Evaluation of *Dandelion Time*

Final Report

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I must also thank the young people and parents who spoke to me about their experiences of Dandelion Time and the professionals who made referrals and found the funding for these.

Regardless of the hospitality and support given, the report stands as an independent assessment, reporting what was found. This is overlaid with some cautious judgements about broad-based therapeutic work of this kind, its place in the local network of services, now and as this changes with the coalition's 'localism' agenda. Drawing on earlier evaluations allows me to say something about costs and future developments.

About the author

Carl Parsons is Visiting Professor of Social Inclusion Studies in the Research Centre for Children, Schools and Families at the University of Greenwich. He is well known for his work on school exclusions and is a respected evaluator. As an education researcher of long standing, he has published widely on policy and practice in the interface between education and other services for vulnerable children. He recently published *Strategic Alternatives to Exclusion from School* (Trentham Books, 2011) and is working on a study of a school labelled in the national press, the worst school in England; the outcome is to be a book entitled *Schooling the Estate Kids* (Sense Publications, 2012)

Dandelion Evaluation Final Report, 3 January 2012

Executive Summary

Summary assessment

Dandelion Time family therapy is a well-managed and expertly staffed initiative. It has appropriate structures, policies and management procedures for effective governance. It operates in a farm building and the farm environment which is used extensively for activities and experiences to support and develop individual children, their families and relationships. It works intensively with families and collaboratively with other agencies, providing the counselling and advice for both parents and children flexibly as opportunities and 'the right moment' arrives.

The staff of three practitioners are supported by two administrators, expert consultant support on attachment issues, and around 20 trained volunteers. In the last three years it has worked with over 50 client families per year.

Evidence from the proportion of families for which there is data, indicate positive changes in 'before-after' ratings on the Strength and Difficulties Questionnaire (SDQ) and on goal attainment.

DT offers a service which at £200 a week includes a range of support and inputs and good collaboration with partner services. There is evidence that it is a highly cost effective service delivering a much needed service. The charity is unusual in its farm environment base and range of activities which allow sustained, flexible and holistic therapeutic relationships with the whole family and others crucial to the child with a focus on long term prevention. It offers the prospect of a model which could be replicated elsewhere in the region.

Carl Parsons, Visiting Professor at the University of Greenwich, conducted an independent evaluation of Dandelion Time (DT). He has long experience of researching issues of exclusion from school and of evaluating initiatives to support vulnerable children and families. In this evaluation much of the material was supplied by DT and then processed and interpreted by Professor Parsons. Data available from DT files was supplemented by observations during visits and interviews with the DT staff, four sets of young people and their parent(s) and with five professionals.

Dandelion Time family therapy

Dandelion Time (DT), established in 2003 operates in a farm environment near Maidstone, with a staff of three therapists supported by administrative staff, key advisors and around 20 volunteers. DT achieves a calm, kind, informal, safe and active environment where families learn to interact together rewardingly in a highly supported atmosphere. The modelling of behaviours from staff is consistent and exemplary within a subtly disciplined, careful safeguarding, therapeutic environment.

The DT therapeutic approach is integrated, holistic, systemic and person centred, developing self esteem and resilience through engagement with the hands in practical craftwork activity in the farm environment. DT works with theories of attachment and trauma. Strengths and Difficulties Questionnaire (SDQ) scores indicate that, on referral, high proportions of the children are in the abnormal range. Two thirds of the children are assessed as having attachment difficulties and/or

experience of trauma and/or with multiple complex difficulties. Data suggest that the range and depth of problems confronting parents and children reflect in many cases 'upper tier 2' and even tiers 3 and 4, as the level of intervention required.

Professionals' perceptions

Five professionals from across the range of agencies working with children and families were interviewed. All made positive comments on the effectiveness of DT. Referrers have been impressed by the ability of DT to get families engaged when there had previously been resistance. There are accounts of family relationships improving, of the behaviour of a child changing dramatically and of more satisfying relationships. Schools were very positive and used terms like 'invaluable', 'the magic place', 'nothing else like it'. DT was generally considered to have made an impact by offering a service at a level, breadth and intensity which other agencies cannot offer.

DT is praised for its communications and that it keeps in touch and feeds back. The impact has been to reduce problems at home and school, helped to re-engage some young people at risk of being lost to the system, raised self-esteem and happiness levels of some children and helped families function in a more constructive and mutually rewarding way. Some children have been prevented from moving to higher levels of care and more expensive service involvement including interrupting the move to court and child protection proceedings. Referrers reported generally wanting more provision like this but mentioned funding as an issue.

Families' perceptions

Parents and children were full of praise for what DT had done for them. There was a striking consistency in talk about all the activities – woodwork, cooking, leatherwork, cleaning out the chicken, gardening, painting, pottery - done in a social environment which is utterly positive and full of encouragement and acceptance.

Parents referred to the experience as 'advice' and 'chats, not counselling as such', 'not by appointment, informal. It is subtle therapy'. Another called it 'weird', in that it was a natural part of the supportive and kindly interaction.

One young person said, 'They help with a sort of therapy but you don't know it is happening. They would just talk to you as you were doing something else'. DT was referred to as 'a lifeline', 'amazing', the best thing that could happen to any child who's got problems'. Parents reported finding nothing before which met their needs, 'There isn't anything like it'. 'Absolutely brilliant. Coming here you feel hope'. One boy, who had had long term contact with DT, said, 'They changed my life'.

The outcomes for the children and young people interviewed were all positive in terms of their happiness, self esteem, self confidence and ability to socialise. Maintenance in school or reintegration into mainstream education was not always an outcome, though they stayed in some form of education. Movement on to further education was the most immediate and obvious outcome for some.

Impact of DT interventions

Before-after SDQ data for the small samples of young people show impressive movement of children from 'abnormal' to 'normal': from 82% to 24% in 2009/10, though only from 71% to 58% in 2010/11 when, it was suggested, cases had become more complex. For 50 cases over three years, the proportion of young people in the

‘abnormal’ fell by 46% after the DT experience.

Quantitative data on the rating of the closeness to full achievement of goals for 13 cases indicated positive results in 10 cases, sometimes strikingly so.

Finance

The costs for one DT family is £200 per week to the referring agency, subsidised by DT’s charitable income and allows longer periods of working with a family if it is required. A ten week programme costs £2,000. For a full year, it is £6,000. This is not expensive by comparison with other mental health services.

There is much evidence from Family Intervention Projects (FIPs) that such interventions could produce savings to other agencies dealing with families of over £80,000 per family. Applying the DfE model of savings speculatively to DT suggests, that working with other partners, the savings could be of a similar order. The ‘spend to save’ strategy often talked of in LA circles appears to apply with some confidence to DT. There is the view that DT has the potential to save other agencies a considerable amount of money conservative calculations are that £6,000 spent on a full year’s participation in DT will save on average £10,160. Scaled up, the annual costs for 100 young people and their families would be £600,000 and the savings over £1M.

Future potential

DT’s position in the multi-agency network of providers is very much in line with the Allen, Field, Marmot and Monroe reports. To capitalise on and evidence its achievements, and consolidate its position, DT should implement more fully its monitoring and assessment procedures to have full data on at least 60% of its client families and children.

The DT model is innovative and mature with provision of group therapeutic provision for some and bespoke provision for others using activities in the natural environment to enable the development of trust and for therapy to take place in an ‘informal’ way. The service is flexible and responsive and has shown itself to be an effective partner in communicating and co-working with partner agencies and currently receives over 60% of its funding from statutory sources.

DT has established a support base of expert and other volunteers, a practice of ‘supervision’ in the management of cases and safeguarding procedures at the farm environment where they work to ensure the safety and well-being of clients.

As a tried and tested service, DT could support the establishment of further sites elsewhere in the region, operating with the same principles and practices and with many similar environmental features.

1. Background to *Dandelion Time* Family Therapy Intervention and the evaluation

Dandelion Time family therapy

Dandelion Time (DT) was established in 2003 as the Dandelion Trust for Children. It was based to begin with at another farm near Maidstone before moving to its present site. It operates with a staff of three full time therapists supported by administrative staff, key advisors and around 20 volunteers. It works from a beautiful, rural setting, occupying a farmhouse and using the 40 acre working farm environment extensively for activities and experiences to support and develop individual children, their family and relationships amongst young people and amongst family members. The impression a visitor gets is of a calm, kind, informal, safe and active environment where groups work together at making things (pots, pasta, stools, etc) and learn to interact together rewardingly in a highly supported atmosphere. The modelling of behaviours from staff is consistent and exemplary yet behind the informality lies a discipline, careful safeguarding, therapeutic interactions, as and when the opportunity or need arises, and a framework for sound monitoring of progress and change.

DT has in place the appropriate structures, policies and management procedures for effective governance of a third sector organisation. It has annual reports, a business plan and a board of trustees. More recently, it has established a steering group which also involves parents and young people.

DT works from a starting point that, for many children, the effects of early attachment difficulties and trauma can be deep and long lasting with a strong possibility that the child-parent relationship does not become securely established. Poor attachment may mean the child fails to develop his senses - touch, taste, seeing, hearing, smell – and also those 'senses' that lead to a development of the social communication skills and empathy needed to build trusting and open relationships and friendships with others. Such children can feel isolated and may fail to thrive in social and educational settings. There is need for early intervention but probably even later therapeutic and social experiences can be helpful in the immediate term but also for longer term mental health.

These children can go through their school lives struggling with emotional difficulties often expressed as oppositional or defiant behaviour and hiding from seemingly 'normal' classroom situations. They may be bullied or bully other children. Their expressed difficulties are often seen by schools as essentially behavioural issues, that despite provision of nurture groups, classroom support or punitive measures do not go away and schools may respond by permanently excluding these children. My own work over 20 years shows the lasting and long term damage that can result from school exclusion, costs involved and the positive impact of interventions by a wide range of professionals.

Many children have been helped to improve their resilience, to learn to adapt, to discover a sense of purpose in their lives developing a sense of self worth, and have managed to make sustained improvements in their engagement at school. This has been achieved with minimal contact with schools, mostly through TAC (team around the child) meetings, informal discussions and by requesting the inclusion of

observations, ideas and suggestions arising from engagement with Dandelion onto the child's pastoral support plan, held at school.

The Dandelion therapeutic approach is:

- integrated – working with children, their families and others important to them
- holistic in developing self esteem and resilience through engagement with the hands in practical craftwork activity
- systemic using therapeutic models including those drawn from attachment theory
- person centred therapy.

DT employs a specialist in attachment and trauma together with a systemic practice consultant for families who assist in shaping the methodology and responding appropriately to cases.

The therapeutic and developmental engagement has a number of key elements:

- Child centred family working which engages the family in a therapeutic process that views the child's behavioural or emotional condition as an expression of difficulties often within the family, sometimes influenced over generations
- An embedded therapeutic approach which is ongoing throughout sessions and in every aspect of engagement with families whether on site, at meetings or at schools
- Using nature by engaging with natural activities and the natural environment, working with animals to develop empathy, nurture and care. Experiencing the seasons, rhythms in nature, routine in daily life and discovering beauty. Amongst all this, they share family experiences, cohesive and constructive moments that can be replicated at home and stand as positive shared memories
- Learning through work which is meaningful, purposeful practical activities using head, heart and hands
- Experiential learning utilizing the hands in practical skills development, discovering talents and developing new skills and interests which increase self esteem, personal pride, confidence, resilience and self actualization through perseverance as well as habits of respect, acknowledgement and praise between parent/s and children working and learning together
- Good health through an emphasis on eating well and enjoying the outdoors.
- Bringing a sense of belonging and overcoming isolation, meeting others, making friends and participating in shared values, shared vision, shared purpose
- Flexibility is key whether for the length of the period of contracted working with DT or the place of meeting. DT will often extend the contracted period, generally allowing for missed sessions, and will work in the home, community and centre, at times to suit the referred family's needs which can include evening and weekend working, where possible They offer a fast response where other agencies have failed to engage. DT is able to provide services where other interventions have failed, providing the care, energy and

commitment needed to offer hope and trust no matter what symptomatic behaviours associated with anger, shame or sorrow are displayed.

Great care is taken with those present, many of whom will be in a vulnerable state - children and adults. Workers and volunteers are well trained and everything is carefully supervised, even when it appears to be informal, friendly and casual. This is the environment in which the team can carry out their distinctive work which is working in practical and social situations over half a day focussing especially on family relationships; it is these which lie behind many of the presenting problems children have which show themselves in the home and very often in schools. This is often the reason for the referral. The work is of a style, in an environment, in a social arrangement and for lengths of time unique amongst local services. McCarthy et al (2003) are just one set of authors to point to the need to address family dynamics which are a driver behind many risk factors – and a huge protective factors when they operate optimally. There is a 'naturalness' to the interactions such that families and young people can see how the behaviours and feelings could be replicated in the home or other locations.

Two further aspects to the DT way of working are important: firstly, two of the workers will visit the family, both to make the initial invitation and present welcoming faces and to make preliminary assessments of need; secondly, good data are collected, monitoring is sound and assessment procedures are used of a general and case specific kind to help target work with the family and young person and to gauge success over the course of the period with DT which may be as short as weekly sessions for five weeks or much longer depending on need and funding.

Sessions are charged at £200 per week for the half day placement which is complemented by other supportive contacts, engagement with other professionals and attendance at multi-agency meetings. Training is also offered to support relevant professionals in their work with children. Costs are currently low as placement fees are subsidised by charitable contributions, mostly from bids put in or requests made by DT.

DT has built a reputation for quality tailored provision but also for flexibility – where families miss sessions, the timescale is extended so they get the full programme booked – and for high rates of engagement from children and families. DT is establishing a record of effectiveness and impact, partly assured by the follow-up and a continuing contact with families. Few families decline the offer of a place (about 5% annually) and few drop out (under 10%).

2. The evaluation process and *Dandelion Time*

In this evaluation, much of the material was supplied by DT and then processed and interpreted by the evaluator. The DT data comprised

- Documentation including annual reports and business plans
- Data on the children's backgrounds and presenting problems
- Strengths and difficulties questionnaire data for most, usually for before and after and often from child, parent and teacher
- Data from the goal setting procedures and the assessment of attainment of the goals.

Data available from DT files was supplemented by:

- Observations of DT sessions in action
- Scrutiny of the site and resources
- Examination of the staffing structure, management and working arrangements, particularly safeguarding
- Interviews with three DT staff and one expert volunteer
- Interviews with four sets of young people and their parent(s)
- Interviews with five professionals who make referrals to DT.

Care has been taken to anonymise illustrative case material so that families are not identifiable.

In addition to processing and presenting data and making localised judgements, DT was examined in the light of research findings from other projects and government policy documents. Drawing on these, supported judgments on costing and effectiveness.

3. Evaluation findings

3.1 Dandelion Time client group

The number of cases taken on by DT increased in 2008, doubling numbers from the previous year (table 1), and rising to 63 in the last full year. In the last three years around 80% of referrals have come from education (table 2). DT seldom rejects a referral and the numbers who do not engage is under 10%. Most who do attend come for most or all of the sessions allocated.

Table 1: DT Cases 2003 - 2011

Year	Cases	Referred children who did not engage or only attended once
2003/04	16	1
2004/05	15	0
2005/06	16	1
2006/07	16	0
2007/08	25	0
2008/09	53	1
2009/10	49	5
2010/11	63	4

In the early period, files indicate that most referrals were from health, often GPs. Many were not funded, and DT had to rely on its charitable contributions to carry out its work. Most are now referred by education (table 2) and the bulk of the funding comes from statutory agencies. Statutory agency funding in the 20010/11 year had risen significantly and constituted 68% of the income. It had been 40% the year before and never higher than this in earlier years.

Table 2: Sources of referrals

Year	Number of children referred by:			
	Health	Education	Social Services	% referred by Education
2008/09	0	48	5	91%
2009/10	5	36	6	77%
2010/11	4	55	8	82%

About a quarter of referrals are for 5 – 10 weeks but over one third are for more than 15 weeks. A majority of the children referred are boys and they are fairly evenly divided between primary and secondary age ranges.

Table 3: Backgrounds of children referred

Year	Number of children	Young carers	SEN confirm-ed	SEN descrip-tors used	Looked after children	Physical health problems	Mental health problems	Domestic violence	Other domestic abuse	Child affected by child abuse
2003/04	**16**	5	3	5	1	3	4	10	12	9
2004/05	**15**	3	2	5	2	2	3	8	8	7
2005/06	**16**	7	4	2	0	3	5	8	9	13
2006/07	**16**	7	2	4	0	1	4	14	13	15
2007/08	**25**	4	5	6	1	4	12	15	15	20
2008/09	**53**	14	6	16	12	3	16	39	38	45
2009/10	**49**	15	6	11	5	5	15	25	41	44
2010/11	**63**	14	7	17	9	5	15	37	54	49

The range of individual and family circumstances and the problems they face are indicated in table 3. Various forms of domestic violence and domestic abuse occur and the vast majority of children are deemed to be affected by child abuse even if this is a cold and repressive relationship with the prime carer rather than a nurturing one. Because of parental illness, many are classed as young carers and about a third are considered to have some level of special educational need.

Table 4 indicates the extent of experience of trauma amongst the children though the increase to two thirds of the total is not reflected in the SDQ scores (see later) or in table 5 below.

Table 4: Trauma and attachment issues

Year	Number of children	Parental early life trauma	Children with attachment difficulties	Children with experience of trauma	Multiple complex difficulties
2007/08	**25**	16	12	14	7
2008/09	**53**	22	13	40	26
2009/10	**49**	30	20	35	26
2010/11	**63**	34	40	43	41

Table 5: Strengths and Difficulties scores on entry 2008/09, 2009/10, 2010/11

Year			% parent	
2008/09	Normal 0-13		10.4%	
	Borderline 14-16		10.4%	
total = 53	Abnormal 17-40		79.2%	
	TOTAL NUMBER OF SCORES		**48**	
		% child	**% parent**	**% teacher**
2009/10	Normal 0-13	33.3%	22.7%	41.2%
	Borderline 14-16	0.0%	9.1%	5.9%
total = 49	Abnormal 17-40	66.7%	68.2%	52.9%
	TOTAL NUMBER OF SCORES	**6**	**22**	**17**
		% child	**% parent**	**% teacher**
2010/11	Normal 0-13	6.3%	7.9%	27.7%
	Borderline 14-16	25.0%	21.1%	10.6%
total = 63	Abnormal 17-40	68.8%	71.1%	61.7%
	TOTAL NUMBER OF SCORES	**16**	**38**	**47**

The SDQ assessments have been increasingly made by children and teachers as well as parents, but it is sometimes difficult or inappropriate to collect this data from all three. The scores indicate that, on referral, high proportions of the children are in the abnormal range. Furthermore, it is the parents who are more likely to score their children at this level. The conclusion to be drawn form the above data is that the range and depth of problems confronting parents and children reflect in many cases 'upper tier 2' and even tiers 3 and 4, as the level of intervention required. Tier 2 is a relatively slight intervention but Tier 3 is intensive and expensive. The holistic and family approach in a kind of replication of a family environment would seem to be very much along the lines of what is needed. It certainly responds to the findings of research (Dixon; Kendall; McCarthy) the policy proposals (Allen; Field; Marmot) and the most recent government reports (Cabinet Office; DfE; Monroe).

A recent evaluation of Family Intervention Projects (DfE, 2011c), more intensive and costing around £7,000 per family, report very positive results:

- a 53% reduction in the percentage of families who had a school aged child who was either truanting, excluded or behaving badly at school
- on average, a 47% reduction in the proportion of families experiencing risks associated with poor family functioning including poor parenting, relationship or family breakdown, domestic violence or child protection issues [including] a 34% reduction in the number of families with child protection issues
- on average, a 34% reduction in the proportion of families with health risks including mental or physical health and drug or alcohol problems.

The need is very considerable country-wide and locally.

3.2 The work of DT staff

The visitor to Elmcroft House in West Farleigh is met with a busy atmosphere where up to 20 people may be on site including six to eight children, nearly as many parents or carers and two staff and four volunteers. Some may be preparing to cook the midday meal from digging up vegetables through to the actual cooking *with* a member of staff. Others will be engaged in woodwork with the turning machines they have made in a barn structure in the next field, but what ever the activity it is marked by friendliness, pleasantness, talk which is full of encouragement and praise and an experience of joint working with others. It supports children in relating to each other and family groups in developing improved relationships.

The 'therapy' side of the work is not overt and, as Carol Bridges explained, 'We work with families on their relationships by using the natural world in an experiential way which allows the families to use their hands to engage in activities and build trust. We can encourage families to participate who are very afraid of authority, of schools and they see everyone outside the home as a threat.'

They work with the family and while much that they do is with groups they can also offer a very bespoke package to each family. In a number of important respects, the environment and activities model what goes on in the home with joint enjoyment of doing things, useful things, some of which are to do with the garden and following a process through to the meal which involves fetching the vegetables, cleaning and cooking them and serving them to all collected there and eating the meal in a very pleasant, positive conversational atmosphere, which continues the sharing. The dining room when pasta is being made with the pasta machine with different arms coming in to hold the pasta and hang it over bamboos to dry a little epitomises the 'we can all help here' style.

The use of the natural environment is both a connecting directly with life processes around including the feel and smell of things living and growing, which some children and families have never given themselves the opportunity to soak up. The process of seeing through from beginning to end is deemed to be a healthy experience, and, as with the cooking, the green woodworking extends through the whole process from cutting down the branch, cutting it to size, scraping it, turning it and eventually producing a stool leg. These activities, while individual achievements for a young person, are joint activities and are an opportunity for sustained effort, all round praise and sharing pride in what a young person has done. Sometimes the child or young person will work with other young people, a member of staff or their parent or carer

The activities are in an environment for the development of trust and a context within which conversations can take place about issues and more private therapeutic talk can happen as the need and opportunity arises. These talks can be with individual children, parents or with the family group. Behind the therapeutic intent of DT lies a depth of expertise, consideration and planning that means that the roots of the family

Sessions will generally be from 10am until 2pm. These are run from Monday to Friday and families will attend weekly. Only some of the client families are part of the group approach as some would not be ready or their difficulties unsuitable to

deal with in this way. With families so troubled that a group approach would not help an individual package of consultation, biographical therapeutic work and support for change strategies will be worked out. For one family with an adopted child with ADHD the team worked with the parents to develop new calmer ways of coping 'only for these to be counter-productively challenged by the grown up children'. This meant working with the extended family as some of the children could not bear to see their parents treated badly and aggressively by the young child. All attended except where work prevented it. Ways in which they could understand their aggressive reactions to this behaviour and more appropriate responses with developed with the family. After the series of additional sessions (four) they held an evening barbeque for the whole extended family which all attended to celebrate and confirm their new, more effective family relationships. Part of this comprehensive, systemic way of working is about developing a new narrative for the family with the family.

For group work or for working individually with families, there is much behind the scenes work where cases are discussed about what the family needs and how this might be broached. There may be discussion with DT's expert volunteers which include an attachment and trauma specialist, a consultant systems psychotherapist and a consultant child psychiatrist. There are also further visits to the home, the school and attendance at TAC or CAF meetings or visits to schools and PRUs.

The management of both group and individual sessions is carried out with the utmost of care to fulfil safeguarding requirements. All staff and volunteers are trained to supervise and accompany to make sure all children and adults are safe. Some families have longstanding and deeply embedded difficulties which can present difficulties to others if not acknowledged and handled well.

Most distinctive and different from what any statutory service can offer are the extended period of contact in a setting as near natural as it can be to allow the changing and therapeutic support to be given quite subtly and without it being a booked session or artificially imposed on people.

The flexibility, which a third sector organisation like DT can accomplish, is seen in the adjustments to the programme that they can make, often extending the period of referral and calling on other funds already brought in from charitable sources to enable this. For many families, there is a continuing link with DT if only by telephone for most. One family whose period of referral had finished some months before telephoned to talk through an upsetting violent incident and the whole family was invited in for an evening session.

As well as the work with groups and individual families, DT serves as a base for a small number of young people receiving individual tuition. They have also run projects: Aiming High which involved 39 families over 25 days of activity; Great Food for Kids which involved 208 children, nine parents and 52 professionals from seven primary schools, young carers and other parent support groups.

An additional observation from attending DT and talking to parents and young people is how the adults feel they help each other and many of their children talk about their 'mates' there.

3.3 Professionals' perceptions of DT

Five professionals were interviewed. These had a role in referring one or more young people to DT and covered a range of roles from Pupil Referral Unit manager through social services to teacher. They had referred over 20 young people to DT over the last three years.

Several cases have related to school exclusion, even to the extent of children who will not engage with the alternative provision offered. Others have concerned very ill parents with the consequent reactions of children and others' difficulties have more obviously stemmed from problems of family functioning and concerned Children in Need (ChIN) and Child Protection (CP).

One referrer has sent 12 children to DT, mostly children with complex needs. He has funded seven and supported other stakeholders to fund the others. Key to the provision is the accessing of and working with parents, and often working with them together. A further feature of the provision is its flexibility in that a one day a week placement may be extended to two following uncovering of need. Some children are hosted at DT for their tuition because it is so strongly associated with happy and calm experiences.

Referrers have been impressed by the ability of DT to get families engaged when there had previously been resistance or apathy. The initial family visit is well conducted and a most important step. There are accounts of family relationships improving, of a well-meaning father, but with an 'inappropriate' lifestyle who agreed to everything but did not follow through; 'within weeks Carol had him involved as a volunteer on the farm'.

A referral from a primary school stemmed from the determination of one class teacher to find a solution to one very angry young man. 'I was desperate for this child!' Problems have decreased and it has helped mum. For over a full year a London charity paid (around £6,000) and it helped in that the child found five days at school difficult but with one day off-site in a less pressured environment he could manage the rest. The school saw a different boy at Dandelion and could get support from DT, even asking if they could find out what was upsetting him if he had displayed difficult behaviour at school.

Schools that had used DT were very positive and used terms like 'invaluable', 'the magic place', 'nothing else like it'. Described as a 'high tier 2 service' may under-rate the level of need of some of the children but it is clearly recognised as offering therapeutic expertise on a wide front and to demonstrate impact.

DT is praised for its communications and the fact that it keeps in touch and feeds back. The impact has been to reduce problems at home and school, helped to re-engage some young people at risk of being lost to the system, raised self-esteem and happiness levels of some children dramatically and helped families function in a more constructive and mutually rewarding way. Some children have been prevented from moving to higher levels of care and more expensive service involvement. Some children have been through CAMHS tiers 2 and 3 and 'boomeranged back' before DT has engaged with them. DT worked with one family which was at the pre-court stage on the child protection procedures and the referral to DT was seen as 'the last

chance for the family to sort it out'. The child is now down from the Child Protection proceedings to Child in Need status.

Interviewees were asked to judge the effectiveness of DT on a five point scale; all rated DT at above four and three were unequivocally on five. People compared DT with other services around and could see nothing equivalent. CAMHS is rigid and has strict criteria while with DT, 'They never reject'.

'I don't think there is any child we have sent through where there have not been positive outcomes'. 'As a model, this service is holistic, wrapping a nice warm towel around the family'. Few other services do the 'wrap-around' or reach out so directly and positively to the family.

Budget issues were referred to and the comparison with CAMHS was made - they do not have to pay for this – but it is acknowledged that that service does not do the job required with young people and certainly not on the timescale needed or with the flexibility, which is so important.

One professional, while praising what DT did and how it helped them through the current difficulties and the challenge of making suitable provision, wondered about the long term effects and whether the good that DT did carried through to several years beyond the placement.

3.4 Families' and young people's perceptions of DT

Four parents and their children were interviewed, (See Annex 2, Interview Framework for Parents and children). From the evidence from parents interviewed, it is clear that the support from DT was invaluable and they were full of praise for what it had done for them and their child(ren).

A striking consistency arises from the question, 'What do you do?' Parents and children talk about all the activities – woodwork, cooking, leatherwork, cleaning out the chicken, gardening, painting, pottery etc. This is all done in a social environment with others and is utterly positive and full of encouragement and acceptance.

Parents referred to the experience as 'advice' and 'chats, not counselling as such'. One said that she had told C things she had told no one else and knew that she could have these chats whenever she came. They recognised it as counselling or therapy but 'not by appointment, informal. It is subtle therapy'. Another called it 'weird', in that it was a natural part of the supportive and kindly interaction. One parent recognised that her children were not 'put upon' with some counselling requirement, and the children recognised that they would not have liked that. Indeed, some had experienced the professional, appointment-based system and found it difficult to engage with in the usual artificial circumstances that it takes place and with someone they have built no real relationship with. One young person said of DT, 'They help with a sort of therapy but you don't know it is happening. They would just talk to you as you were doing something else'.

Young people and adults alike remarked on doing things with and for other people. It was very much about sharing. People acknowledged how much they liked that giving and sharing, the making friends and looking forward to seeing them the following week. There is a sense of reward in a young person saying, 'I help a lot'. One young man in the initial encounter with DT staff on the home visit actually had it put to him that, 'they wanted my help around the farm'.

The initial home visit is most important as it is an invitation given to an already pained family to try something else, when all of them have already been through a series of initiatives and battles before the referral to DT. It is clearly important that the impression is left of warmth and support. One parent said, 'We thought, "What lovely people"'. The first session is also important and this is made a very positive experience. One boy was reported as saying after the first visit, 'There's only one thing wrong with it, it was too short'.

Young people report that they enjoy the time at DT and parents endorse this, for themselves too. 'There are no negatives here; it's all positive'. As well as expressing pride and pleasure in what they have made – stools, pots, bracelets etc – they see how it has affected them emotionally; 'All my mates are here. It makes me feel normal and not always the bad boy'. 'They make everyone feel special' and 'They find the hidden talent in every person. That seems to be one of their goals'.

In that DT aims to help improve family functioning and overcome trauma or poor early attachment, the family environment on the farm, doing things together and eating together (once a standard part of family life) seems thoroughly appropriate. There is constant and consistent modelling of behaviours and the intention that,

being pleasurable, it will encourage these behaviours at home and at school. The therapy staff become for the children in particular additional ‘significant adults’. A number referred to the DT staff like relations, ‘It’s like coming down to see your favourite uncle and aunt on the farm and helping out’.

DT clearly collaborates well with other key providers, like school or alternative education provision, which are key to the young person’s development. One mother had only praise for the primary school and all they had done with the head teacher and other staff actually visiting DT to see what it was like and how the young man was functioning there.

It was referred to as ‘a lifeline’, ‘amazing’, the best thing that could happen to any child who’s got problems’. Asked if she missed coming to DT now that the referral period was over, she replied, ‘Oh God, yes. But we can always come back’.

Parents reported finding nothing before which met the needs of the child or their needs as a family. ‘There isn’t anything like it’. ‘Absolutely brilliant. Coming here you feel hope’. One boy, who had had long term contact with DT, said, ‘They changed my life’.

It was noted that the majority of the referrals were boys and suggested that the activities were more boy-oriented. At the same time it was noted that girls dealt differently with problems than boys (shutting it in rather than ‘acting out’), but that DT responded to each on an individual level anyway.

The outcomes for the children and young people interviewed were all positive in terms of their happiness (some had been through ‘very dark times’), self esteem, self confidence and ability to socialise. In a more restricted sense, maintenance in school or reintegration with mainstream education was not always an outcome, though they were maintained in some form of education and in some cases DT was the designated location for the tuition. Movement on to further education was the most immediate and obvious outcome for some in terms of engagement with mainstream education. Professionals had reported that a DT placement had helped retain the young person in many cases.

Some of the children have diagnoses for aspergers or ADHD and this individual condition is something to be managed by them, their parents and schools. Others have a family conflict situation which has become embedded and routine. Still others are in families facing a range of challenges covering adult relationships, mental health, substance abuse and domestic violence. Some have all of these going on. Reading the presenting problems and background data on some of the children (provided in anonymised form) leads to a conclusion that if DT is upper tier 2 service it is of a type used to prevent movement to higher (and therefore more expensive) tiers of intervention.

3.5 The impact of DT interventions

One approach to assessing impact is to record the presenting problems at the point of referral and the extent of reduction of these problems after the period of support. If this is scored before and after, this adds strength to the judgements. If the rating is done by several people (the home and the school are two obvious rating sources), this adds further to evidence of change or not. The figures below cover three years and show the before after changes using the SDQ diagnostic tool and for the most recent year the goal setting and the ratings of closeness to the goal before and afterwards on a 10 point scale..

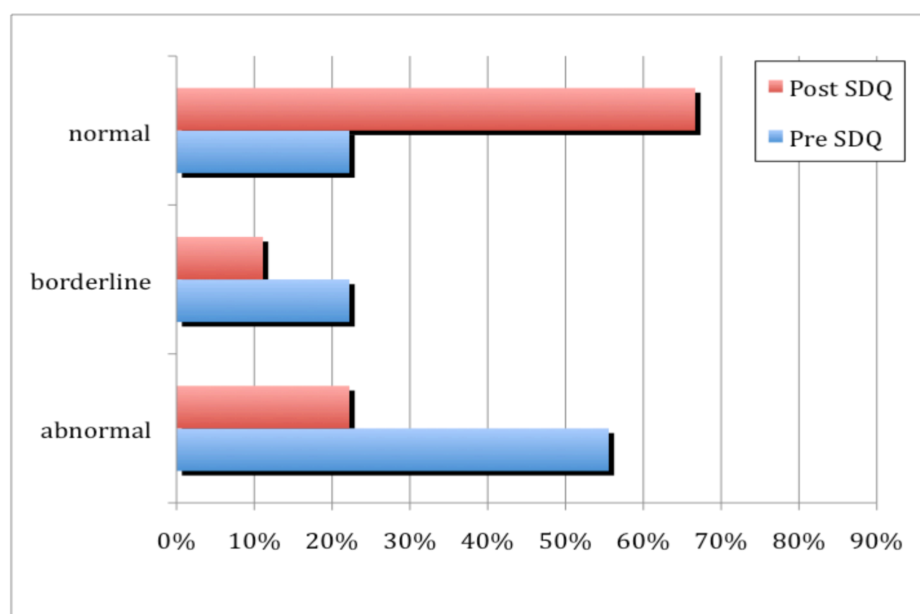
The Goodman Strengths and Difficulties Questionnaire (SDQ) is a brief, behavioural screening questionnaire that asks about children's and teenagers' symptoms and positive attributes:

1) emotional symptoms (5 items)
2) conduct problems (5 items)
3) hyperactivity/inattention (5 items)
4) peer relationship problems (5 items)
5) prosocial behaviour (5 items)

Subscales 1 to 4 added together generate a *total difficulties score* based on 20 items. The responses to the items are scored 0, 1 or 2 (‘not true’, ‘somewhat true’, ‘certainly true’) thus generating a score between 0 and 40. Scores between 0 and 13 are deemed ‘normal’, 14 – 16 ‘borderline’ and 17 – 40 ‘abnormal’.

The data DT has amassed has gaps and whilst a growing proportion of cases are covered, it is a minority only for which data has been provided, rising to about half of those completing in the most recent two years. Where the SDQ has been completed by two people the mean is taken. There are many factors what make return of forms difficult including children changing educational provision, so different teachers complete entry and exit SDQs, and also chaotic home circumstances.

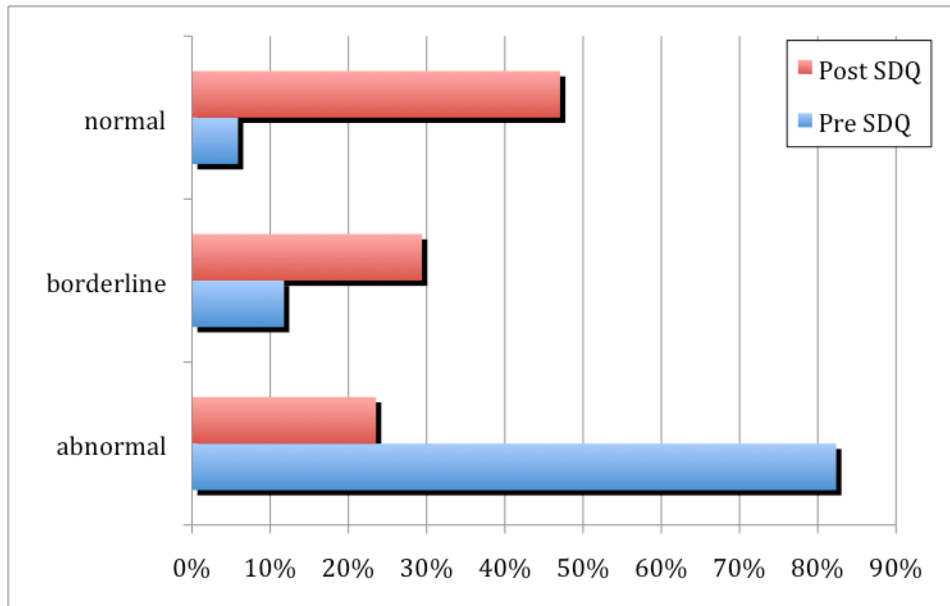
Figure 1: 2008/09 SDQ scores



Total cases: 53 (44 completed within the year)   Responding sample SDQs: 9

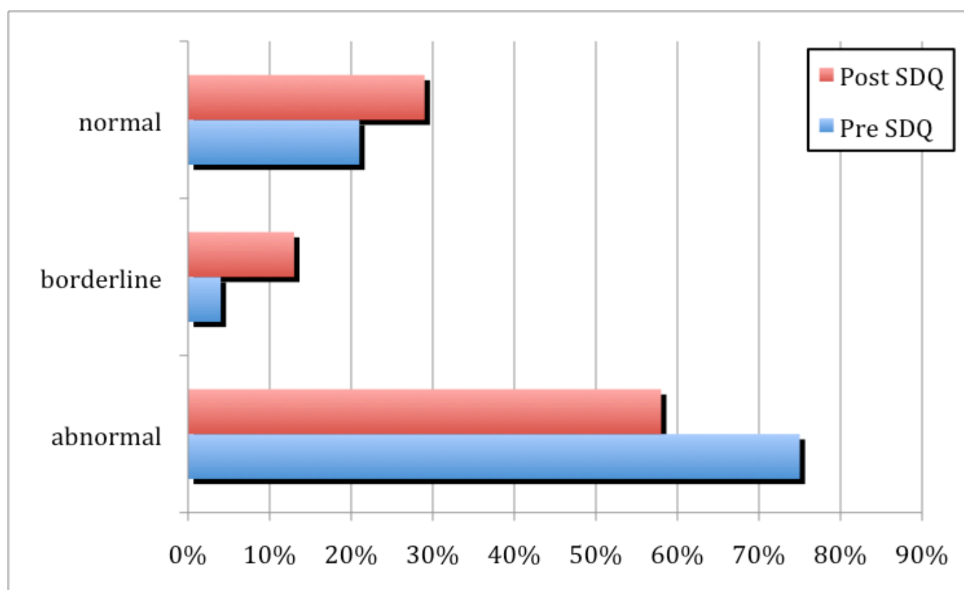
Figures 1 and 2 indicate for the small sample of young people the movement of children from 'abnormal' to 'normal'. The impact on these young people for these two years is impressive. For 2009/10, of the 17 young people assessed, the proportion deemed 'abnormal' reduced from 82% to 24%. The corresponding reduction for 24 cases in 2010/11 was 71% to 58%. It is suggested that cases referred have become more complex.

Figure 2: 2009/10 SDQ scores



Total cases: 49 (32 completed within the year) Responding sample SDQs: 17

Figure 3: 2010/11 SDQ scores



Total cases: 63 (44 completed within the year) Responding sample SDQs: 24

Figure 4: Aggregate of SDQ scores for 50 cases for which there is data over 3 years

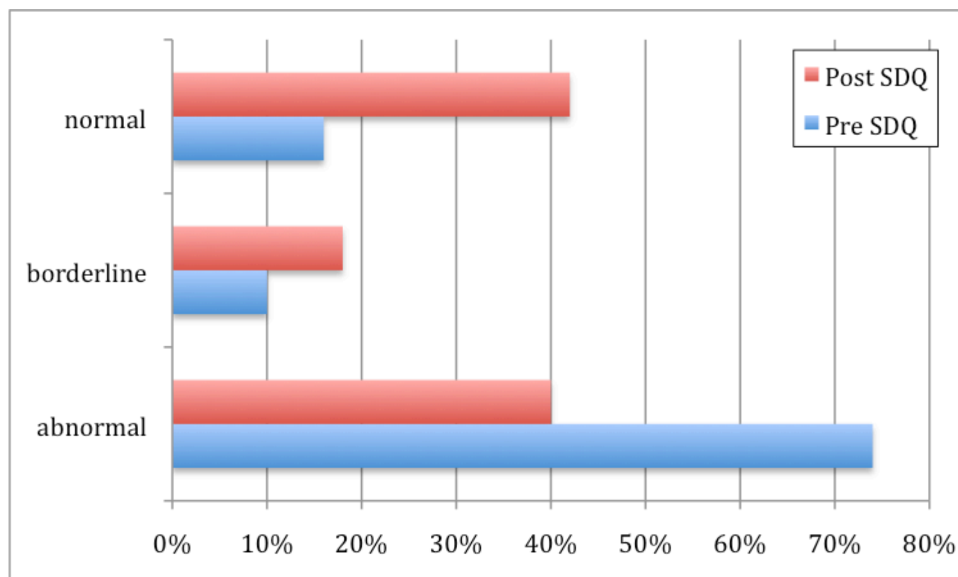


Figure 4 shows impressively the contribution made by DT over the most recently completed three years. Most important is the reduction overall in the numbers of young people in the 'abnormal range' by 46% as judged by the individual or averaged scores across parents and teachers.

The goal setting and the qualitative record keeping is very full, running to 70 pages of text across the 2010/11 cases. Goals are set with the parents and young people and sometimes the referrer too. Feedback is sought from and recorded from all parties so far as this can be obtained. Quantitative data on the rating of the closeness to full achievement of the goal on a 10 scale and rated again at the end was available for only 13 cases and in 10 of these the results were positive, sometimes strikingly so. As examples:

A primary school pupil who would refuse to do any work and go into a silence that could last hours was rated 0/10 at the outset and 5 to 6 out of 10 at the conclusion.

Three goals for another primary school child had positive results:

- low self-confidence and self-esteem; on entry: 1-2/10; On exit 7-8/10
- talking to mum; on entry: 3-4/10; On exit 9/10.
- learning and staying in classroom; on entry: 0-1/10. On exit: 8/10.

For a tempestuous five year-old, B's mum said she felt calmer through coming to Dandelion. B's siblings noticed that when he gets home from Dandelion he is calmer and happier. Although not resolved, going to DT has been 'a worthwhile/wonderful experience' for them both.

P (mother) said she loved Dandelion – it helped with her problems, 'There was time to talk, support was brilliant'. M (aged 10) thinks DT is, 'a great place to be with helpful, lovely people'**.** Comments from two parents were: 'The team genuinely cared'. 'It was fantastic'. Another mum said: 'I was made to feel very welcome and each time we came we would go home laughing. At Dandelion everything is possible and Graham, Carol and Laura go out of their way to help.'

There were also reports of lesser levels of success, to be expected in circumstances where children and families have complex and longstanding difficulties which play out in a range of arenas. Mum says that both children loved coming to Dandelion and that they were very disappointed when their time here came to an end. She doesn't think that the positive impact Dandelion had when they were there carried over into family life.

A referrer said of one young man that, 'He has been brilliant at Dandelion, but has struggled to transfer this into school'. In another example, 'S has improved but has a significant way to go. The family lurches from one issue to another – attachment still part of the problem. Behaviour is fragile as is her self esteem and confidence. Attendance remains a big issue. DT was just what this family needed but a substantial amount of further work needed by other agencies and then maybe another referral to Dandelion might be necessary'.

Another referrer said: 'Not sure the family found it very useful (according to grandmother). H enjoyed his time, but not sure the impact was as much as was hoped.'

4. Costing Dandelion Time interventions

Family intervention projects (FIPs) funded by the DCSF across a number of local authorities were judged to be very effective (Kendall et al, 2010). A costing tool was developed to support calculations of savings resulting from interventions (DfE, 2011b). FIP workers had a caseload of six and staffing costs would amount to a £7,000 per family. Savings, however, were estimated to be in the order of an average of over £80,000 (some of which was lifetime costs). Westminster Council (2010) is the leader in this work on 'repairing broken families).

The costs for one DT family is £200 per week, which is both subsidised by other charitable income but also allows longer periods of working with a family if it is required and statutory agencies cannot pay or cannot pay in the timescale required. A ten week programme costs £2,000. For a full year, it is £6,000.

The evidence suggest both that there is a level of effectiveness which reducing problems and in contributing to family and people's happiness. This in itself *may* result in better functioning and reduced call upon other services such as social services, GPs and educational welfare. Fuller quantitative data from SDQs and goal attainment would allow a more confident assertion of DT's success.

Costing savings resulting from DT work is difficult and is only sensible if it is clear that the following apply:

- preventing a family moving to a higher tier of intervention
- preventing a child going into care
- maintaining a child in full-time mainstream education
- supporting a child to remain engaged in alternative education and move on to FE (and not becoming NEET)
- preventing domestic violence and thus avoiding court and other intervention costs
- preventing antisocial behaviour and criminal activity.

Costing DT's contribution alone may be too challenging but as the organisation is networking effectively with other agencies one could foresee a broader approach to what still might count as early intervention and preventative work, costable in total in a similar way to FIPs.

At present, the most that one can say about DT's contribution to future savings is that even applying a conservative contribution of 20% to savings then the savings set out in Table 6 would result. A 30 week programme would cost £6,000, or be charged at this subsidised level, and make 60% savings above this if these selected example costs were involved.

Table: 6 Estimated savings from a 30 week DT programme

Service	**Cost** (Figures taken from Annex 3: DfE ~ Negative Outcomes Costing Tool Template)	**20% reduction in future costs, annualised**
CAMHS team case	£2,923	£584
Group parenting programme	£1,200	£240
Domestic violence (inc health, soc services & crim justice	£23,315	£4,663
Education - truancy	£44,468 (lifetime) £3,500 (annualised	£700
Education - exclusion	£63,851 (lifetime) £14,664 (annualised –PRU cost	£2,933
ASBO	£5,350	£1,070
Total estimated savings		**£10,190**

At times of increasingly constrained funding, it is difficult to press the moral argument effectively about increasing happiness for children and families unless linked with future financial savings. The 'spend to save' strategy often talked of in LA circles appears to apply with some confidence to DT.

The calculations set out here are conservative and the annualised costing, rather than using 'lifetime costs', give a fair, real time saving in the short term. The annualised approach was used on the Medway FIP evaluation (Parsons and Howlett, 2011). In any individual case, the mix of problems will be different and the amounts of potential future costs avoided will vary. Looking at what is at the top end of DT's period of engagement, 30 weeks and £6,000, the costs for 100 children would be £600,000 and the savings over £1M. This is aside from the 'softer' benefits of more satisfying relationships and lives for children and their families.

5. Current achievements and future potential

The Monroe review of child protection (see Annex 1) advocated that there be a requirement on local authorities and statutory partners ‘to secure the sufficient provision of local early help services for children, young people and families’ (recommendation 10) and that LAs and partners ‘review and redesign the ways in which child and family social work is delivered, drawing on evidence of effectiveness of helping methods’ (recommendation 13). The Marmot Report’s first two policy objectives are: give every child the best start in life, and, enable all children, young people and adults to maximise their capabilities and have control over their lives. To do this, there needs to be: routine support to families through parenting programmes, children’s centres and key workers, delivered to meet social need via outreach to families and extending the role of schools in supporting families and communities and taking a ‘whole child’ approach to education; a school-based workforce [with] skills in working across school– home boundaries and addressing social and emotional development, physical and mental health and well-being. The Allen Report states central objectives of Early Intervention to provide a social and emotional bedrock for the current and future generations of babies, children and young people and, with the encouragement of the Government, the best and most rigorously proven Early Intervention programmes should be pulled together. DT, in its ninth year of operation, does much that conforms to the exhortations of these reports. It is a significant partner in the Maidstone area of Kent providing a cost effective model for working with a proportion of troubled families.

The DT model is innovative in terms of its roots in family and individual therapy, its combination of group provision for some and bespoke provision for others, its use of the natural environment, and it is the activities taking place in this environment which allow the development of trust and for therapy to take place in a seemingly informal way. The service has shown itself to be flexible both in terms of length of referral and the responsiveness of the therapeutic interventions.

In its eight years of operating, DT has established a support base of expert and other volunteers, a practice of ‘supervision’ in the management of cases and safeguarding procedures at the farm environment where they work to ensure the safety and well-being of clients.

DT’s funding model currently shows over 60% of funding from statutory sources with the rest coming from charitable contributions. This provides DT with the space to be independent and flexible and, more importantly, to adjust periods of involvement with families if the enhancement of offerings to particular families, fits the purposes for which the funding was given (eg domestic violence, children’s special needs).

DT has shown itself to be an effective partner, working with other services, attending Team Around the Child (TAC), Common Assessment Framework (CAF) and other meetings and communicating effectively and sensitively with partner agencies.

Being tried and tested, DT could be established elsewhere in the local area (Kent, Sussex and south London) with the same principles and practices, and many similar environmental features. At its core is the therapy, working with focus on the presenting problems which a family has, particularly as displayed through the

behaviour of children. It is its effectiveness in this defined area for which DT deserves to be recognised. To capitalise on achievements, consolidate its position and develop further, it should implement more fully its monitoring and assessment procedures to have full data sets on at least 60% of its completing client families and children.

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Annex 1: Extracts from recent government reports on children and early intervention

The Monroe Report (2011)

Recommendation 10: The Government should place a duty on local authorities and statutory partners to secure the sufficient provision of local early help services for children, young people and families. The arrangements setting out how they will do this should:

- specify the range of professional help available to local children, young people and families, through statutory, voluntary and community services, against the local profile of need set out in the local Joint Strategic Needs Analysis (JSNA);
- specify how they will identify children who are suffering or who are likely to suffer significant harm, including the availability of social work expertise to all professionals working with children, young people and families who are not being supported by children's social care services and specify the training available locally to support professionals working at the frontline of universal services;
- set out the local resourcing of the early help services for children, young people and families; and, most importantly
- lead to the identification of the early help that is needed by a particular child and their family, and to the provision of an "early help offer" where their needs do not meet the criteria for receiving children's social care services. (P 12)

Recommendation 13: Local authorities and their partners should start an ongoing process to review and redesign the ways in which child and family social work is delivered, drawing on evidence of effectiveness of helping methods where appropriate and supporting practice that can implement evidence based ways of working with children and families. (P 13)

Allen Report (2011) P. v Letter to the PM

2. All parties should commit to the central objective of Early Intervention to provide a social and emotional bedrock for the current and future generations of babies, children and young people by helping them and their parents (or other main caregivers) before problems arise.

3. With the encouragement of the Government, the best and most rigorously proven Early Intervention programmes should be pulled together using the best methodology and science available, to promote their wider use.

Marmot Report (2010)

The first two policy objectives of the Marmot report are:

Give every child the best start in life
Enable all children, young people and adults to maximise their capabilities and have control over their lives.

Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families (P 97)

Extending the role of schools in supporting families and communities and taking a 'whole child' approach to education (P105)

Developing the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being (P 105)

Annex 1: Evaluation Toolkit

1. Information sheet

Evaluating Dandelion Time ~ July 2011 – October 2011

Carl Parsons has been asked to carry out an evaluation of the work of Dandelion Time. The way of working over a four month period will be in partnership with Dandelion relying heavily on data gathered over previous years and drawing on accounts Dandelion staff can provide. The aim is to give an account of the range of work Dandelion does and assess the extent to which its model of working is successful in helping families and young people. This will involve:

- appraising the Dandelion team experience and background, training, model of working and environment
- Interviewing a small number of family members and young people about their experience of Dandelion
- Interviewing a small number of professionals who may be working with families or commission Dandelion services
- Bringing together data over eight years of numbers of families supported and the impact that has been recorded
- examining the costs of the service and the amount of savings that result from support and early intervention for families experiencing difficulties.

Any information given to us will be strictly confidential; nobody else will know what we have been told or by whom without us checking that it is okay with the participant first.

Those interviewed will be asked to sign a consent form before any interview. They can change their mind at anytime – they just need to tell the Carl or a Dandelion staff member. Parents/carers are asked for their permission to approach the young person to take part in the evaluation but they do not have to take part if they do not want to. Children also sign a consent form before an interview.

If participants have any questions or would like more information about this evaluation they can ask Carl prior to the interview, or earlier using the telephone number or email below. He will be happy to explain more. Participants can also ask the Dandelion staff if that would be easier. There will be a short account of findings and recommendations available to all in November 2011.

Contact details

Carl Parsons
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Brief biography

Carl Parsons worked in teacher education at Canterbury Christ Church University from 1981 and was Professor of Education from 1998. He is now a Visiting Professor in the Research Centre for Children, Schools and Families at the University of Greenwich His recent research has been into school exclusions, multi-agency support and evaluations of initiatives to support children and families in challenging circumstances. His most recent publication is *Strategic Alternatives to Exclusion from School* (Trentham Books, 2011).

2. PARTICIPANT CONSENT FORM

Dandelion Time Evaluation

A Participant Consent Form should normally accompany all applications

The consent form **must** be signed by the actual investigator concerned with the project after having spoken to the participant to explain the project and after having answered his or her questions about the project.

To be completed by the participant		**To be completed by participant if under 18**	
1. I have read the information sheet about the evaluation	YES/NO	1. I have read the information sheet about the evaluation	YES/NO
2. I have had an opportunity to ask questions and discuss the evaluation	YES/NO	2. I have had an opportunity to ask questions and discuss the evaluation	YES/NO
3. I have received satisfactory answers to all my questions	YES/NO	3. I have received satisfactory answers to all my questions	YES/NO
4. I have received enough information about the evaluation	YES/NO	4. I have received enough information about the evaluation	YES/NO
5. I understand that I am free to withdraw		5. I understand that I am free to withdraw	
• at any time	YES/NO	• at any time	YES/NO
• without giving a reason for withdrawing	YES/NO	• without giving a reason for withdrawing	YES/NO
• withdrawal from the evaluation will not affect the involvement of my family in Dandelion Time or the receipt of support and other benefits	YES/NO	• withdrawal from the evaluation will not affect the involvement of my family in Dandelion Time or the receipt of support and other benefits	YES/NO
6. I agree to take part in this study	YES/NO	6. I agree that the named participant may take part in this study	YES/NO
7. I agree that my child can be asked to be part of the evaluation	YES/NO		
Signed (Participant)	Date	**Signed (Parent/Guardian)**	Date
Name in block letters		**Name in block letters**	
Signature of investigator	Date	**Signature of investigator**	Date

This Project is Supervised by: Carl Parsons
Carl Parsons Visiting Professor of Social Inclusion Studies University of Greenwich Avery Hill Campus LONDON SE9 2UG Email: c.parsons@greenwich.ac.uk Mobile: 07710489033

3. Interview framework for parents and children

Dandelion Time Evaluation

Date …………………

Introduction

Explanation of the evaluation and provision of information sheet

Ask for agreement to the interview to be ratified by signing of the permission form

Ask for permission to record

Explain that you will be trying to get the opinions of both parent and child

Name of Interviewee(s) ……………………………. Name of Interviewer ……………….

1. Can you describe what you actually do when you come to Dandelion?
2. How were you first put in contact with Dandelion?
3. What were your first thoughts when you had your first contact with the Dandelion people?
4. What are the best things you have done here?
5. What things that you have done here have helped you most?
6. What particular things have you managed to improve because you have come here?
7. What would you say are the problems facing you and your family?
8. How have your problems reduced as a result of Dandelion's help?
9. Who else helps you with these problems?

   (social worker, doctor, teachers etc)
10. What do you still struggle with?
11. What other help do you need and how would that help you to move forward?
12. What else would you say about how Dandelion Time

4. Interview framework for professionals

Dandelion Time Evaluation Date ………………….

Introduction

Explanation of the evaluation and provision of information sheet

Ask for agreement to the interview to be ratified by signing of the permission form

Name of Interviewee ……………………………. Name of Interviewer ………… Date ……..

1. Role/Service …………………………………………………
2. What is your involvement with the children or families with which Dandelion is working?
3. How is your work supported by what Dandelion Time does for children and families?
4. What are the problems facing families and young people with which affect your area of work?

   Education

   Health including mental health

   Support from social care agencies

   Domestic violence

   Drug and alcohol use

   Crime/Antisocial behaviour (adult or child)

   Other

5. How has Dandelion helped?
   (on a scale of 1- 5, how effective do you think they have been)
6. What is it that Dandelion provides which seems to work?
7. How have problems reduced (if at all) as a result of Dandelion help?
8. How good is communication and collaboration in your experience of Dandelion?
9. What other help is needed to help the individuals and the family forward?

Annex 3: Negative Outcomes Costing Tool Template

	Organisation bearing the cost	Cost	% Reduction of Risk	Pre-intervention Incidents	Predicted savings
Crime/anti-social behaviour					
Vehicle theft	Police	£5,376	**47%**		
Abandoned vehicle (collect & dispose)	Local authority	£73	**47%**		
Disposal	Local authority	£83.91	**36%**		
Hoax fire call	Local authority	£500	**47%**		
Police call out	Police	£110*	**47%**		
Cost of LA house vandalism	Local authority	£734.21	**86%**		
Demolition of property	Local authority	£6,462	**86%**		
Replacing bus shelter	Private sector	£2,585	**86%**		
Graffiti (low)	Various	£6,462	**86%**		
Graffiti (high)	Various	£81,427	**86%**		
ASB Warning letter	Various	£66	**54%**		
Acceptable Behaviour Contract	YOT	£230	**59%**		
Parenting Order	Various	£781	**62%**		
Intensive Supervision and Surveillance Programme	YOT	£31,865 6 mth cost	**62%***		
Referral Order	YOT	£1,102	**53%**		
Reparation Order	YOT	£1,139	**14%**		
Supervision Order	YOT	£3,098	**20%**		
ASBOs	Police	£5,350	**32%**		
Missing from home	Police	£110*	**64%**		
Arrest	Police	£1,930	**64%**		
Magistrates' court proceeding	Crim Justice	£550	**64%****		
Crown court proceeding	Crim Justice	£8,600	**64%****		
Prison day	Crim Justice	£99.36	**64%****		
Education/Employment					
Truancy	Society	£44,468/ lifetime	**58%**		
No qualifications at 16/17. Weekly earnings gap experienced for 21 months for 16/17-year-old	Society	£40/week	**38%**		
No qualifications for women aged 18. Weekly earnings gap for 9 mths	Society	£45/week	**38%**		
No qualifications for men aged 18. Weekly earnings gap for 9 mths	Society	£60/week	**38%**		
Exclusion from school	Society	£63,851/ lifetime	**54%**		
Lost days of work	Society	£95/day	**5%**		
PRU	Society	£14,664/ yr	**54%**		
Housing					
Noise – including staff time and prosecution	Local authority	£624.69	**70%**		
Noise – Housing department informal intervention	Local authority	£62.47	**70%**		

Noise – transfer of tenancy	Local authority	£1,041	**70%**		
Noise – legal action	Local authority	£2,664	**70%**		
Nuisance behaviour – legal action to local authority	Local authority	£12,994	**70%**		
Nuisance behaviour – possession action	Local authority	£3,748	**70%**		
Nuisance behaviour – eviction	Local authority	£6,872	**70%**		
Neighbourhood disputes – costs including staff time	Local authority	£778	**70%**		
Neighbourhood disputes – possession order	Local authority	£4,060	**70%**		
Eviction for anti-social behaviour	Local authority	£6,500	**70%**		
Neighbourhood disputes – injunction	Local authority	£1,249.39	**70%**		
Notice of Seeking Possession	Local authority	£544.64	**70%**		
Rent arrears *** (£1,000)	Local authority		**41%**		
Health Care					
A&E	Health Service	£105/visit	**28%**		
Inpatient treatment for drugs/alcohol misuse	Health Service	£205/day	**28%**		
Emergency ambulance	Health Service	£246/ journey	**28%**		
Inpatient	Health Service	£286/day	**28%**		
Outpatient	Health Service	£113/visit	**28%**		
Day care for adults with mental health problems	Health Service	£105/day	**28%**		
GP	Health Service	£27/visit	**28%**		
PN	Health Service	£9/visit	**23%**		
GP Home	Health Service	£59/visit	**28%**		
PN Home	Health Service	£12/visit	**23%**		
CPN Home	Health Service	£62/hour	**28%**		
NHS Direct	Health Service	£17/visit	**28%**		
Prescription	Health Service	£34/visit	**28%**		
Alternative medical practitioner	Health Service	£11/visit	**28%**		
Specialist/OP	Health Service	£101/ appoint-ment	**23%**		
Child and Adolescent Mental Health Service	Health Service	£41/hour	**18%**		
Child and Adolescent Mental Health Service	Health Service	£70/hour	**18%**		
Child and Adolescent Mental Health Service	Health Service	£87/hour	**18%**		
Child and Adolescent Mental Health Service	Health Service	£2,923/ case per team	**18%**		
Drug and Alcohol Services					
Street agency visit	Various	£72	**47%**		

Voluntary sector residential rehabilitation	Various	£732/week	**39%**		
NHS inpatient treatment	Health Service	£205/day	**39%**		
Counsellor	Various	£44/hour	**39%**		
Alcohol Health Worker	Health Service	£24/hour	**48%**		
Methadone treatment	Health Service	£53/week	**39%**		
Social Care					
Occupational Therapist	Soc Services	£51/hour	**28%**		
Social worker	Soc Services	£38/hour	**48%**		
Benefits adviser	Soc Services	£31/hour	**50%**		
Housing Benefit adviser	Soc Services	£31/hour	**50%**		
Other social adviser	Soc Services	£31/hour	**48%**		
Psychiatrist	Soc Services	£210/hour	**18%**		
Psychologist	Soc Services	£66/hour	**18%**		
Child being taken into care (residential)	Local authority	£5,865 + £1,844/mth	**37%**		
Child being taken into care (fostering)	Local authority	£6,011 + £14,624/mth	**37%**		
Child Protection Plan	Soc Services		**42%**		
Parenting programmes					
• Group in-clinic ****	Local authority	£500/ programme	**-**		
• Group in-community ****	Local authority	£1200/ programme	**-**		
• Individual in-clinic ****	Local authority	£2,000/ programme	**-**		
• Individual in-home ****	Local authority	£3,000/ programme	**-**		
Domestic Violence					
Domestic Violence	Society	£19,707	**59%**		
Domestic Violence	Health Service	£1,610	**59%**		
Domestic Violence	Crim Justice	£1,173	**59%**		
Domestic Violence	Police	£562	**59%**		
Domestic Violence	Soc Services	£263	**59%**		

* The police costs for callout and for 'missing from home' were calculated from police hourly rates obtained locally

** No cost/risk reduction percentage is included in the 1.7.7A version; the percentage reduction attributed to the police items above is continued to these three items

*** A sum of £1,000 is entered here, almost certainly an underestimate

**** These items are calculated in the costing package as a continuing cost not leading to savings. This is disputed and has been included as a cost like others and calculated as offering the prospect of 50% savings