EITP Work-stream 2

Informing the development of a regional Early Intervention Service (EIS) for Northern Ireland

Report 2: Towards a shortlist of potential approaches and interventions for delivery of EIS

Final version

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Contents

The Early Intervention Transformation Programme (EITP) is a Northern Ireland Executive/Atlantic Philanthropies Delivering Social Change Signature Programme, funded jointly by the Delivering Social Change fund, DoH, DE, DoJ, DfC, DfE and The Atlantic Philanthropies. EITP aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches.

This report was produced for the Early Intervention Transformation Programme and funded by Atlantic Philanthropies. This report is primarily intended to inform the decision making relating to the development of the Early Intervention Transformation Programme projects.

1. Introduction and purpose of this report

Background

The Early Intervention Transformation Programme (EITP) represents the coming together of six Government departments and private philanthropy, as part of the Delivering Social Change (DSC) initiative, to jointly fund a programme of early intervention.

The Programme's activity is being delivered via three work streams with specific aims:

- *Work stream 1:* To equip all parents with the skills needed to give their child the best start in life;
- *Work stream 2:* To support families when problems emerge; and
- *Work stream 3:* To positively address the impact of adversity on children by intervening both earlier and more effectively to reduce the risk of poor outcomes later in life.

NCB NI has been commissioned to provide arrange of technical support services across the EITP work stream teams including undertaking evidence reviews to inform the development of project proposals.

Purpose of this report

In October 2014, the National Children's Bureau undertook a Rapid Evidence Review to inform the development of the Early Intervention Service (EIS). As part of that review, NCB was specifically asked to:

- Identify the evidence base for a range of interventions[1] which may from part of the proposed EIS delivery model using a key worker.
- Identify and recommend other appropriate evidence based family support interventions appropriate to the proposed EIS i.e. those that target Tier 2 families and are delivered using a key worker.
- Provide learning from similar approaches to early intervention elsewhere that use a key worker approach.

[1] Family Group Conferencing; Motivational Interviewing; Video Interactive Guidance; Solihull; and Brief Intervention Therapy.

As can be seen from the above, the scope of the review was quite broad as the precise parameters for the EIS delivery model had not been substantively developed at, or prior to, the time at which the evidence review had taken place. In addition, the extent of unmet need across Northern Ireland for tier 2 families was not readily available.

Since then, there has been extensive stakeholder engagement across all localities to inform the development of the Early Intervention Service by the Project Lead; Change Coordinator and Regional FSH (Family Support Hub) Coordinator through the CYPSP[2] Outcomes Groups; Locality Planning Groups and stakeholder workshops in collaboration with the Directors of Social Services within each locality. Key stakeholders from community, voluntary and statutory agencies have been included within this process[3].

A number of key themes emerged from the stakeholder events in relation to the types of families/issues that required additional support. These include:

- Transitions – key points in the child's/young person's life where there is increased vulnerability e.g. transition from home to school; through the education system; adolescence; life transitions including bereavement, parental separation, diagnosis of illness.
- Children/young people with disability;
- 0-4 year old children outside Sure Start areas; and
- Children with behavioural issues.

In addition to this, an overarching issue was identified across all localities in relation to getting children, young peoples and families to engage with services. This issue is documented in the literature, for example, Newman et al (2009)[4] and Siraj-Blatchford and Siraj-Blatchford (2010)[5] have highlighted that services face the challenge that families who are most in need of support are often the least likely to access it. Evidence on engagement focuses on the importance of the relationship between the worker and the client and the characteristics of skilled practitioners. This is something which is discussed in greater detail below.

NCB has compiled this focused report to further elaborate on potential aspects of the delivery model for EIS including:

- **What works in family support** looking specifically at the role of the key worker; the importance of the relationship between the worker and the family based on which workers can most effectively engage families to provide a flexible needs led family centred approach;

- **Potential approaches and interventions to engage and affect change with Tier 2 families** including Motivational Interviewing and the Solihull approach[6], Family Group Conferencing and Solution Focused Brief Therapy[7]; and

[2] Children and Young People's Strategic Partnership.
[3] Key stakeholders included: service users; health visitors; midwives; school nurses; learning disability nurses; community children's nurses; GPs; Sure Starts; family support providers and CAMHS.
[4] Newman, T., McEwen, J., Mackin, H., Slowley, M. & Morris, M. (2009) *Improving the wellbeing of disabled children (up to age 8) and their families through increasing the quality and range of early years interventions (C4EO disability research review 1).* London: Centre for Excellence and Outcomes in Children and Young People's Services.
[5] Siraj-Blatchford, I. & Siraj-Blatchford, J. (2010a) *Improving development outcomes for children through effective practice in integrating early years services (C4EO early years knowledge review 3).* London: Centre for Excellence and Outcomes in Children and Young People's Services.
[6] Motivational Interviewing are defined as approaches.
[7] Family Group Conferencing (FGC) and Solution Focus Brief Therapy (SFBT) are defined as interventions.

- **Implications for EIS.**

The proposed Early Intervention Service

This proposed new service sits within work stream 2 of EITP and is led by the Public Health Agency. Its overall aim is to work with families with 'Tier 2'[8] level needs. The EIS has set out to deliver and coordinate personalised, evidence-based early interventions for children, young people and their families with the aims of de-escalating issues of concern, achieving sustainable change, promoting capability and capacity within families to problem solve difficulties they are or may experience in the future and diverting them from statutory intervention services using the combined expertise of participating agencies.

Key operational parameters of the proposed EIS, as defined within the draft EIS proposal are that it will consist of approximately 20 multi-disciplinary teams across NI. The EIS teams will be aligned to Family Support Hubs (FSHs) and will work together with existing services to ensure the right services are engaged with the family resulting in the development of multi-agency working. Each team will be led by a professional with a qualification in a health/education related discipline who will be supported by a number of family support workers. It is proposed that a key worker will be provided for each family with whom they will work on an individual basis in providing a range of time-limited interventions as well providing access to evidence based/evidence informed parenting programmes.

[8] Families are supported according to their level of need. Families may receive services through one of four tiers. Tier 1 is the lowest tier and normally involves a family and/or children receiving services through professionals currently engaged with the child (e.g. GP, teacher etc.). Tier 4 is the highest tier and normally involves a full range of professionals and specialists including Clinical Psychologists, Child Psychiatrists and Community Paediatricians. This service is targeted at Tier 2 families, which involves the full range of professionals who may come into contact with families on a daily/weekly basis in addition to a range of other professionals (e.g. Child care social workers, Education psychologist).

2. What works in Family Support

Introduction

The focus of the Early Intervention Service is on providing direct support to Tier 2 families. The model for how that support is provided is critical in terms of whether, and to what extent, the service will be successful in improving the lives of families.

This section of the report begins by outlining some of the critical factors of effective family support which have been drawn from an international evidence review on what works in family support. It then goes on to look at the critical role that key working can play in delivering effective family support and ends by outlining the skills and experience required by a key worker and how they might be best supported in working with families (e.g. in terms of optimal case load).

The critical factors in effective family support

The implementation of effective family support is as much dependent on how that support is delivered as it is about the content of that support. A review of international evidence, undertaken by Moran et al. (2004), on what works in terms of family and parenting support sets out a wide range of factors that ought to be considered in terms of successful implementation of family interventions including:

- **Practical factors:** This includes the full range of concrete factors that can contribute to the ease with which services can both get and keep parents and families. Examples include: provision of childcare facilities and provision of transport;

- **Cultural, contextual and situational factors**: This group of factors refers to the ecological context of parenting, and the importance of recognising that parenting is influenced by a wider range of interactive and interdependent factors. Attention to and understanding of users' life circumstances (including their sex, living situations and general well-being) as well as their cultural and ethnic background appear to be a fundamental pre-requisite to engagement of parents with services;

- **Strategic factors**: This refers to the 'strategic' aspects of delivery – essentially, things that services can do to incentivise attendance at family support services and discourage dropping out. Examples include: investing persistent effort in the early stages of referral and attendance and pursuing non-attendees vigorously and persistently; and

- **Structural factors:** Structural factors are principally about the format or mode of service provision, and mainly affect the success of keeping and engaging parents. For example, though group-work is often well-received by parents and is thought to be more cost effective than one-to-one work, groups often do not work well for the most highly stressed or vulnerable families.

In addition to the above, the report also points out the critical role of relationship factors, i.e. the relationship between the staff delivering the support and the families that they support. Relationship factors, they note, are centrally important both for 'getting' and 'keeping' parents, and also in terms of overcoming any 'engagement' hurdles. Specific relationship factors thought to be important include:

- Using 'trusted' local professionals where possible (e.g. staff who are already known to parents);
- Recruiting staff with excellent inter-personal skills, which generally matters more than personal attributes such as the sex or ethnicity of the staff member;
- Ensuring that all staff are fully trained for the job;
- Building rapport with parents before they begin formally using a service (for example, using home visits by facilitators both for assessment and introductory purposes);
- Using interactive rather than didactic style of working;
- Avoiding 'talking down' to service users or making them feel belittled or inexpert in their own lives; and
- Ensuring that user feedback is incorporated into changes to the service, and that this is conveyed to users.

Whilst the report by Moran et al. did not recommend a specific model (i.e. one-to-one dedicated support or group support), it recognised the importance of matching the model to the needs of each family. Indeed, it cites a number of family support programme/services (e.g. Enhanced Family Treatment) which have used dedicated workers to support families and which have achieved successful outcomes.

More recent evidence from the UK looking specifically at the Troubled Families programme (2012) recognises the centrality of a key worker model where workers are dedicated to individual families and provide a critical link between the family and statutory agencies (see below for more details). In their evidence and good practice guide, they set out five family intervention factors which they suggest form critical components of what they have termed 'the family intervention factor'. These include:

- **Dedicated workers, dedicated to families:** Much of the success of family intervention work is attributed to the skills of individual workers in terms of building productive relationships with families and ensuring the appropriate level of interaction between the family and statutory and non-statutory agencies.

- **Practical 'hands on' support:** An initial focus on practical help (e.g. cleaning projects or rubbish clearance) is important in terms of building rapport with families and in helping them to establish routines.

- **A persistent, assertive and challenging approach:** One of the key definitive characteristics of family intervention workers is that they are persistent, assertive and tenacious. In addition, spelling out clearly the consequences of inaction to families unwilling to change was also defined as a key attribute of effective family intervention practice.

- **Considering the family as a whole:** Effective family intervention work entails considering the experience and needs of the family as a whole rather than looking at the needs of individuals within the family unit separately.

- **A common purpose and agreed action:** Following on from the above, it is important that each family has one plan and one worker who pools the expertise of multiple-agencies to deliver against that plan. This can help to ensure that the right interventions/activities are put in place throughout the various stages of the intervention.

Other studies such as the Family Intervention Projects (FIP) undertaken by the National Centre for Social Research) support the findings presented above. In addition, the FIPs evaluation also identified the importance of small caseloads and the flexibility of services to stay involved with families for as long as is necessary. In a 2011 study undertaken by York Consulting, findings in support of the above were also noted when examining how professionals develop effective relationships with vulnerable parents to improve outcomes for children. The study, commissioned by Action for Children, resulted in the development of a skills framework for professionals with the following highlighted as important features:

- Maintaining a child focused approach
- Supporting and challenging
- Being open
- Building trust and mutual respect
- Empowering and enabling families
- Action-focused practice
- Interacting positively with children and young people
- Facilitating parents' understanding

The key worker approach

As identified above, one of the critical ingredients in working successfully with families and in bringing about substantive change is the use of key workers who are dedicated to particular families. A key worker is a single point of contact that a parent approaches for advice about any problems

related to their child. The key worker approach has been most commonly implemented in services that engage with disabled children and their families. As alluded to above, there are a number of potential impacts of key worker approach, namely[9]:

- The quality of life of families with children engaged in services is improved;
- Better/more effective coordination of services around the family so that other practitioners' time and that of the families is freed up, potentially leading to a more efficient and effective system.
- Providing families with better and quicker access to services and reduced levels of stress.

Other studies (Sloper et al. 2006) concur with this in suggesting a wide array of potential impacts of key working including empowerment of parent carers; better relationships with services; higher morale, and; less isolation and feelings of burden amongst other things. Whilst these 'soft' impacts are important in their own right, we could not find evidence of 'hard' quantitative impacts of key working on particular aspects of family functioning (e.g. young people's attendance rates).

It is important to note that key workers are a fundamental component of a key working service. A key working service is a set of functions which enable an integrated approach to supporting children and their families, rather than as an add-on service. Embedding a key working approach across the commissioning of all services for children and young people has the potential to significantly improve how these services are delivered and to subsequently improve children and young people's outcomes. Those children and families that receive a key working service should be provided with a named key worker.

The role of a key worker, the characteristics and skills necessary to fulfil this role and supporting factors are listed below. In addition, an indication is provided of the potential caseload that a key worker might have at any one point in time.

The role of a key worker

The role of key worker is a complex one for which there is no blueprint - however emerging research has identified some key facets of the role:

- Providing information and advice to families about services and support available both locally and nationally, and how to access these;
- Identifying, assessing and addressing the needs of all family members;
- Providing emotional and practical support as required;
- Assisting families in their dealings with agencies and acting as an advocate if required; and
- Elements of a key worker role which are particularly valued by families include proactive, regular contact within the context of a supportive, open relationship, together with a family-centred, rather than a child-centred approach.

[9] See Care Co-ordination Network UK (2007) *Best practice in key working: what do research and policy have to say?* London: CCNUK.

The skills and experience required of a key worker

Research to date suggests that there is no particular profession whose members are best suited to act as key workers. Systemic factors (such as effects of training, supervision and time allocation) have more effect on key workers' effectiveness than their professional backgrounds.

Research literature does however identify many necessary attributes of an effective key worker including the need to:

- Be flexible and have the ability to learn and adapt rapidly in what is a developing field;
- Be able to recognise families' strengths to represent the families' interests rather than those of employing agencies;
- Have basic counselling, communication and listening skills;
- Be able to work in partnership with parents and children, respecting their expertise;
- Have negotiation skills;
- Be able to act as advocates for children; this includes both children engaged directly with services and their siblings; and
- Have extensive knowledge of children's and families' needs and relevant services so that they can provide advice to families about the range of services and support available.

Specialist training for key workers

At any one time, key workers may deal with a wide array of family issues and therefore the type of training they receive is important. Research undertaken by the Children's Workforce Development Council in 2011[10] point to the need for key workers to be trained in the following areas:

- Mental health;
- Understanding of other agencies/services;
- Therapeutic approaches (e.g. Brief Intervention);
- Motivational interviewing;
- Sexual health;
- Safeguarding and domestic violence;
- Assessment;
- Communication and participation skills;
- Challenging behaviour;
- Personal safety;
- Record keeping including IT systems;

[10] Children's Workforce Development Council (2011) *Providing intense support for families with multiple and complex needs.* London: CWDC.

- Multi-agency working;
- Assertive working;
- Housing protocol and legislation;
- Supervision and management; and
- Youth crime and anti-social behaviour.

The above list is a suggested list of training to equip key workers with the knowledge and skills required to undertake their role, however the precise training activities will be determined by the range of issues key workers have to address as part of their role.

Supporting key worker practice

Research identifies the following as necessary supports to enabling effective key worker practice:

- Local key workers should have access to a central administrative resource. This would ensure that key workers can focus the majority of their time on working with children and young people whilst the administrative support is able to follow-up appointments, for example;

- The provision of a key worker for all children and young people aged between 0-25 years would ensure that the benefits can be reaped across the difficult period of transition from child to adult services; and

- There is a need for better evaluation of key worker approaches. These evaluations should be taking place on an on-going basis so that practitioners can alter and improve their practice based on results.

Caseload of a key worker, duration of intervention and cost

The literature suggests that the caseload of key workers varies significantly from one initiative to the next - there is therefore no 'typical' caseload. However, the literature is clear that smaller caseloads (six or fewer families) are more effective and achieving greater positive impact when working with families who have complex needs. Key points from the literature in relation to caseloads when working with families with complex needs include:

- The Think Family Toolkit which provided guidance for the implementation of the Family Intervention Projects recommends small caseloads of up to six at any one time. This enables the intensity of the intervention to reflect the level of need of the families (on average nine hours a week, including evenings and weekends). In terms of duration of intervention, it recommends that key workers stay involved for as long as necessary, with a target for average length of involvement of just over twelve months per family. Actual average caseload for the Family Intervention Projects (involving 53 separate projects) ranged from three to seven families per key worker; however the evaluation of FIP mentioned the importance of flexibility in terms of increasing/reducing caseload according to the needs of the families being supported.

- The National Centre for Social Research (NCSR) compiled a list of eight critical features of family intervention provisions. One of those elements relates to caseload in which it recommended a caseload of around five or six families at one time to reflect the intensity and complexity of the

intervention. This also helps to build trust and rapport, enabling a persistent and tenacious approach to working with families and coordinating other agencies.

Whilst the majority of literature on key working relates to its use with families facing multiple and complex difficulties, there are some examples both locally and in England where the approach is being used been with families facing less challenging circumstances and where average caseloads are therefore greater. For example, in Lambeth key workers working as part of an early intervention multi-Agency team work with up to 20 clients, depending on the family's level of need - the less complex the need, the greater the caseload. There is no specific data available on the recommended duration of the interventions from these examples nor is there evidence of impact on children's outcomes.

In relation to costs of key working, it was not possible to source any reliable estimates for this from the literature. Caseloads and duration of support will obviously be key drivers of cost and it is important that the EIS team carefully considers the potential budgetary implications of adopting key working model of working.

Conclusion

Overall, the evidence is clear that effective family support is predicated on a wide range of factors ranging from practical considerations such as the provision of child care facilities through to structural factors including the format or mode of service provision (whether group-based or one-to-one). However, given that many issues within families are multi-dimensional and require the input of more than one professional, often at various points in time, the literature points strongly to the use of dedicated workers who are dedicated to individual families as a central component of effective family support.

Whilst the evidence shows that key working can impact on a range of 'soft' areas (e.g. providing families with improved access to services), there is not yet a substantive body of evidence that we are aware of that points to 'hard' impacts of key working on families. This is perhaps something which EIS should carefully consider when putting in place performance management arrangements for the service.

In terms of optimal caseload and duration, whilst the evidence shows some variation in approach, most of the available information relates to the use of key working with families with complex needs and therefore smaller caseloads (six or fewer families). Effective administrative support is well documented as a key ingredient of effective family support and the EIS team will need to ensure that this is built into their delivery model and costs. The evidence is less clear on duration of family intervention suggesting that this should vary across families according to need. There was no information available about the typical costs associated with a key worker model.

3. Potential approaches and interventions to engage and affect change among Tier 2 families

Introduction

As part of the Rapid Evidence Review undertaken in October 2014, NCB was asked to explore a range of potential interventions/approaches for supporting Tier 2 families. The EIS management team has further reflected on these interventions/approaches and has asked NCB to explore the following in more detail:

- Motivational Interviewing;
- Solihull approach; and
- Family Group Conferencing;
- Brief Intervention (specifically Solution Focused Brief Therapy).

This section of the report provides further details for all four interventions/approaches above.

Potential approaches to engage Tier 2 families

Motivational Interviewing (MI) and Solihull are practice approaches that seek to actively engage and encourage families to identify the need for change and be actively involved in bringing about that change. In the sub-sections which follow, a brief description of each of the interventions is provided, alongside a summary table of the two approaches under the following headings:

- When and where is it used (including local use in NI);
- Qualifications and skills required to deliver;
- Delivery structure (i.e. in group format or one-to-one);
- Training and related costs;
- Cost benefit evidence; and
- Evidence of impact (i.e. whether or not the intervention is subject to experimental design such as a Randomised Controlled Trial which involves the use of treatment[11] and control[12] group and which is deemed to be the gold standard for assessing programme effectiveness).

[11] A treatment group comprises all of those individuals who have received a particular programme.
[12] A control group comprises all of those individuals who have not received a particular programme or intervention and whose results are used to assess whether the programme has had an impact on the treatment group.

Motivational interviewing

Motivational Interviewing is a client-centred method that aims to enhance a person or family's motivation to change a problematic behaviour by exploring and resolving their ambivalence about change without evoking resistance to change. The overarching goals of MI are to:

- Enhance internal motivation to change;
- Reinforce this motivation; and
- Develop a plan to achieve change.

It is based on three key concepts:

- **Collaboration:** This is about implementing a partnership that honours the family's expertise and perspectives. The key worker provides an atmosphere that is conducive rather than coercive to change.
- **Evocation:** this presumes that the resources and motivation for change reside within the family. Intrinsic motivation for change is enhanced by drawing on the family's own perceptions, goals and values.
- **Autonomy:** the key worker affirms the family's right and capacity for self-direction and facilitates informed choice.

Other key aspects of Motivational interviewing are outlined in Table 1 below.

Table 1: Key aspects of the Motivational Interviewing method

Motivational Interviewing	
1. When and where is it used?	• MI is used to address a variety of issues and is provided directly to parents/ caregivers/families. • MI is used across the health and social care trusts (HSCTs) in Northern Ireland by nurses, midwives, health visitors, social workers, outreach support workers, psychologists, occupational therapy condition management teams and self-harm practitioners. • Approximately 170 HSCT practitioners have received MI training through the Clinical Education Centre in the last 7 years. It is estimated that the total number of practitioners trained is however much greater than this. • Staff from BELB use MI techniques in order to involve parents more in school life. • MI was incorporated into the PHA Active Belfast project. • It is also used by the community and voluntary sector in Northern Ireland, e.g. the Together For You mental well being project which is a partnership of 9 different organisations, Extern, Council for the Homeless in Northern Ireland and Breakthrough, Addiction NI. • MI is also used by the Probation Board for Northern Ireland in its work with offenders.
2. Qualifications and skill set required to deliver	• Research suggests that it is possible to train professionals and lay people to offer the simplest components of MI during routine clinical practice. However, developers of MI recommend considerable training and support in order to develop the skills necessary for the technique. • Training for MI appears to be most effective when it begins early in professionals' careers, when it explores the philosophy underpinning the approach rather than being implemented as an isolated skill.

Motivational Interviewing	
3. Delivery Structure (delivered 1-1, in home settings etc; time required to implement)	• MI sessions can be delivered as a one-off. However, evidence suggests that 2-3 sessions are more effective than a single session. • The recommended duration of a single session is 30-50 minutes. • MI mostly requires one-to-one interaction between the practitioner and family members. • MI sessions are captured by the acronym OARS: Open-ended questions; Affirmations; Reflective Listening; and Summaries.
4. Training and costs	• HSC Clinical Education Centre run 2 MI training courses: MI and Stages of Health Behaviour Change (2 days £164) and MI within Midwifery care (1 day £82). These courses are free if organisations have a Service Level Agreement with HSC CEC. • MI is a modular option in degree programmes offered by the School of Nursing and Midwifery at Queen's University Belfast and the School of Nursing in the University of Ulster. • Private training provided by Glenn Hinds Level 1 Skills Development (2 days £220 for statutory organisations, £200 for voluntary organisations).
5. Cost benefit	• No information identified
6. Evidence of impact	• Results from several RCTs and 4 meta analyses have identified positive short and long term effects of MI on a number of outcome areas including substance misuse, diet and exercise, adherence to medication plans, mental illness, eating disorders and risky behaviours. It was also found to be effective in increasing client engagement in treatments for conduct problem children.

Solihull approach

The Solihull Approach employs a theoretical model that integrates psychotherapeutic, child development and behavioural concepts. It was originally designed to be used as a brief intervention (5 sessions or less) for practitioners working with infants and young children and their families. It aims to give these practitioners the knowledge and skills to help them work with parents to solve various behaviour problems in children.

The approach has been further developed and can now be used by a range of professionals working with children and young people up to the age of 18.

Other key aspects of the Solihull Approach are outlined in Table 2 below.

Table 2: Key aspects of the Solihull approach

Solihull approach	
1. When and where is it used?	• The Solihull Approach is mostly used in situations where parents require support in solving various behaviour problems in their children. • It is used mainly by health visitors in their engagement with parents during home visits. It can also be used by school nurses, midwives, ante-natal practitioners, and by community and voluntary organisations. • Thousands of practitioners have been trained in its use across the UK. • Whilst figures from the HSC leadership centre suggest that 120 practitioners have been trained in the Solihull Approach Foundation programme across the 5 HSCTs, it is widely acknowledged that this number is much greater among health professionals, particularly health visitors where training in Solihull is now mandatory. Many community and voluntary sector staff across NI are also trained in the approach.
2. Qualifications and skill set required to	• Those who typically receive training in Solihull include health visitors, midwives, school nurses, nursery nurses, doctors, psychologists, speech and language therapists, midwives, Sure Start teams, social workers and teachers.

	deliver	
3.	Delivery Structure (delivered 1-1, in home settings etc; time required to implement)	• It is largely based on one-to-one delivery between the professional and the parent. • Solihull can also be delivered to groups of parents and carers - usually to groups of 12 over 10 weekly sessions. • Parents can also receive training through an online course.
4.	Training and costs	• The HSC Clinical Education Centre (HSC CEC) and Public Health Agency offers 5 training courses to health and social care practitioners in the Solihull Approach: — Solihull Approach Foundation Programme (2 days, £160). — Solihull Approach Programme for Health and Social Care, Voluntary and Community Staff (2 days followed by 2 weeks practice and 4 mandatory practice sessions. No direct cost if organization has service level agreement with CEC). — Solihull Approach workshop for managers (1 day £82). — Solihull Regional Trainers Forum (1 day £82). — Solihull Train the Trainer (1 day, no direct cost if organisation has a Service Level Agreement). • Each practitioner that attends the above training is provided with a Solihull Approach Manual specific to their service area. • CEC does not currently deliver training on the Solihull Approach Parenting Course, but this training may become available in 2015-2016. • The online parenting course costs £39.
5.	Cost benefit	• No information identified
6.	Evidence of impact	• The majority of evidence found on Solihull focuses on its short term impact and is drawn from non-experimental evaluation designs. This evidence reports that the approach improved consistency of practice between health visitors; improved relations with other health professionals; increased job satisfaction; reduced the need for children with less complex behavioural issues to be referred to psychology and psychotherapy services; and reduced general parental anxiety and anxiety relating to problem child behaviour.

Potential interventions to affect change among Tier 2 families

This subsection discusses two potential interventions which EIS could use to both empower and affect change among Tier 2 families, namely:

- Family Group Conferencing; and
- Brief Intervention as a therapeutic model of intervention.

Family Group Conferencing

FGCs are gatherings that integrate families into the decision making process to help ensure child safety. They are based on the underlying presumption that by involving families in the resolution of difficulties, the outcomes for children will be improved. It is a model of practice that recognizes the value of extended family support and promotes service providers and families working together. FGCs are generally structured to incorporate four distinct stages[13]:

- **Referral:** Family members and agency agree that FGC is required and co-ordinator is appointed.

[13] Scottish Executive (2007) *Examining the Use and Impact of Family Group Conferencing.* Edinburgh: Scottish Executive.

- **Preparation:** Co-ordinator identifies family network, meets with people attending to discuss the reason for the meeting and invite them to participate.

- **Meeting:** Agency staff and/or other parties provide information to enable the family to develop a plan for the child, everyone attending discusses situation, family meets in private to discuss plan, plan is deliberated upon, amended if necessary and agreed by all attendees. In some situations the plan may then need to be agreed by another forum e.g. child protection case conference or LAC reviews.

- **Review:** Operation of plan is reviewed, FGC may be convened to amend/replace plan.

Our review of the evidence-based for FGC shows that there is a dearth of information regarding Family Group Conferencing in relation to its use with high risk families (i.e. Tier 3 or above), and centres mainly around its use in terms of care prevention/reduction (i.e. targeting reduced numbers of young people going into care). The evidence that is available in relation to short term impacts show that:

- It is popular amongst families and practitioners;
- It contributes to improving working relationships between families and practitioners;
- It is effective in engaging the wider family in issues impacting on children.

Aside from its extensive use in terms of care prevention, FGC has been used with young carers and their families with the aim of reducing the extent and impact on young people who care for others in their family[14]. In its report on the use and effectiveness of FGC in this context, Barnardos found that outside of their own study there was only one published research report specifically looking at the use of FGCs with young carers. However, they noted that the study did not report on the actual impact of FGC on young carers. In their own report, Barnardos reported a range of 'soft' impacts similar to those reported above in terms of its use with high risk families.

Overall, therefore, our review could not find any substantive evidence of the short or long-term impacts of FGCs' in terms of its effectiveness with families that have less complex needs (i.e. Tier 2 or below).

Other key aspects of Family Group Conferencing are illustrated in Table 3 below.

Table 3: Family Group Conferencing

Family Group Conferencing	
1. When and where is it used?	• FGC can be used in any serious situation where a plan and decision needs to be made about a vulnerable adult or child. • In the UK FGCs are mainly used in child welfare cases, particularly when a child is at risk of going into care, although some local areas are using the approach to prevent school exclusions, tackle anti-social behaviour, address youth offending and in planning for vulnerable adults. • In Northern Ireland, the approach is used by each of the five Health and Social Care Trusts, Barnardo's and Action for Children. • In England and Wales, c.75% of local authorities have implemented or

[14] Barnardos (2010) *Making plans: Using Family Group Conferencing to reduce the impact of caring on young people.* Essex: Barnardos.

Family Group Conferencing	
	commissioned FGC for children in their area or are planning to do so. • FGC has been implemented in over 20 other countries worldwide.
2. Qualifications and skill set required to deliver	• Those who wish to become trained as a Family Group Conferencing co-ordinator must hold a social work qualification.
3. Delivery Structure (delivered 1-1, in home settings etc; time required to implement)	• Families receive guidance and supervision from an independent FGC coordinator. • The organisation of an FGC takes a considerable amount of time. For example, in order to set-up a FGC, co-ordinators, alongside the young person and immediate carers, must identify potential participants from the family network. Co-ordinators must then meet with these family members individually in order to prepare them for the meeting. The time required for this process will depend on the number of family members identified. The actual FGC meeting is likely to take several hours and at the end of the meeting families will have developed a plan. A review FGC meeting is usually arranged to review how the plan is working and to make new plans if necessary.
4. Training and costs	• Training is available through the University of Ulster (UU) in partnership with The Family Group Conference Forum (NI). • The programme combines an introductory session and three taught days for skills development. The cost of training at UU is £500.
5. Cost benefit	• The Barnardo's Bristol family Intervention Project found that the cost of FGCs vary from £840-£2,200, with an average cost of £1,700. • Research suggests that FGC result in substantial savings since they are likely to reduce the use and costs of court proceedings. This is supported by a more recent survey by Family Rights Group (2010) which shows that for every £1 spent on delivering FGCs the savings to the state are £11.
6. Evidence of impact	• The most common sources of evidence for FCG are based on non-experimental evaluation designs which focus on the short-term impacts and largely conclude positive results. These results include its popularity amongst families and practitioners, its impact on improving working relationships between families and practitioners, and its effectiveness in engaging the wider family in issues impacting on children. Some inconsistencies in the evidence were found in relation to its longer term impact on preventing future care proceedings and returning children in care to their family settings.

Brief intervention as a therapeutic model of intervention

Brief intervention is a generic term referring to a variety of encounters with a client/patient that require relatively little time (Cavill et al, 2011) It is not a single intervention, but is part of a family of interventions varying in duration, content, targets of intervention, and providers responsible for their delivery (Nilsen et al, 2008).

The most commonly cited models of specific brief intervention in practice are Solution Focused Brief Therapy (SFBT) and Brief Encounters. Brief Encounters is a model used where problems in family relationships exist and in that respect deal with a very specific set of issues. SFBT, on the other hand, is used as an intervention across all age groups and a whole range of problems, including adult mental health, behavioural problems in school, eating disorders, child abuse, family breakdown homelessness, drug use, relationship problems and psychiatric problems. SFBT is used globally and in NI.

The common theme throughout all brief interventions is that they are short interactions that focus on changing behaviour at an early stage before problems reach a crisis point. Brief interventions can range from a single five-minute session providing information and advice to 15-30 minutes of brief counselling to a number of sessions of motivational interviewing or behaviour change counselling (Cavill et al, 2011, Nilsen et al, 2008).

Other aspects of Brief Intervention that readily lend itself as a potentially useful therapeutic model of intervention for EIS include:

- **Delivery flexibility:** Brief intervention can be delivered either to individuals or to groups;
- **Fit with Tier 2 needs:** Brief intervention is typically used with individuals or groups who have mild to moderate issues (i.e. do not require specialist support); and
- **Fit with other interventions:** Each EIS team will be led by a professional who can flexibly deliver brief intervention therapy as an additional intervention service beyond key working.

Table 4 below provides further information and detail on the approach.

Table 4: Brief Intervention

Brief Intervention	
1. When and where is it used?	• HSCT professionals, including staff within primary care and A&E are trained and encouraged to undertake brief alcohol intervention programmes in Northern Ireland. • Brief Interventions are available in Alcohol Clinics across the South-eastern HSCT. • Practitioners (n=24) from across the 5 HSCTs were trained in Steps to Cope, a brief intervention for children and young people living with parental substance misuse and/or parental mental health problems. More recently Steps to Cope has been introduced to the Down District Council area. • Given the generic nature of brief interventions they are used widely by health professionals on a worldwide basis and most commonly in the treatment of substance misuse, dietary habits, weight reduction, smoking cessation and risky behaviours. • The most commonly cited models of specific brief intervention in practice are Solution Focused Brief Therapy (SFBT) and Brief Encounters. • Brief Encounters is a model used where problems in family relationships exist - over 3,000 practitioners have been trained in the UK and c. 400 practitioners have been trained in Ireland.

Brief Intervention	
	• SFBT is used as an intervention across all age groups and a whole range of problems, including adult mental health, behavioural problems in school, eating disorders, child abuse, family breakdown homelessness, drug use, relationship problems and psychiatric problems. SFBT is used globally and in NI.
2. Qualifications and skill set required to deliver	• Brief Encounters can be delivered by: Health practitioners, family support workers and all staff and volunteers working in the frontline with families. Adapted training has been produced for volunteers. • SFBT can be delivered by: all health and social care professionals, outreach workers, housing support staff, probation officers, and youth workers.
3. Delivery Structure (delivered 1-1, in home settings etc; time required to implement)	• SFBT: Can be delivered to groups or individuals. • Brief Encounters is usually delivered in a one to one situation between a practitioner and client.
4. Training and costs	• Ascert offers 2 training courses on using brief interventions for substance misuse practitioners. These are 2-day courses and are free of charge for Belfast and South Eastern HSCT staff. • Brief intervention for smoking cessation is offered by the Northern HSCT, North Eastern and South Eastern ELB youth service. These courses are free. • Brief Encounters: Ag Eisteacht in the Republic of Ireland offers the 3 Day Brief Encounters® Course at a cost of €300. It also offered by Oneplusone in UK (costs not available). • SFBT: HSC Clinical Education Centre run a one day course £160. Free if organisation has Service Level Agreement with HSC CEC.
5. Cost benefit	• No information identified
6. Evidence of impact	Due to its wide application on varied range of outcome areas, there is extensive evidence reporting on the effectiveness of brief interventions. This evidence comes from evaluations using both experimental and non-experimental designs. The most compelling evidence relates to the positive impact of brief intervention on alcohol misuse and it is therefore recommended as a tool by the WHO for this purpose. There is a strong evidence base for SFBT (the specific and commonly used model of brief intervention referred to above) in that numerous high quality experimental evaluations report positive impacts on the outcome areas targeted e.g. behavioural problems in school, eating disorders, child abuse, family breakdown and relationship breakdown. In a review of all of the available controlled outcome studies of solution-focused brief therapy (SFBT) undertaken in May 2013[15], thirty-two (74%) of the studies reported significant positive benefit from SFBT, whilst a further 10 (23%) reported positive trends. The strongest evidence of effectiveness came in the treatment of depression in adults where four separate studies found SFBT to be comparable to well-established alternative treatments. Three studies examined length of treatment and all found SFBT used fewer sessions than alternative therapies.

[15] Gingerich, W. & Peterson, L. (2013) Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. In *Research on Social Work Practice*, 23(3), pp. 266-283.

Brief Intervention	
	The study reached the conclusion that SFBT is an effective treatment for a wide variety of behavioural and psychological outcome. In addition, as the treatment generally tends to be briefer could be less costly than alternative approaches. Brief Encounters (the other specific model identified in this review) has a very limited evidence base and the one RCT study conducted on it dates back to 1999.

Conclusion

Of the two potential approaches (Motivational Interviewing and Solihull) described in this Chapter – – the evidence base is strongest for Motivational Interviewing (MI). There were a range of identified positive short and long term effects of MI on a number of outcome areas including substance misuse, diet and exercise and risky behaviours. It was also found to be effective in increasing client engagement in treatments for conduct problem children. The evidence base was less well developed for Solihull both in terms of study design (relying almost exclusively on non-experimental evaluation designs) and in terms of long-term impact. Notwithstanding this, the available evidence suggests that the approach may yield significant short term impacts (e.g. reduced general parental anxiety and anxiety relating to problem child behaviour). Therefore, in terms of potential implementation, EIS may wish to generate its own evidence base as to the effective intervention should it wish to proceed in using this approach.

Family Group Conferencing and Brief Intervention were also discussed as potential interventions for affecting change. Family Group Conferencing is a well recognised intervention in the field of care prevention and reduction and specifically is used in relation to Tier 3 families. Whilst the evidence suggests that it has an impact on resolving family related issues; there is a little evidence of its long term effectiveness. The literature points to greater use of FGC amongst Tier 2 families but little evidence exists as to its effectiveness (either short term or long term) amongst this client group. EIS may therefore wish to further consider FGCs fit with service provision.

In contrast, the evidence base for Solution Focused Brief Therapy is clear and compelling and given that it is delivered over a short space of time, the systematic review of SFBT undertaken by Gingerich and Peterson concludes that it could, by extension, be more cost effective than alternative interventions. In addition to this, SFBT is also appealing because of the full range of issues it can be used to address beyond other models of brief intervention (such as Brief Encounters). It is for these reasons that SFBT should be considered as a potential intervention that could be used alongside other interventions being delivered to families.

4. Implications for EIS

The following points summarise the implications arising from the evidence in this Phase 2 report in terms of EIS:

- **Effective family support and key working:** Overall, the evidence is clear that key working is a critical component of effective family support. The literature points to an array of potential 'soft' impacts of key working (e.g. by providing families with improved access to services), however, there is no substantive body of evidence available in relation to 'hard' impacts of key working. Therefore, EIS may wish to give this careful consideration in terms of design and implementation of performance management arrangements for the service should it pursue the key working model.

- **Costs of key working:** The research could not identify cost data for key working and there are a number of factors that will influence costs such as average caseloads and duration of support. Bigger caseloads per worker and shorter support durations will cost less and the only way of estimating these factors for EIS budgeting purposes lies in forecasting the number of families the service will benefit and understanding their needs. EIS will need to monitor caseloads and required support duration carefully and based on this consider whether adaptations to this model of working are required to deliver the service within the budgetary envelope available.

- **Key worker training and support plan:** In order for key workers to be effective in their practice and to meet the needs of the families with whom they work, it is important that consideration is given to developing a programme of training to support practice. This could include the full range of areas identified above (e.g. training in therapeutic approaches). Given that staff may already be trained in a number of these areas, EIS may wish to undertake a skills audit to identify training needs and put in place an individualised training plan.

- **Potential approaches to engage Tier 2 families:** Two approaches to engage Tier 2 families were examined in more detail – Motivational Interviewing and Solihull. The evidence base for Motivational Interviewing is strong and the approach fits well with the current proposed EIS delivery model as it spans multiple outcome areas and can be delivered on a 1:1 basis within the family unit. It should therefore be considered as a core approach to the provision of family support. In comparison, the evidence base for Solihull is less well developed particularly in relation to its potential long term impacts. Should EIS wish to pursue this as a potential approach, it may wish to give consideration to developing its own evidence base around its effectiveness.

- **Potential interventions to affect change among Tier 2 families:** Two interventions were considered – Family Group Conferencing and Brief Interventions. In relation to the first of these, there is some evidence of their effectiveness in terms of care reduction/prevention and specifically in relation to Tier 3 families. This evidence points to a range of short-term benefits and impacts and there is little evidence in relation long-term impacts. In contrast, there is a robust evidence base for Solution Focused Brief Therapy (one type of Brief Intervention) which derives from over 40 high quality experimental evaluations. This, coupled with the flexibility to use SFBT with a variety of issues, makes it an appropriate intervention to be used within EIS.

- **Match between needs identified and potential approaches/interventions to meet those needs:** It is not immediately apparent whether the identified approaches/interventions will fully meet the needs identified by EIS stakeholders. Family Group Conferencing, for example, may have a direct/indirect impact on improving family functioning and reducing problem behaviours, however the link between the other needs identified and the suggested approaches/interventions put forward is not as readily apparent. EIS may wish to reflect on the extent of read-across between needs and the actual approaches/interventions they wish to implement. At a minimum, EIS might wish to ensure that key workers are aware of the full range of services that are available in the area in which the family are supported so that they are in a position to sign-post families to services that meet their particular needs/context.

- **Delivering the service with fidelity:** In order for the service to generate systemic change and be delivered consistently across Northern Ireland, it is important that consideration is given to ensuring that some core fidelity building blocks are in place. This could include, for example, clearly defining supervision arrangements in place to help ensure consistency in service delivery.

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