makes a good referral to the PFBT

**11.2 Team consultations**

The PFBT are a small, county wide team and therefore, there are often days when we work from home or other Locality offices if visiting families in the area so as to be more efficient and cost effective. Due to this, there can be days when the number of people in the office is limited which can impact on the collaborative elements of our work. To combat this we often book team consultations so workers have time to reflect about and plan their work with their PFBT colleagues. This can be useful when we are feeling stuck with a family, where we want to undertake a particular task with colleagues (e.g. a formulation, role plays, intervention planning). Everyone is expected to make themselves available for team consultations to ensure we continue to work collaboratively but this is not always possible. Ideally at least three PFBT workers should participate in a team consultation and at times it may be useful to invite the Locality Social Worker.

# **12. Case study**

Case Study of Fred

Referral from Social Worker with following background information:

Fred is currently assessed as a Child in Need and is being supported by Social Care following referral from school stating Fred had disclosed that his father had restrained him during a physical incident in the home. During Single Assessment parents disclosed they have been struggling with Fred’s behaviour for years and stated that now his behaviour has deteriorated to the extent that they are struggling to cope. Dad feels he can no longer take part in dealing with incidents in the home after the referral and Mum feels alone and unable to manage. Parents are now asking for Fred to be accommodated. Parents have engaged with MAT and CAMHS for a number of years and CAMHS are now assessing Fred for ASD.

Fred’s voice:

* “I’m treated differently to my younger brother – my parents prefer him”
* “I want to stop being angry and stressed”
* “I want to live at home but want my parents to chill”

Recent concerning behaviours (in the last three months):

* Fred is destroying his home and the contents of it. He has broken two televisions in one week and two microwaves in a month, he has broken glass cabinets and he has broken doors off of the kitchen cupboards. The house is beginning to feel sparse due to the amount of things that have had to be thrown away. Parents have stopped repairing and replacing things that are damaged.
* Fred has presented at A&E on several occasions with injuries he has inflicted on himself when causing damage to property.
* Fred has harmed his younger brother during his violent outbursts as well as his parents – so far this has been when throwing things but Fred also makes threats to seriously harm his family.

PFBT completed an **initial crisis safety plan** with parents and Locality Social Worker:

|  |  |
| --- | --- |
| **Risk**  | **Plan – who will do what** |
| Fred being physically aggressive and/orthrowing/damaging property and objects.  | Mum and Dad to tell Fred they are going to give him space to calm down but tell him they will still remain nearby.Leave his physical space, make sure everyone is safe and try to do something to occupy yourself. Remove anything especially dangerous (ensure all lighters, knives and medicines are securely locked away)If Fred continues to be aggressive or moves rooms, family to leave the house. Go next door, for a walk, for a drive or just sit in the car. Call Grandparents to collect younger brother or arrange for him to go next door to Jean’s house.If parents feel the need, they will call their supporters:Jean: 07123 456 789 Jeremy: 01234 567890 Dave and Sue: 01875 563 235 These supporters will attend the home when able to support parents in dealing with incidents giving them the confidence to cope. Call 999 for support if Fred or anyone in the house is in serious danger. Take Fred to A&E if he hurts himself seriously during his outburst.  |

**PFB complete their finding out:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem**What is the problem?  | **Frequency**How often does it happen? Be specific | **Intensity**What exactly happens and how bad is it, what is the impact? | **Duration**How long has this been happening? | **Onset**What is the trigger? What happened before? |
| Fred is physically aggressive towards people at objects in the home  | Will throw objects, whatever is to hand, can be own personal stuff – this happens 2/3 times per day Threats are daily at least once per day Brother is sent away (for safety) every two days on average  | Incidents usually last about 45 mins to hour. Can be longer. Has pulled kitchen cupboard doors offSmashed TVs, microwave, mirrors, glass doors, phones, TV remotes, Xbox“Squares up” to DadThrows objects often at family – has hit brother in face with TV remote, has smashed glasses next to brother who has bare feet. Fred makes threats to stab Dad and kick younger brother’s head in. Brother has to spend a lot of time at Grandparents to get away from Fred but wants to be at home.  | Parents say they have found Fred’s behaviour difficult from birth. Parents asked for help when he was 18 months old.Aggression towards brother started when he was born (Fred was 3).Behaviour has got progressively worse since aged 10 Serious physical aggression started in last two years  | Age 4 Fred fell off a stool and smashed his head on rim of a machine in arcade. Family feel this has impacted on Fred’s behaviour. Fred seemed jealous of young brother and never got over this Fred found starting secondary school difficult  |
| **Problem**What is the problem?  | **Frequency**How often does it happen? Be specific | **Intensity**What exactly happens and how bad is it, what is the impact? | **Duration**How long has this been happening? | **Onset**What is the trigger? What happened before? |
| Fred is verbally aggressive with parents and brother | Every day, several times a day up to 10 significant verbal outbursts a day  | Shouts and swears- will swear in general Calls family hurtful, derogatory names which he knows they hateShouts in people’s faces, particularly Mum and Brother’s.  | Fred has been a shouter from early age. Seems to think it is the only way he can be heard Has become much worse over last two years.  | Fred’s language and verbal aggression has got worse with each school move Transition to secondary school marked most recent increase in verbal aggression  |
| Fred leaves home after an argument and doesn’t return or let parents know where he is.  | About once a week  | Fred used to leave for an hour or so but has been out all night before. Parents admit they now just enjoy the peace and quiet after the incident and dread him coming home. Parents have stopped looking for Fred or contacting him and haven’t been reporting him missing.  | Fred has always stormed off after arguments Started leaving the home in the last year and only stopped answering/texting in last 6 months  | Older, more confident out and about aloneHas friends’ parents don’t know since secondary school  |

Stakeholder views and aims were gathered as follows:

|  |  |
| --- | --- |
| Stakeholder | What are their goals? What do they want to be different for the family? What would things be like in a few months if we did something really helpful?  |
| Fred | My parents to chill out The arguments to stop To feel less angry  |
| Parents | To be able to go out as a familyFamily to be happyAggression & violence to stop Brother to be safe and at home moreFred to be at school (respite for parents) Mum would like more support from Dad |
| Grandparents | Family at breaking pointThink Fred needs anger management Brother needs to be at home moreFamily need respite House needs to be calm - worry younger brother will start copying behaviour.  |
| School  | Fred to attend school dailyTo be able to socialise with peers at break and lunch times |
| PCSO | For violence in the home to reduce.Dad to be more proactive in supporting Mum rather than avoiding situationsFred has said to her before that he feels Dad does not give him attention - cares more about his football team than him |
| Neighbour Jean  | Noise to stop/reduce!Family to be safe and happy and to be able to go on holiday and on outings  |

**The following goals were agreed with the family:**

1. Everyone to be safe at home

As evidenced by:

* No smashing objects
* No swearing at other people without apologising
* Aggressive outburst to be no more than twice a week

2. Family relationships to be good

As evidenced by:

* Whole family to go on a positive trip outside the house once a week
* Fred and younger brother to have at least one positive interaction per week

It was agreed goal 1 was the family’s priority as it was about safety. A map of a recent incident was created to help identify what was contributing towards Fred’s aggressive behaviour. From this map the family identified things they felt were likely to irritate Fred a lot but were easy to change e.g. Dad saying in a minute, Mum repeating instructions and anyone eating in front of Fred.

Map of goal 1:



The family made changes to test out these hypotheses:

* Family bought a clock and made efforts to help Fred understand time
* Dad agreed to stop saying “in a minute” and instead was more specific e.g. “I’ll be with you when I’ve finished my cup of tea”.
* Mum limited her instructions as Fred could only process one at a time.
* Family agreed that Fred could eat separately or with his headphones in so he couldn’t hear others eating.

After unpicking some of the issues which affected Fred, we hypothesised he had some sensory issues. We completed a map around why Fred struggles in school and it identified he couldn’t cope with noise and that some of the classrooms and corridors amplified the noise which he would try to avoid. Strategies were put in place in school to enable Fred to learn in an environment which he felt most comfortable in and he started attending school daily.

The PFBT Improving Access to Psychological Therapies (IAPT) trained Family Practitioner undertook some direct work with Fred regarding his anxiety about school. This highlighted that over time Fred’s anxiety had increased due to specific and sometimes subtle difficulties in his cognitive processing.

Outcomes:

The aggression reduced to the point that family were able to make repairs to their home and included Fred in choosing to wallpaper etc. These repairs had a massive impact on Fred as he wasn’t reminded daily of his previous behaviour. The family have learned to live with the verbal aggression but have recognised that because Fred is very impulsive, he will swear and then apologise which has been an accepted compromise.



Sustainability Plan created with family to ensure they have a plan of action if things begin to deteriorate in the future.

|  |
| --- |
| Sustainability Plan |
| Name: Fred  |
| Positive changes made:* Reduced physical and extreme verbal aggression
* Improvement in relationships / socialising
* Reduced anxiety
 |
| What are the steps to maintain this | What might go wrong? | How we will manage possible problems |
| Recognise the triggers which lead to Fred’s aggressive behaviour and try to reduce the impact of these: * Repeated instructions
* Family eating
* Dad saying in a minute
* Noise
* Crowds
* Having no concept of time
 | Fred is more prone to angry outbursts due to his ASDFred’s coping strategies are very limited, and he may forget the ones he’s learntParents may get complacent/frustrated  | Sequence out incidents as they happen to identify the triggers which led up to the argument. These can hopefully be avoided in the future.Don’t lose sight of the triggers you have already identified. Remember where you were and how far you’ve come – making a bit more effort on the small things saves you time and effort later! Use constrained choices instead of direct instructions wherever possible. For example – Would you like to put your coat on before we leave for school or shall we just take it with us? Are you wearing the yellow T shirt or the red T shirt? Either way he is wearing a T shirt it just makes him feel he has a choice rather than it is feeling like a demand.  |
|  Having a routine - Keeping a routine for bedtime, taking medication, school etc. - We know Fred feels less anxious if he is familiar with a routine.  | Fred may push against rulesIf Fred feels anxious, he will try to take more control of situations in order to reduce his anxiety. Life gets in the way!  | Remind yourself why you have the routine and that it’s worth it. If you let things go, don’t worry, but pull it back as soon as you can. Remind the children of the routine and what’s expected if necessary. Make a wall chart – this will help you all! If things change its ok to change the routine but explain this and why and stick to the new routine.  |
| Work on the relationships! Spend time together * Enjoying outings as a family
* Do things together in the house
 | Fred may choose not to participateLife may get busy and this gets forgotten  | The fact that this time is offered at a set time each week will be enough to have a positive impact on Fred. He knows you are there to spend the time with him should he choose to participate. Offers of outings and activities Fred enjoys:* Board games
* Trip to garden centre
* Playing pool
* Cinema
* Throwing stones in the lake

Talk to Fred about his anxiety to help identify where this mostly happens and why to help plan the outing.  |

# **13. Appendices**

# **13.1 Safety Plan Guidance**

**What is a Safety Plan?**

A safety plan is a short-term solution to manage the situation – it is not an intervention! It is simply there to keep everyone safe. Think about the fire safety plans we have around all DCC buildings. They are short, clear, one-page posters with vital information and simple instructions to follow in the moment. This this is what we are looking to create for the family.

Often people will object to safety plans saying, “I can’t do that forever”, or “it will make her think she’s got away with it” etc. We just have to reassure them that this not the long-term plan and sometimes our safety plans have negative consequences – it doesn’t matter as it is a short-term measure.

**How to write a Safety Plan**

* Firstly, we need to meet with parents/carers to find out what exactly happens in the crisis or what they are frightened of happening. Usually we only safety plan one or two crisis situations which are usually linked to the referral and FIDO (e.g. going missing, getting aggressive).
* Look through case files and discuss with other professionals who know the family well – what has been tried before and worked and what made it worse.
* Ask the family for ideas – when calm they often know what would help. Include stakeholders – they may offer a different perspective
* The final written document needs to be one page long, in clear, large text and something the family is happy to have pinned to the fridge. It is designed to aid their thinking in the heat of the moment so needs to be simple.
* Make sure that anyone the family want to refer to in the safety plan is not only aware of this but consents to it. Potentially they could have OOH calling them and referring to the safety plan so it’s vital they’re fully on-board!

**What do we Safety Plan?**

Common things we plan for happening are:

* Children going missing/not returning home
* Aggression/violence in the home
* Drug/alcohol use (by either parents or children)
* Self-harm/suicidal thoughts

**What goes in a Safety Plan?**

A Safety Plan is a step by step guide for parents and carers about what they need to do, in order, as soon as they notice that something is wrong.

Safety Plans vary significantly depending on the crisis and the family, but some common ideas are:

* Separating people
* Distracting people
* Going out to look for people
* Contacting the child’s friends
* Removing objects/people
* Directing people to self-help/online support
* Making checks on people
* Alerting others when necessary
* Using someone to help calm the situation down – someone in the home, getting someone else to text or ring the child?
* Bringing in back up – consider friends, family, neighbours, who has helped before?
* Accessing services who can help – A&E, Police, OOH

It’s useful to include telephone numbers in this document so that people have them all recorded in one place. This means that if someone else is in the home when an incident occurs, they also have easy access to these numbers.

# **13.2 Sequencing an event**

What happened when…

Continued…





# **13.5 Consultation form**

Preventing Family Breakdown Team

Record of case consultation

Date:

Child’s PIN:

Name:

Locality worker:

PFBT worker:

1. What do you want to achieve from this consultation?
2. Key risks/Worries/Concerns as presented by allocated worker:
3. PFBT observations on the case (if file review completed prior to consultation)
4. Case discussion
5. Recommendations/ideas for action

# **13.6 The Unit Plan**

|  |  |
| --- | --- |
| Name | Date and week |
|  |  |
| Voice of the child/ child’s experience of daily life: | Summary of risk assessment: |
|  |   |
| Goals and evidence: |
|  |
| Plan from last meeting | Outcome: |
| 1.
2.
 |  |
| Plans for next 2 weeks: |
| Discussion points: |
|  |
| Direction of travel: | Plan agreed by: |
|  |  |

# **14. References**

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