

Families First Pioneer programme

Research Review - Integrated Pathways for Family Support

June 2011

Families First Pioneer programme

Research Review - Integrated Pathways for Family Support

Introduction

This review has been prepared by IPC to support the development and implementation of the Families First Pioneer programme within the partnership area of Dylanshire, Kentigernshire and Mabinogion. A central objective for this programme is to improve the life chances of children and young people and particularly those in low-income families through earlier, more holistic and integrated interventions aimed at reducing the number of children developing more complex needs. National consultation and research has identified that preventative interventions focusing solely on the child aren't usually enough to ensure good child outcomes – the whole family requires support.

The Pioneer Programme has two distinct but inter-linked components:

- The further development of more integrated systems for identifying and supporting families of children with emerging additional needs.
- The development of integrated and 'family-centred' support services across all levels of needs.

This review is concerned with the second of these two components and is comprised of four parts. It should be read in conjunction with a complementary report prepared by IPC that considers the development of integrated processes and models of delivery for families with additional and multiple needs.

Part One of this report considers some of the definitional issues concerned with ideas about 'the family', provides an overview of conceptual approaches to whole family support and looks at what is currently known about families with additional needs and their support requirements.

Part Two explores some of the conceptual and definitional issues concerned with integrated pathways, critical success factors in development, the evidence of impact both on service users and professionals, and their applicability to non-clinical settings.

Part Three provides a summary of general findings on what constitutes effective provision in the design, configuration and delivery of effective services and programmes. The focus adopted here is primarily the family and provision to meet the 'prevention' and 'protection' domains of need although clearly there is relevant evidence that can and should be drawn from research within 'remedial' provision.

Part Four distils a series of key messages from the review that are intended to help promote and support development of more integrated family support pathways within the three authorities. A number of potentially useful case studies drawn from experience elsewhere in Wales and England are provided in

Appendix One to demonstrate the current scope and operation of integrated support pathways in practice. Finally Appendix Two contains a brief overview of specific programme interventions that are particularly relevant to early support and prevention objectives and for which there is a reasonably good evidence base.

1 Part One. Thinking about the family

1.1 Defining 'the family'

One of the clear conclusions contained within the wide-ranging literature review carried out by Morris *et al* (2008) and which underpinned the 'Think Family' pathfinder programme in England *was evidence that existing service provision finds 'thinking family' both challenging and controversial and this has implications for professional knowledge and frameworks, training and ultimately the arrival at shared objectives.* One of the identified contributory factors here concerned professional as well as practice assumptions about the nature of the family itself. Without care, these may inadvertently reflect normative understandings about what the family should be and may limit recognition of the actual diversity of family and family life.

Indeed, this influential study did not itself seek to apply a common definition of the family simply because *the 'family' in whole family approaches can vary significantly and cannot easily be fitted within existing policy discourses of family services.* Rather, it advocates a conceptual and inclusive approach that sees 'the family' as self determined by those within it. At the same time a functional understanding about the family (for example, as the first 'place' or source of support when things go wrong) remains centrally important for most people but defining what this might look like for any particular family cannot be usefully or exclusively grounded in terms of immediacy (for example by those sharing an address or co-residence) and/or the *traditional norms of kinship.*

Morris *et al* (2008) also draw attention to a tendency within both the literature and practice of using the term 'parent' either interchangeably with or as a synonym for 'the family'. They found *repeated evidence of family-based services or models in reality being adult or child-based provision, with little acknowledgement of the important differences between working with families as opposed to working with members of families* (the evidence is of the latter rather than the former being the dominant approach). The argument here is that misuse of terms simply *masks the paucity of whole family service provision and approaches.* In addition there may also be a risk, at least in terms of creating individual pathologies where the 'family' *is interpreted as 'parent' and, specifically, as mother because mothers are seen as the principal means for achieving the desired outcomes in children.*

1.2 The 'family' as object of concern or locus of solutions?

In developing the earlier findings of the Morris *et al* review, Hughes (2010) recognises that while most families are *a source of strength and protection' for family members, providing the resources needed to overcome or deal with 'risk'* there is also a *potential for the family to act as a site in which such 'risk' can be transferred between family members and generations, suggesting that 'family*

experiences can limit aspiration, reinforce cycles of poverty, and provide poor models of behaviour that can impact on a child's development and well-being. Families therefore can act as 'a source of risk' to their children, via a number of 'parent based family disadvantages' across a range of areas, including poverty, education and skills, worklessness, housing, parental alcohol and drug use and parental mental and physical health. Family factors are thus positioned as the primary cause of both problem behaviour and poor child outcomes (Loveless and Hickling 2010).

In conceptualising the family as a resource to address risk, Hughes suggests that two competing discourses can be identified. The first presents *'families with complex needs' as requiring and/or being entitled to the support necessary to effectively address these needs. This discourse will be seen to give rise to strength-based, empowerment-focused approaches, where for example, the family will assume a lead role in decision-making whilst professionals are primarily limited to resource provider and formal roles related to statute. The 'family' is also likely to be interpreted more widely to include any member of a support network, with immediate family members encouraged to identify this support network. As such, services tend to work with naturally occurring family structure.* Increasingly, the focus of service delivery has shifted to a more positive strengths-based model, in which strengths and resources of families (for example, resilience and social capital) are recognised and emphasised (WAG 2010).

The second and counter discourse *constructs certain families as posing a risk to themselves and to others, and is instead based on a notion of 'failing families' who warrant and require state or professional intervention. Such a discourse will be seen to give rise to a deficit-based pathologising and professional-led response.* In very general terms, historically *there has been a deficit model in services supporting families - practice has assumed that the appropriate response to any stated need for help is an assessment of weaknesses and the remedial interventions required (WAG 2010).* Within the deficit model, approaches and service plans are professionally led and characterised by increased levels of prescription, coercion and sanctions *in which professionals intervene in order to take control away from families.* Correspondingly, the scope for families to determine provision is diminished. At the same time, the definition of the 'family' also tends to narrow with a focus on the shared household.

One potential inference here is that as families move from the prevention towards the remedial domain their characterisation by professionals is seen to change. Certainly, this is the basis of the critique developed by Hughes and others of the Family Intervention Projects (FIPs). These tend to be located at or around the interface between the Protection and Remedial domains and although based on consent and family agreement the family is narrowly defined in his case by residence. Nonetheless it is not clear that this shift is completely inevitable with, for example, the use of Family Group Conferences (FGCs) at a comparable level of complexity being a case in point.

Whichever way the family is construed, the kinds of support most families require are intrinsically the same (Hughes 2010). These include *the need for adequate income, housing, formal and informal supports, engagement with schools, activities within and outside of family life, access to mainstream facilities, and so on. For all families the need for such support changes and*

develops over time. Equally, the evidence (for example Morris et al 2008) suggests that families who are marginalised share with the less marginalised and more economically well-off parents a range of difficulties: for example, barriers to the use of formal supports, leisure services and community resources (such as children's schools); specific barriers to support that can be erected when negative judgements are made by professionals, neighbours, or family members in relation to disabled people's role in family life.

Therefore, assumptions that *the family is an appropriate (or even the appropriate) solution to 'the problem'* may be misplaced. It remains important to question *whether it is always appropriate to Think Family, or whether the problem and the solution may instead be found within socioeconomic inequalities, insufficient service provision or ineffective social policy (Morris et al 2008).*

2 Part Two. Defining an integrated pathway

'The right people, in the right order, in the right place, doing the right thing, in the right time, with the right outcome, all with attention to the patient experience' (Davis 2005)

Care pathways are designed to minimise delays, make best use of resources, and maximise quality of care. They offer a way to improve accessibility, assessment and the planning and delivery of care through effective monitoring, evaluation and information sharing processes. (EIU 2003)

2.1 Introduction

The concept of an integrated pathway for family support derives in part from a set of tools known as structured 'care methodologies'. These are referred to variously in the literature as care pathways, care maps, critical, clinical or integrated care pathways. This multiplicity of terms and the way in which they are sometimes used interchangeably reflects both definitional differences or interpretation and absence of uniform standards in development and implementation (Davis 2005). While there has been considerable discussion within the literature about what differentiates one approach from another, they tend to share similar characteristics.

- Conceptually, these methodologies adopt a systemic and 'whole systems' approach which seeks to identify and encompass the totality of service contribution within the 'user journey'.
- Unlike guidelines, they define and describe parts of the care process, which involve a number of specified activities, tasks, procedures or choices over time.
- These are service improvement tools that look to embed best practice and evidence within a logical and optimised sequence of care and support over time.
- There is an explicit link between points of intervention and user outcomes within a formalised process of care and support.

Pathways were originally developed and used in the USA as a tool to reduce cost and length of hospital stay within acute healthcare services. In the UK the focus has been on clinical outcomes. Increasingly, these methodologies either have

been or are being adapted to suit different settings. So, for example, within the service sector concerned with adult substance misuse, Working Together to Reduce Harm (2008) envisages care pathways as a vehicle to enable an *integrated system where service users move seamlessly between services, or access a number of mutually supportive services without necessarily being aware that they are provided by different service providers or service sectors.*

The use of care pathways as a tool to facilitate integrated working is becoming increasingly commonplace within the health and social care service sectors, where integrated working *involves collaboration between members of different organisations or professions to deliver a service focused on the needs of those who use the service rather than the needs of organisations providing it* (Price 2009). Indeed, they have been described as the 'lynchpin' of integrated services (WAG 2005).

Given the mixed evidence for effectiveness, Allen (2009) considered a number of reasons that might account for the increasing emphasis of care pathways as a tool for service improvement. She concluded that in part their *growing popularity reflects the emergence of new modes of governance in the context of a shift away from trust in professional expertise to confidence in systems and auditable rules and procedures.* In addition it appears that a conceptual 'looseness', which attaches to the idea of a care pathway is also a primary source of attraction to it. *It is precisely because of their vagueness that they facilitate communication and cooperation between members of distinct groups without obliging members to give up the advantages of their respective social identities.*

This *looseness and imprecision* then can make care pathways highly effective in aligning management, service provider and service user interests around the quality agenda. Nonetheless, Allen cautions that this initial cohesion and breadth of appeal is unlikely to endure throughout the process of pathway development where many of the inherent tensions within and between stakeholder interests begin to surface. In seeking to link a multiplicity of interests, the development of care pathways therefore requires *the negotiation and reconciliation of different forms of action and as a consequence are always complex ensembles.*

2.2 Defining care pathways

The European Pathway Association (Vanhaecht *et al* 2007) provides a more or less conventional definition for the primary aim of an integrated care pathway as *enhancing the quality of care across the continuum by improving patient outcomes...and optimising the use of resources.* It goes on to identify five defining characteristics for any pathway:

- (i) An explicit statement of the goals and key elements of care based on evidence, best practice, and patients' expectations and their characteristics;*
- (ii) The facilitation of the communication among the team members and with patients and families;*
- (iii) The coordination of the care process by coordinating the roles and sequencing the activities of the multidisciplinary care team, patients and their relatives;*
- (iv) The documentation, monitoring, and evaluation of variances and outcomes; and*

(v) *The identification of appropriate resources.*

This definition, developed with healthcare systems in mind, appears particularly suited to specific areas of targeted or specialist intervention and perhaps underestimates the potential use of care pathways to support a range of other operational as well as strategic objectives, for example as a vehicle for system change and transformation or as an integral part of strategic commissioning processes.

Given the breadth and complexity of the service landscape in which family support occurs, a definitional framework, again developed within a health service context by Furley (2006) looks to be more valuable. This proposes four overall types of care pathway each of which depends upon and is developed in line with a specific strategic objective. The premise here is that integrated care pathways *are only one tool to deliver service improvement and are not the answer by themselves...By 'layering' care pathways, a service model is developed to provide strategic direction supported by 'bolt on' ICPs and/or algorithms in selected areas to deliver operational change.* This differentiated use of care pathways reflects findings from care pathway development experience in practice and the need to identify *the strategic use of the right tool for the job* (Zander 2002).

2.3 High-level care pathways

Referred to also as service pathways or models, these are used to agree medium to longer-term strategic visions for services. These models identify service re-design requirements within a whole-systems framework that accommodate the entirety of service user's journey regardless of organisational boundaries. They draw on the available evidence base, the benefits that can be realised, the targets to be met and the provider and commissioning changes needed. These models can be used to engage and support multi-professional and agency groups in developing shared objectives and a commitment to longer-term strategic development.

2.4 Integrated care pathways (ICPs)

Integrated care pathways (ICPs) are systematically developed multi-professional tools that set out locally agreed standards of care, based on the available evidence and are designed to ensure the recording and monitoring of that care and the measurement of outcomes (McDonald *et al* 2006). The strengths of using an ICP include delivering evidence-based care at operational level and to support and sustain change in day-to-day practice. The recording of variance (i.e. any deviation from the planned care) and which is a unique element of an ICP, and its analysis at aggregate level for cohorts of users, supports resolution of service provision or delivery issues either through the amendment of an ICP or the development of a business case to support service development via commissioning activity.

2.5 Algorithms

These are sets of rules normally describing a sequence of actions that are agreed by multiagency teams and developed to standardise practice and to embed relevant national and local guidance into practice. Algorithms are succinct and simple to use. As algorithms detail standards, they provide a framework to

measure care and performance. Algorithms do not act as a record or care and are focused on specific episodes of care so their impact may be limited in terms of service re-design across the whole patient journey.

2.6 Pictorial or annotated pathways

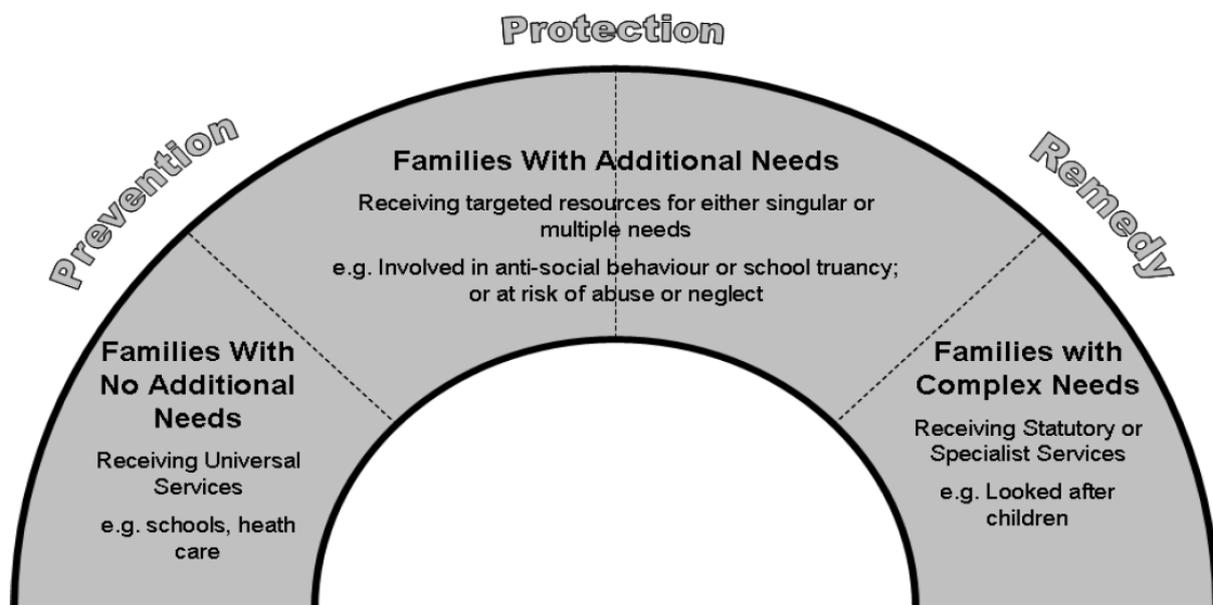
These are developed for use by service users and usually in conjunction with them, as a hand-held document and/or an information leaflet/poster.

2.7 Integrated pathways - an exemplar

How these four approaches might be combined together to support an integrated pathway for family support can be demonstrated in the following and highly simplified example.

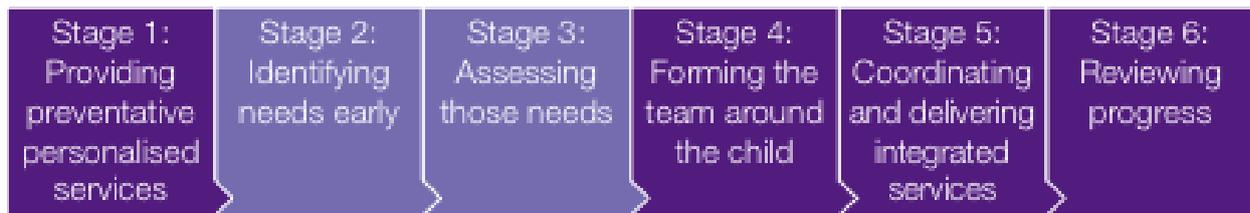
Figure One provides a conceptual model or system-wide framework, covering a continuum of needs and in which services can locate themselves and their relationship to others. This model suggests a high-level service pathway in which it is possible to envisage a service user or family moving in either direction across the continuum through a sequence of stages that might comprise their journey. Figure Two provides an example of the staged approach that begins to apply more detail to key processes within the model, in this case early intervention within the prevention domain and across the interface into the protection domain.

Figure One.



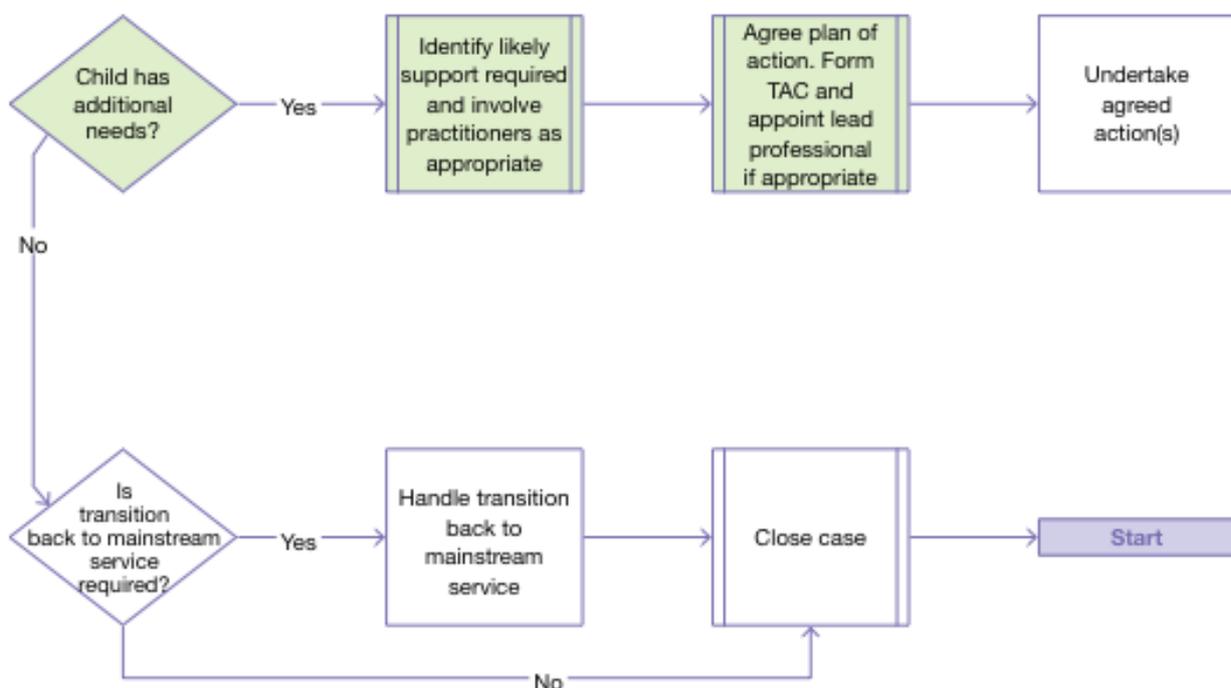
Source: Families First Pioneers Guidance 2011 'New Models of Service Delivery' Efficiency and Innovation Board

Figure Two.



Source: CWDC (2009)

Beneath this staged process, it then becomes possible to delineate more precisely the steps that will constitute the operation of a pathway designed to secure common service delivery. This example only covers stages two to five in Figure Two above and involves the creation of a 'Team around the Child' (TAC) and appointment of a lead professional for a child with additional needs. Figure Three.



Source: CWDC (2009)

This element of the pathway can be considered integrated because it (i) provides a common connection point with all other agency processes i.e. in this case, it is open to any agency to ask the question 'does this child or family have additional needs?' and (ii) then requires agencies to act according to agreed and shared arrangements. At the same time, this discrete element of the pathway will of course connect to other elements (e.g. review of agreed actions and request for additional provision, referral to specialist services and so on). Again each one of these elements will incorporate common connection points and agreed common processes between and within agencies.

Relevant algorithms for this example might include a simple checklist to support practitioners in determining the nature of their concerns and what steps they should take to address these, rules on the appointment of a lead professional and so on. Finally, annotated documents for families might include a description

of the role of the lead professional, the purpose of a TAC or 'Team around the Family' (TAF), a summary of what they can expect to happen and what they will be asked to do?

2.8 Are care pathways effective?

Formal scientific evaluation of integrated pathways has not been extensive and the outcomes of interest have changed over time. The variation in conceptual approaches and definitional terms makes comparative studies difficult to undertake and there is also the usual caveat linked to publication bias i.e. the tendency to focus on pathway initiatives that were at least partially successful in delivering better outcomes or quality of service. In addition, the evidence about their impact from single trials is contradictory (Rotter *et al* 2010). The overall focus of the available literature remains almost exclusively concerned with adults and healthcare. No studies were identified for this review which dealt with the use and impact of care pathways for children or young people within non-health settings.

There are, however, a number of potentially relevant findings that may be useful in considering the development of an integrated pathway for family support.

In a review of the published research, Price (2009) identified two studies that indicated a positive impact on the coordination and management of care services following implementation of care pathways. ICPs may also contribute to improved compliance with standards, promote adherence to guidelines or treatment protocols and documentation of best practice. At the same time the routine reporting of variance appeared to be generally poor across a number of studies, a finding confirmed by Allen *et al* (2009).

In general, stronger effects for length of stay, hospital costs and patient outcomes tend to be found for invasive care (surgical interventions). Allen *et al* (2009) in a systematic review found that integrated care pathways were most effective in proactive care management where patient progress was predictable and in producing behavioural changes where service deficiencies were identified. Where recovery pathways were more variable or where professional working was well established and already based on best evidence, their value appeared to be less clear. The study found that where a significant change in organisational culture is required, effective implementation of a care pathway will require additional mechanisms of support.

While care pathways can contribute to improved teamwork (Evans-Lacko *et al* 2010), for example via an increased understanding of roles within a multi-disciplinary team, the evidence for impact of care pathways on enhanced inter-professional and inter-agency relationships and communication is generally inconclusive.

In a Cochrane review, Rotter *et al* (2010) found positive impact of pathways on reducing in-hospital complications, reduced levels of stay and improved documentation of practice. Nonetheless, generally poor levels of reporting prevented the authors from identifying characteristics that are common and contribute to successful pathways.

2.9 Developing and implementing pathways – common experiences and challenges

In a wide-ranging review of ICP development within the UK health sector, McDonald *et al* (2006) identified specific inadequacies concerning

- The review and audit of ICPs
- Shortcomings in accountability, governance and management processes concerned with ICP planning and development across organisations
- Difficulties in 'locking in' ICP development into wider strategic and organisational structures
- Shortfalls in staff training and user involvement

Middleton *et al* (2000), Furley *et al* (2006), Evans-Lacko (2010) and others have identified a number of critical success factors to the effective development and implementation of care pathways. These include:

- High-level leadership for this type of change project is required together with senior sponsors and champions from those organisations accountable for the care pathway.
- The introduction of an integrated care pathway will not in itself be sufficient to act as a motivator for change. The amount of time that is required to support implementation through change management cannot be underestimated.
- Developing and gaining consensus to integrated care pathways is time and resource expensive and needs to combine both 'top down' and 'bottom up' approaches to ensure strategic alignment as well as engagement of operational staff. Gaining agreement and 'sign off' across all organisations can prove to be time consuming.
- Given the costs associated with ICP development, consideration should be given to targeting areas where there are clearly identified deficiencies in provision or where practice changes are required. ICP developers need to identify need or population sub-groups for whom the pathway might not be appropriate.
- Integrated care pathways are not a panacea in themselves. How well they work depends on those who use it. ICPs need therefore to be owned and completed by all the staff involved with it. How an ICP is implemented will be of at least equal importance to its content and ambitions.
- Variations need to be collated, analysed and used to support service review and development. Where a care pathway is more variable (i.e. where it is reasonable to expect higher levels of variance), ICPs should account for this. When adherence to the pathway is not in the service users' best interests, practitioners should be supported in exercising their professional judgment.
- Good project management is essential, particularly when working across organisational boundaries. Forming a 'core team' to develop the ICP can be effective and should combine both professional staff and service users.
- Shared indicators are key to delivering joint and locally agreed outcomes. The indicators need to link local and national priorities and the evaluation of them needs to provide tangible benefits for service users, service providers and organisations.

- Unwieldy paper-based documents (or their electronic equivalent) developed to support operation of an ICP are unlikely to attract sufficient levels of staff commitment to make them an effective tool. ICPs should make best practice guidelines available for daily practice in a usable form.
- Developing user pictorial pathways elicits the same challenges as developing any written information. There needs to be a good balance between providing enough detail while keeping documents straightforward and concise.

3 Part Three. The characteristics of effective services and programmes.

3.1 Introduction

This part of the review provides a summary of general findings on what constitutes effective provision in the design, configuration and delivery of effective services and programmes. The focus here is primarily the family and provision to meet the prevention and protection domains of need outlined in Figure One. While there remain areas of difference in emphasis, there is a now a reasonable consensus within the literature as to 'what works' and approaches that need to be taken to ensuring more effective delivery of provision.

The findings here have been drawn from two principle sources. Firstly, the learning and key messages from a number of relevant programmes that have sought to identify what works in terms of the commissioning and delivery of services within a whole family context. These include, for example, the

- 'Think Family' programme, launched in England in 2007 which aimed to improve support services for vulnerable families by encouraging a co-ordinated approach between adult and children's services in supporting disadvantaged families
- Local Authority Child Poverty Innovation Pilot (LAIP) established by the Child Poverty Unit (CPU) in 2009 which is a programme that trials locally appropriate and innovative ways of addressing child poverty, to provide local and national learning.
- Parenting Early Intervention Programme (PEIP) which currently provides funding for local authorities to deliver evidence-based parenting programmes which have been shown to improve parenting skills, to parents of children and young people aged 8 to 13 years who are concerned about their child's behaviour.

Secondly, the findings from a series of research and literature reviews, that covers the period from the Moran *et al* (2004) review of international evidence for what works in parenting support to the Allen report (2011) on early intervention. Taken together, these reviews now constitute a considerable body of evidence to inform understanding about the characteristic features of more effective family support arrangements. While many of these reviews deal at least in part with the evidence for or against specific programmes of intervention the emphasis within this report draws on and reflects their more generic findings.

3.2 Setting the scene – some contextual issues

The case for more holistic and integrated forms of family support arrangements to ensure *all families to be better supported, including those 'at risk'* (Clarke and Hughes 2010) is not especially new and derives from a number of reasonably well-established observations concerned not just with the organisation and delivery of services but also continuing evidence for lack in progress in promoting better outcomes for families faced with multiple difficulties. In essence these acknowledge that systems and services for families with multiple problems have evolved to produce a highly complex and fragmented network in which *services only have a partial picture of a family's needs* (WAG 2010). Specific features are usefully summarised by Allen (2011) and include findings that

- Even the best provision does not routinely address needs in a systematic manner.
- Liaison between agencies remains inadequate.
- Attention continues to be focused on 'delivering services' and not on meeting families' needs.
- The people who need services the most often do not or cannot gain access to them.
- Systems are too reactive and do not effectively anticipate problems in families.
- Early warning signs in children and families are either not recognised or receive an inadequate response.

Overall, the evidence clearly indicates that it is difficult for families under significant stress to make best use of programmes of support whilst facing a range of disadvantages, *so policies that reduce everyday stresses (including poverty, unemployment, poor health, housing and education) will support parents in caring for their children* (C4EO 2010).

Although there is now a more comprehensive picture in terms of the evidence about what does and does not work in family support arrangements there is *no silver bullet* (Allen 2011). While the EIB review (2010) identified *a limited core of characteristics that are widely believed to have the potential to increase the effectiveness of team around the family approaches*, they were also unable to find a *'perfect' team around the family model that all public services should replicate*. In addition, Thoburn (2009) acknowledges that *we are still some way away from having a 'menu' of methods known to be effective, particularly with complex families who are hard to reach and hard to change*.

Even here, the notion of an 'off the shelf' prescriptive menu drawn from best practice and research is not entirely without its problems. One of the emerging messages from the pilot initiatives into family-based approaches to support, for example the LAIP is an emphasis on the need for local approaches to meet local challenges: *effective activity to address child poverty should be rooted in local context, in terms of: the local socio- economic context – what are the demographic, labour market, education and other issues for families and that impact upon levels of child poverty; and, the local practice context – what partnerships, structures and services are in place in the local area and what is the history of provision* (Mason et al 2011).

This emphasis is endorsed by the Allen (2011) review which finds that local areas are *best placed to understand the most appropriate model to ensure that parents, children and young people can have the services they require*. In seeking to developed practical and balanced solutions local areas especially are therefore likely to experience *a tension between using proven models and the need to nurture innovation* (Thoburn 2009). Innovation of course brings with it the possibility of solutions that may fail at worst or succeed only partially at best. While a continuing focus on what works is clearly useful, acknowledging and identifying the learning from mistakes and what does not work is not an especially strong feature in many of the evaluations of nationally based pilot programmes in particular. This absence should not in itself either constrain local improvement efforts or serve to place unreasonable expectations upon them by masking the reality of risks inherent to service development and transformation efforts.

Service development and change (which may be more or less transformational) that is associated with moves towards more integrated forms of provision will entail cultural changes, including attitudes and behaviours across the workforce. These changes will take time, commitment and *a professional and managerial culture that values the development of good working relationships both with families and with other professionals* (C4EO 2010). Attempting integration by co-location will not in itself act as an automatic guarantor of *better working relationships or, indeed, 'better joined-up working'* (Tunstill 2007).

The emphasis post-Laming (2003) on the safeguarding and wellbeing of children 'being everyone's business' does mean that a reliance on conventional delineations of barriers between what different people do is unlikely to be helpful. The evidence suggests that a significant proportion of children who experience abuse or neglect in some form either do not come to the attention of child protection services or their needs are not adequately recognised within non-statutory welfare services. Family support therefore needs to be seen as *representing a crucial component in the wider task of safeguarding* (Tunstill 2007). Equally, safeguarding services themselves, rather than being seen as isolated services should be understood as forming part of a potential package of 'family support'. In terms of the requirements to support effective integrated pathways of family both aspects are likely to raise some considerable implications particularly for assessment and support skills within the wider workforce.

3.3 A 'whole systems' perspective to support strategic commissioning

Care pathways envision and encapsulate the totality of the user journey across specified stages of provision. In turn, arrangements that are designed to enable support provision *for the family as a whole will generally mean that a wider network of services is likely to be involved* (C4EO 2010). Effective commissioning starts with a strategic understanding of what this 'whole system' consists of, how it works and the total resource that either is being used or is potentially available for use. While there is a continuing debate on the merits and limitations of early intervention (see especially section 3.8 below) the evidence provided by recent reviews (for example Allen 2011 and C4EO 2010) suggests that a key success factor in realising an emphasis on early support and intervention is the requirement for a reorientation of the system at all levels.

Effective care pathway development cannot happen in isolation from the resources and services required to optimise its implementation and operation. Effective strategic commissioning activity is the essential process required to secure these conditions. This activity needs to be directed to address not just the balance and distribution of resources across a continuum of need but also to be supported itself by data and performance evaluation from the operation of the pathway in practice.

3.4 A combination of approaches across a continuum of need

The C4EO (2010) review suggests that while the problems experienced by some children and families will respond to a single intervention, others will require longer term support; some will be complex and may even cross generations. It is, therefore, essential that a continuum of support is available with the capacity to meet specific needs at a particular time. This continuum covers all three domains of the model underpinning the Families First programme (Figure One) and therefore incorporates services provided universally as well as selected and indicated provision.

In terms of the overall focus of provision, while the Allen (2011) review makes a persuasive case for the rebalancing of resources towards early intervention it has also been argued that it is simply unlikely that difficulties can be easily resolved simply by being identified at an early stage. Most 'problems' are not prevented or rectified by a simple or single intervention. For the majority of children with additional needs there will be a number of inter-related, and often inter-dependent disadvantaging factors which impinge on them, their families and apply to the environment in which they live...It is unrealistic to think of earlier intervention as an alternative to later intervention when problems have become established: both are needed...Some children may have their lives sufficiently changed by an 'earlier' intervention to not require later interventions, but many are likely to need continuing support at later stages (Statham et al 2010). A similar situation may exist for some parents who would like support to be available for longer. Here provision for a low level of ongoing contact and the ability to re-access services when needed might help to avoid the 'revolving door' syndrome that characterises the relationship of many high need families with children's services (Statham et al 2010).

Indeed, the evidence suggests that effective programmes are available to address both earlier as well as late intervention. An effective model for family support, rather than conceptualising earlier intervention as an alternative to later intervention...would be a continuum of graduated interventions that are appropriate at different stages in the life course of problems, with the key issue being to identify the most appropriate intervention to match specific needs at a particular point (Statham et al 2010). The point is endorsed in a recent review by the EIB (2010) in Wales, which concluded that for holistic and multi-agency provision to be effective there was a requirement for a graduated and differentiated response to complex problems, addressing inter-related needs. This might involve co-ordination of the input of different services that may be supporting the family, or supported signposting or fast-tracking to other services.

It is now clear that for family support arrangements to be effective a 'one-approach-fits-all' is unlikely to lead to sustained change (Barlow et al 2009) and that families need and value services that are tailored around their individual

strengths and support needs (WAG 2010). At any one time they are likely to emphasise one of three categories outlined by Morris et al (2008) and Hughes (2010):

- **Working with the Family to Support the Service User.** In this case the family is seen as a basis for support for an individual within that family. As such the focus of service provision remains primarily on a service user within that family (for example, the disabled child or parent, the potential young offender, the substance user), with the focus on other family members determined by their ability to offer support and assistance.
- **Identifying and Addressing the Needs of Family Members.** In this instance, family members are recognised within service provision as having their own specific needs arising out of their relationship with the primary service user. The emphasis here then, as in the category above is on supporting specific family members.
- **Whole Family Support.** Here the focus of services is work with the family unit as a whole. Rather than addressing the needs of the service user or individual family members in isolation, provision recognises and focuses on shared needs and/or the strengths apparent in inter- relationships and collective assets.

Neither Hughes (2010) nor the review by Morris *et al* (2008) is suggesting that any one particular category is necessarily 'better' or 'more effective' than another and it cannot be assumed that 'whole family' approaches are always helpful or appropriate. *Addressing family-based barriers and building on strengths does not always require a 'whole-family' approach, but it does require an understanding of the family as a unit and the individuals within it and an approach that takes account of this* (Mason and Brown 2011). While family-based approaches are required to fully identify, understand and then address the range of barriers that parents and their families face when accessing provision *effective provision does not necessarily engage the whole family but rather ensures that issues within the family are addressed through a co-ordinated approach that ensures any support delivered is not done so in isolation* (Mason and Brown 2011).

There may also be particular risks within whole family approaches in not identifying an individual's support needs with reference to their family role, and local family and community network. *Approaches specifically targeted at the whole family may not respond adequately to individuals who have needs in relation to, for example, safety, experience of disability or caring responsibilities. Whole family support might therefore necessarily be understood as additional to the identification of individuals' roles and relationships (such as parent or child), and instead seek to provide a 'joined up' response to difficulties faced in the private context of family life* (Clarke and Hughes 2010).

There is a reasonable consensus within the literature that multi-method approaches may be more effective in promoting better outcomes. Statham et al (2010) found, for example, that *the research evidence suggests that a multi-faceted approach to supporting children with additional needs is likely to be the most effective*. The LAIP evaluation in England established that *when targeting and engaging parents and families for support, towards employment or with broader familial issues a combination of approaches is required. Effective*

practice often features 'multi-method' programmes of support, including a combination of different interventions to address different problems. Evidence suggests that a package of support, with formal and informal activities, helps to engage families and the individuals within them. Informal support might include opportunities for respite and access to leisure; and the emotional support delivered by 'a professional friend' is also highly valued by families (Mason and Lloyd 2010). In addition, Barlow et al (2009) concluded that the weight of the evidence points to the need for multi-level interventions or methods of working that target not only parenting practices but other causal factors that may be operating within the parent including mental health problems, intimate partner violence, and substance misuse.

Interventions should match and be appropriate to levels of need: 'Light touch' interventions are unlikely to be effective for 'heavy end' problems, nor intensive programmes targeted at specific difficulties for those without such problems. Therefore, when *children and their families have a relatively high level of additional needs, brief, single-focus interventions are unlikely to produce a significant or lasting effect (Statham et al 2010).* In general terms, longer duration and more intense home visiting programmes have been shown to have better outcomes in terms of child maltreatment measures than shorter, less intense programmes, with effect sizes increasing as the length of the intervention increases. There is also some evidence *that a longer duration may be necessary to achieve changes in behaviour rather than in 'softer' outcomes such as attitudes, intentions and confidence. (Statham et al 2010)*

3.5 Addressing barriers to access and engagement with services.

The nature and extent of the barriers to accessing and engaging services are now well established and cover physical, practical and social dimensions (Statham et al 2010). These include:

- Lack of knowledge of local services and how they could help.
- Geographical location, physical access and opening times.
- Culture, language, disability, female ethos of services, poverty, suspicion and stigma.
- A previous history of being turned down when asking for help.
- Service culture and responsiveness to families.
- The true cost of the service to the family.

In general, the literature suggests that there is evidence for much lower rates of take up of targeted services and of open access services by families experiencing particular hardship (Morris et al 2008).

Addressing these barriers is a crucial element in securing more sustainable change particularly for families in poverty (Mason and Lloyd 2011). Overall, families perceived to be most 'in need' are least likely to take up offers of help or support and there appears to be a positive correlation between levels of drop-out, for example from parenting programmes and levels of social disadvantage (Statham et al 2010). For those children at risk of or experiencing neglect, the evidence suggests that *their parents are unlikely to directly seek help from 'child protection' or 'safeguarding' services or, indeed, more informal 'family support' services offered by the state or other organisations (Daniel et al 2009).*

There is a consensus within the literature that services that *'reach out' to families and offer multiple referral routes, including self-referral, are better at 'getting,' 'keeping' and 'engaging' families* (Mason 2011). Many families are likely to need support at some point and *efforts to 'normalise' access to support seem likely to generate strong benefits and increase take up, especially at critical points for early intervention* (C4EO 2010). Efforts to improve access and engagement arrangements with *'hard to reach' families in particular need to be complemented by service by strategies to ensure that services are not 'hard to access'* (Daniel et al 2009).

Since the fear of stigma is routinely identified as a key factor in deterring families from looking for support when difficulties emerge, managers of *'targeted' as well as specialist services should consider whether their intake and assessment processes reduce stigma and minimise the sense that parents, children and professionals will lose all control of the situation once targeted additional services are sought* (Thoburn 2009).

While co-located and integrated teams *can bring benefits (both for workers, and for those for whom they provide services) for staff to be able to be accessed in the same building, there are some instances where some users of services may be disadvantaged. Co-location should certainly not be seen as a 'magic solution' and it's consequences for different groups of families should be carefully thought through. Some families...may be going through especially stressful and difficult periods, including being the subject of formal child protection inquiries. In these circumstances their level of distress, and in some cases of aggression, may mean they require a more discrete and/or confidential entry point to services than through the front door of a children's centre* (Tunstall 2007).

Integration efforts that have the effect of rationalising and reducing access arrangements (for example through a single point of entry) are only likely to increase disincentives on take-up by some families and *need to be mitigated by effective outreach services* (C4EO 2010). Achieving *'think family'* fundamentally requires that *there is 'no wrong door' for families to initially go through* (Clarke and Hughes 2010).

In terms of practical improvements to improve access and engagement arrangements the following activities have been identified within the literature and appear especially useful within the context of *'whole family'* approaches. It is important to emphasise here that the evidence suggests that protocols and guidelines are not in themselves sufficient to secure improvements. Gaining the cooperation of complex families requires services to be dependable and professional. *This includes providing assistance that is educative, supportive and timely from the start. The importance of providing a dependable professional relationship for parents and children who may conceal or minimise their difficulties, is highlighted in research and practice commentaries...The research shows that the interpersonal qualities of the practitioner are the strongest determinant of whether or not people engage with interventions* (C4EO 2010). So, it is *human issues such as trust, relationships, communication, anxiety, fear and confidence affect willingness to act on concerns* (Daniel et al 2009) that will be key to securing change.

Key attributes of successful approaches include:

- Raising awareness of services available to families through advertising and information.
- Providing access to services through multiple facilities.
- Use of targeted 'outreach' services in combination with facility provided support through a mix of 'come' and 'go' provision. 'Go' structures in particular may be effective in overcoming factors to do with parental inertia, uncertainty, lack of confidence or fear of rejection.
- Providing services to families in the home and/or within easy reach of home (especially when children are young and for those in greatest need).
- Addressing cost barriers to service engagement and employment particularly access to affordable childcare.
- Services that are culturally sensitive, understand parental perspectives and what will motivate them to engage.
- Services that look to build relationships over time and support the development of trusting personal relationships between providers and service users.
- Services that emphasise the importance of engaging families in a collaborative approach, pay attention to family strengths as well as needs and take account of their views and experiences.
- Effective engagement intervention depends not only on the fact of engaging family members but also on the way this is done.

3.6 Assessment and planning arrangements

The wider the scope of integration efforts becomes the more complex the requirement to secure coherence on assessment and eligibility is likely to be. Pathways, for example, into CAF processes, if this is the vehicle chosen to support integrated assessment and co-ordination of services, need to be identified and agreed by all relevant and accountable agencies and include all inclusion and exclusion criteria that will apply to the integrated pathway. These criteria should also be capable of supporting 'step-up' arrangements (for example, when to refer to specialist children's services). Equally, it remains important for specialist services to remember that children and families should have the relevant support in place when they no longer require their services. Therefore, the criteria should also be applied to support 'step-down' arrangements at the 'remedial' and 'protection' interface. The overall objective here is to form a coherent alignment of services that does not lead, inadvertently, to routine constraints, response delays or unanticipated refusal of service.

For a variety of reasons, not least the sensitivity and specificity of screening instruments, the literature on risk assessment suggests *that while consideration of risk factors can be useful as a way of focusing attention on those most likely to need support, it is insufficient on its own as a means to identify children with additional needs, and good assessment of individual children is also required* (Statham *et al* 2010).

So far as assessment is concerned, an integrated and standardised document (based for example on an adapted CAF) is likely to be of value both to

professionals and families (DCSF 2010). Equally, family-based assessments need to lead to the development and recording of a single and coherent plan for the family that takes account of the varying needs and problems of family members and is clear about the outcomes to be achieved (DCSF 2010).

Characteristics of effective provision identified by the 'Think Family' evaluation (DCSF 2010) include:

- Use of family based assessments.
- A consent based approach to engaging families.
- Use of family action plans, clearly outlining the roles and responsibilities of both family members and practitioners.
- Joint assessments and delivery (for example, adult services and children's services).
- Minimising the numbers of professionals involved with a family at any one time, in order to improve family engagement by providing a more streamlined, planned and coherent package of support.

3.7 Common characteristics of successful programmes

There is now a broad consensus within the literature (see for example, Moran *et al* 2004, Morris *et al* 2008, Barrett H 2010, Lindsay *et al* 2010, Allen G 2011) that the more successful programmes aimed at family support tend to share some common characteristics.

- In general, approaches that target specific populations with additional needs have been found to be more effective than universal approaches. Efficacy and cost-effectiveness are likely to be optimised within groups of higher levels of need.
- Where family difficulties are severe and where intervention is late rather than early, stronger impacts on child welfare outcomes tend to correlate with programmes that provide intensive services involving a relatively high level of professional resources (deployed in a variety of functions, for example 24-hour staff availability, home based counselling and services) and requiring a good level of participation from families. Overall, parents with complex problems and multiple needs do better in programmes of longer duration and greater intensity. By way of contrast, the use of brief interventions tends to be more effective in securing simpler objectives, for example, the giving of information or modifying straightforward behaviours.
- 'Manualised' programmes with delivery adhering to all programme requirements (i.e. full integrity) tend to deliver better outcomes. Where these criteria are loosened (for example in terms of content or staff training and competence) results are likely to be less good or may even make matters worse.
- Successful programmes draw on and are informed by a strong theoretical base, supported by a clearly articulated model of change i.e. *Interventions tend to be more successful when they know not just where they want to go, but also have a clear idea of how they are going to get there.* They will also incorporate measurable and concrete objectives as well as overarching aims.
- Successful programmes incorporate a focus on behavioural rather than instructional approaches and are likely to include provision for 'cognitive'

interventions designed to support change in beliefs, attitudes and self-perceptions. Most successful programmes include both parents and children and take an approach that acknowledges the central role of the parent-child relationship in child outcomes.

- Multi-component programmes appear more likely to succeed than uni-modal designs. Successful programmes tend to involve more than one method of delivery. This might, for example, include group work, where parents can benefit from social aspects of working with peers, and individual work where problems are severe or parents are not ready/able to work in a group (often including home visits and tailored one-to-one support).
- The quality and training of staff together with good support and supervision is a key requirement of programme success. Training in specific skills, rather than just generic support skills, is needed to address those issues that are central to poorer outcomes if workers are to support families effectively. Research findings indicate that one critical factor is the ability of staff to build good relationships with parents. This requires skills in partnership building with service users.
- More successful programmes also pay very close attention to implementation factors such as how to 'get', 'keep' and 'engage with' families and promote good attendance. How family support is delivered may be as important if not more important than what is delivered.

3.8 Evaluating cost and impact

While the DCSF (2010) report concerned with the 'Think Family' initiative in England suggested that *co-ordinated, multi-agency interventions can be a cost-effective way of improving outcomes for both the children and adults within these families*, in general the impact on outcomes for families of these changes in emphasis and indeed the extent to which they can be attributed to the realisation of these objectives remains both under-researched and inconclusive to a degree.

The continuing debate about the impact and cost of refocusing on early intervention provides a useful example. On the one hand, Allen (2011) argues for an evidence-based whole system review (both nationally and at the local level) of the distribution of resources to achieve a more effective balance of provision across the preventative to remedial continuum of need and in so doing to address the issue of the established tendency of allocating *budgets on the basis of historic levels, not on the basis of what would make a difference*. This position was previously endorsed by a C4EO (2010) which concluded that *early intervention clearly works – when it is an appropriate intervention, applied well, following timely identification of a problem; and the earlier the better to secure maximum impact and greatest long term sustainability (both as early in the child's life as possible and/or as soon as possible after a difficulty becomes apparent)*. The review made specific recommendations on spending priorities including children's centres and early years, speech, language and communication needs, parenting programmes, targeted family support, and young people on the edge of care.

On the other hand, Statham *et al* (2010), while recognising the attractiveness of the proposition that augmenting early support has the potential to save money, conclude that *attempts to demonstrate this through empirical research have*

proved challenging. There are very few studies where an intervention early in the life course of a problem has been compared directly with later interventions, so direct empirical tests of the assumptions are hard to make. They also make the point that it remains difficult in practice to fully answer the question of whether it is more cost effective to offer some additional support to a large number of children and families or deliver more intense interventions targeted at those with a clear need for. An emphasis on early intervention with a preventive aim is itself not without risk or free from ethical concerns. These include: cost effectiveness, and issues of waste with the allocation and use of scarce resources for interventions involving the larger group of people who may not need them, rather than strategic deployment to the smaller number with identified needs; concerns about the impact of screening for risks at an early stage on individual rights, associated psychological costs and the ethics of interfering in people's lives; the sensitivity and specificity of screening and assessment tools and particularly the use of factors with low levels of predictive validity to identify 'risk' that will fail to identify some children who genuinely are at risk and will go on to develop problems.

Despite these important qualifications to the limits and evidence base for early intervention and prevention there are some broadly consensual findings on cost and impact that bear on the design and operation of integrated working with a focus on families.

- There is currently stronger evidence of savings for remedial and protective approaches than for more preventative approaches. This reflects in part the difficulties associated in measuring the impact of the latter on outcomes (EIB 2010).
- In general, targeted approaches tend to be judged more cost-effective than universal approaches. In universal intervention programmes, children with few problems often show little benefit. There is also currently very little evidence that whole population-based approaches or strategies have any measureable impact on reducing rates of child neglect or abuse (Barlow *et al* 2009) The less targeted an intervention, the greater the scale and hence also the costs. Cost effectiveness is likely to be greater for the individuals with higher levels of need (Statham *et al* 2010, Lindsay *et al* 2010).
- Geographical targeting of services on its own is unlikely to prove a wholly effective approach and risks exacerbating gaps in disadvantage for those families who face multiple difficulties but are excluded from accessing provision while less needy families may obtain additional support, all by virtue of their location (Tunstall *et al* 2007, Statham *et al* 2010).
- The risks and associated costs of intervening inappropriately or ineffectively apply equally to both universal and targeted interventions (Statham *et al* 2010).
- There is a need to improve the use of data to support both financial as well as service outcomes for integrated provision including interventions designed to support holistic approaches in work with families (C4EO 2010, PSW 2010). This evidence should be used both to support evaluation of effectiveness as well as local innovation. *In short, if we cannot provide evidence to show that an intervention is having a positive impact, how can we justify funding it?* (C4EO 2010).
- Sustainability of integrated approaches, such as the team around the family, requires that a good funding model – linked to a robust approach to

measuring benefits – is put in place from the outset (PSW 2010) and supported by baseline assessments to enable subsequent evaluation of impact on outcomes. In particular, approaches to the measurement of functional strengths and environmental resources are underdeveloped and underutilised. At some level then, interventions operating on a strengths-based model may need to recognise steps towards identifying and mobilising the strengths and resources present within the family (EIB 2010).

- Finally, integrated family support activities will necessarily extend the breadth and 'reach' of partnership and participation activity. There are some identified benefits to this, for example in improving service accessibility and levels of professional trust but the literature *does not uniformly assume that a greater reach or breadth of participation is inevitably positive in its impacts or effects* (Robinson et al 2008). For example, *while an increased reach in partnerships may generate greater involvement, democracy and potential to respond to user needs, it may undermine accountability...The sheer number of members, and their disparate sizes, budgets and modes of governance may create accountability problems, which may need to be directly addressed if any negative impacts of wider partnerships are to be pre-empted* (Robinson et al 2008). In general, integration efforts including extensive organisational integration are identified as resource intensive and relatively expensive to introduce and support. The costs of full integration therefore need to be balanced by the benefits of other approaches that have the potential to support co-ordinated activities. What does appear vital is that whatever local management and governance arrangements are established, these should support and obtain their legitimacy from a broad and more open network of services and stakeholders, including providers and service users.

3.9 Workforce issues

A number of key implications arising for the workforce, as a result of the move towards more integrated forms of working, were considered in parts three to five of the complementary paper 'Research Review – Integrated processes and models of delivery' (IPC May 2011) and are not repeated here. The following summary of additional findings has been identified as specifically relevant to pathway development and operation but should be also be seen as part of the overall picture of opportunities and challenges likely to be faced by professionals in the transition to new forms of integrated activity.

- Developing and implementing integrated pathways for family support will involve change management activities linked at least in part to role review and redesign opportunities particularly within the protective domain of need. The emphasis of integrated effort to promote early intervention and prevention, and outlined at the beginning of part seven of this review, has implications for workforce reform and the deployment of new roles (for example lead professionals, intensive support and outreach out of 'normal' hours) to meet new objectives. In turn these new roles are likely *to demand a novel balance between profession-specific and generic skills* (Robinson et al 2008).
- There is evidence to suggest that professionals in all kinds of settings, including many early years staff and primary teachers, may lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged (C4EO). In addition, many professionals in regular

contact with children need better preparation to enable them to identify when children need extra help or are at risk of harm, and to have confidence to act on their concerns (Statham *et al* 2010). Front-line staff in *agencies providing universal services are central to the early identification and provision of effective services to complex families who are characterised as hard to reach and hard to change. It is therefore essential that front-line staff receive appropriate training in assessment skills* (Thoburn 2009).

- While training to support awareness and effective operation of new arrangements is clearly necessary, there needs to be a stronger connection between the level and purpose of training inputs and their impact on improved outcomes for children and families. In general, the evidence for actual impact of training on outcomes remains poorly researched or understood (Daniel *et al* 2009).
- Within the use of formal programme interventions, there is now strong evidence to suggest that provision with *low fidelity to the design of their originators generally fail to achieve their intended results. Attempts to use less qualified staff have resulted in weaker improvement* (Allen 2011).
- The impact of case and workload pressures on key professional groups (i.e. those who have a crucial role to play in early identification of need, and in referring children and families for early and appropriate support, for example health visitors and midwives) is likely to present as a key constraint on the effective operation of a pathway. Unless attended to there is at least an increased risk within universal services of marginalising families who may already be disadvantaged as a result of limitations on engagement and continuing support resources (Statham *et al* 2010).

4 Part Four. Integrated Family Support Pathways – Implications for Design

This final part of the report distils a series of key messages from the research review that are intended to help promote and support development of more integrated family support pathways within the three authorities. Given the different contextual circumstances and developmental stage for these initiatives these findings will not of course apply equally to each authority.

4.1 Having a vision and principles for service development

While the objectives for service organisation are already given within Families First guidance (i.e. services need to be family-focused, bespoke, integrated, proactive, intensive and local), authority areas might want to consider developing a series of principles to inform their service improvement programme. These principles need at least to affirm the centrality of families as partners in service design and configuration and as co-producers of better outcomes. They may also inform a series of standards which provide a useful framework to assess and review progress towards more integrated forms of family support. An example set of principles is included as Appendix Three. These have been drawn from The Early Support Service Audit Tool (2009) originally designed to inform and support early co-ordinated and family-focused service delivery for children under five, with known or emerging disabilities. The focus here is on universal and targeted services and the tool is designed to enable multi-agency groups and

service users to review services, identify service development priorities and track progress over time.

4.2 Developing a focus on the family as a whole

Developing a focus on the family as a whole means that a wider network of services is likely to be involved than has conventionally been the case. Authority areas will need to review the scope and reach of integration needed to effectively support the new arrangements and the capability of existing partnerships to meet identified requirements. It is unlikely that a single integrated structure will be able to accommodate the breadth of inclusion needed, full realisation of community and family resources and the flexibility to support innovation in the face of emerging needs. What is important is that the network of partnership and participation arrangements underpinning pathway development and operation are sufficiently comprehensive and robust and aligned at least to common objectives.

Approaches to tackling the alignment and 'buy in' from services not traditionally part of children and young people's partnerships include:

- Protocols and agreements about the nature and level of services to be provided (for example from adult mental health or substance misuse services, housing, and debt advice) based on an estimated cohort per annum (for example likely number accessing Team around the Family arrangements).
- Joint or coordinated assessment of families accessing Team around the Family arrangements (for example a common assessment undertaken in tandem with assessment of parental mental health problems).
- Multi-disciplinary service delivery teams (for example across adult substance misuse, domestic violence and more traditional family support services for children and young people and their families).

4.3 Pathway development and implementation

Pathway development and implementation should be undertaken with full attention to what are now reasonably well-established critical success factors. Specific consideration needs to be given to variance reporting and pathway review as these consistently appear as areas of weakness in operation. Pathways need to be locally scoped and owned and to reflect local contexts, histories and circumstances. While there are established approaches and resources to support pathway development, grafting a pre-existing or 'off the shelf' model pathway from elsewhere onto local arrangements should be avoided. Pathways by themselves are not a panacea. How well they work depends on those who use it. How well a pathway is implemented will be of at least equal importance to its content and ambitions. Their development and implementation therefore needs to combine both 'top down' and 'bottom up' approaches to ensure strategic alignment as well as engagement of operational staff and the participation of service users.

While the idea of an integrated pathway development has the ability to attract a diverse stakeholder audience, the actual process of development and implementation is likely to involve complex and resource-intensive activities. It seems sensible to identify a project team to lead and coordinate this work and to

ensure service user participation within it. A balance needs to be struck between comprehensiveness of scope and manageability, suggesting that pathway development should be an incremental process with an initial focus on high-level mapping and detailed work within identified areas of change that are likely to make the most difference in terms of improving outcomes for families.

Supporting guidance for professionals and families needs to reconcile comprehensiveness of detail with usefulness and usability. Given the potential breadth of circumstances and needs (and therefore variance) accommodated within a family support pathway this guidance needs to emphasise the scope and importance of professional judgment and decision-making.

Information generated by pathways should not be simply confined to reviewing the operation of the pathway itself but be utilised to inform broader commissioning activities. Introducing an emphasis on co-production and the resources that families bring to the resolution of difficulties implies that baskets of local indicators and measures will need to be developed that are sufficiently sophisticated to capture these elements. Reliance on national performance indicators alone, even where these form a shared framework of performance across agencies, will limit robust local learning about needs and outcomes generated by activity within an integrated pathway.

4.4 Design of services

While there remain areas of difference in emphasis, there is now a reasonable consensus within the literature as to what does and does not work in family support arrangements. A graduated mix of services and interventions across a continuum of need that is sensitive to and has the capacity to meet specific needs in a timely way is essential. The evidence is clear that families need and value services that are tailored around their individual strengths and support needs.

Family-based approaches to support can assume a variety of forms. Effective provision does not necessarily involve the simultaneous engagement of the whole family but rather ensures that issues within the family are addressed through a co-ordinated approach that ensures any support delivered is not done so in isolation. It should not be assumed that 'whole family' approaches are always helpful or appropriate.

The operation and success of pathways that are designed to address emerging family support needs are likely to be optimised when the distribution of resources underpinning them are configured to support these objectives. There is no precise or ideal ratio for this distribution across the preventive, protective and remedial domains but authority areas should use the results of mapping activities to assess the pattern of distribution and whether or where scope for re-distribution might be most effective.

There is no 'silver bullet' 'or 'perfect' team around the family service model that all areas should attempt to replicate. A 'one-approach-fits-all' is unlikely to lead to sustained change. While there is a gathering evidence base for effective interventions particularly within targeted provision there is no simple established menu of effective methods that is capable of addressing in a fully comprehensive way the needs of families who may be hard to reach and hard to change. Local

areas do need to reconcile existing provision against best evidence and to identify where changes need to be made through the commissioning of new provision and/or the adaptation or cessation of specific resources. In so doing, they are likely to experience a tension between drawing on and using proven models of intervention and the need to nurture innovation. It is important that this tension does not act to produce a severe constraint on local improvement efforts or serve to place unreasonable expectations upon them by masking the reality of risks inherent to most service development and transformation efforts.

There is clear evidence for much lower rates of take up of targeted services and of open access services by families experiencing particular hardship. Overall, families perceived to be most 'in need' are least likely to take up offers of help or support and there appears to be a positive correlation between levels of drop-out, for example from parenting programmes and levels of social disadvantage. Addressing engagement and barriers to services is a crucial element in securing more sustainable change particularly for families in poverty. In terms of practical improvements to improve access and engagement arrangements attention should be given to those established activities identified within the literature which appear especially useful within the context of 'whole family' approaches. All services involved connected to a support pathway need to consider whether and how their intake and assessment processes maximise engagement opportunities and reduce stigma.

Integration efforts that have the effect of rationalising and reducing access arrangements (i.e. points of entry) are likely to be ineffective for families in need of support and serve only to widen levels of disadvantage. Pathway development needs to accommodate and support multiple points of entry to services.

4.5 The influence and impact of integrated processes and systems

Shared documents, such as single or common assessment and family-based plans can serve as useful and powerful vehicles for integration as they draw the perspectives and contributions of many stakeholders into one coherent record. The design and usability of these documents will be an important factor in promoting adherence to the practice requirements of a pathway. Good design here is likely to contribute to higher levels of reliability in and comprehensiveness of information generated by pathway activities. The first paper in this series deals in more detail with how to maximise the impact of all aspects of a Team around the Family system.

4.6 Implementing change

Developing and implementing integrated pathways for family support will involve change management activity. The introduction of an integrated pathway will not in itself be sufficient to act as a motivator for change. In addition, an emphasis on integrated effort to promote early intervention and prevention has implications for workforce reform and the deployment of new roles. The amount of time that is required to support this kind of implementation through change management cannot be underestimated and authority partnerships will need to consider how best this can be resourced.

Early support and intervention objectives also have implications for the skills base and workload pressures for key professional groups particularly within universal services. There is now evidence to suggest that a considerable number of professionals within, for example early years and primary settings lack confidence and experience in working directly with parents and families, particularly if they are disadvantaged. Training programmes designed to support implementation of a new pathway need to take account of this and to address identified deficits. In addition a realistic assessment of the impact of new roles on workload pressures within key staff groups needs to be undertaken and made subject to routine review. Left unaddressed, this issue is likely to act as a severe constraint in realising the optimum operation of and early support ambitions underpinning the integrated pathway.

5 References

- Allen D (2009) From boundary concept to boundary object: The practice and politics of care pathway development. *Social Science & Medicine* 69 pp354-361
- Allen D, Gillen E and Rixson L T (2009) Systematic review of the effectiveness of integrated care pathways: what works, for whom, in what circumstances? *International Journal of Evidence-Based Healthcare* 7(2) pp 61-74
- Allen G (2011) *Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government*
- Barlow J and Schrader-Macmillan A (2009) *Safeguarding children from emotional abuse – what works?* London: DCSF.
- Barrett H (2010) *The delivery of parent skills training programmes Meta-analytic studies and systematic reviews of what works best.* Family & Parenting Institute. London
- C4EO (2010) *Grasping the nettle: early intervention for children, families and communities.* London.
- Clarke H and Hughes N (2010) Whole Family Approaches: understanding and responding to complex needs. *Social Policy & Society* 9(4) pp 527-531
- CWDC (2009) *The Team Around The Child (TAC) and the Lead Professional*
- Daniel B, Taylor J and Scott J (2009). *Noticing and Helping the Neglected Child Literature Review.* Research Brief DCSF-RBX-09-03
- Davis N (2005) *Integrated Care Pathways: A guide to good practice.* National Leadership and Innovation Agency for Healthcare
- DCSF (2010). *Think Family Pathfinders. Research Update.* Nottingham
- DCSF 2010. *Early intervention: Securing good outcomes for all children and young people*
- Effective Interventions Unit (2003). *Integrated Care Pathways. Guide 1: Definitions and Concepts*
- Efficiency and Innovation Board (2010). *New Models of Service Delivery. A Qualitative Study of Team around the Family Approaches*
- Evans-Lacko S, Jarrett M, McCrone P and Thornicroft G (2010). Facilitators and barriers to implementing clinical care pathways. *BMC Health Services Research* 10:182
- Furley S, Redgrave R, Furley D (2006) Three years on: the experience of developing care pathways across a health- and social-care community. *Journal of Integrated Care Pathways.* 10 (2) pp 69-73

Hughes N (2010) Models and Approaches in Family-Focused Policy and Practice. *Social Policy & Society* 9(4) pp 545-555

Lindsay G, Strand S, Cullen M A, Band S and Cullen S (2010) *Parenting Early Intervention Programme: 2nd interim report*. Research Report DFE-RR047 Centre for Educational Development, Appraisal and Research (CEDAR), University of Warwick

Littell I, J. (2005) 'Lessons from a systematic review of effects of multisystemic therapy' *Children and youth services review*, 27, 445-463.

Mason P and Lloyd R (2011) *Local authority child poverty innovation pilot evaluation: third synthesis report*. Research Report DFE – RR076

Mason P (2011) *Effective practice in family-based approaches: literature review* (draft report). GHK

McDonald P, Whittle CL, Dunn L and de Luc K (2006) Shortfalls in integrated care pathways: part 1: what don't they contain? *Journal of Integrated Care Pathways* 10 (1) pp 17-22

McDonald P, Whittle CL, Dunn L and de Luc K (2006) Shortfalls in integrated care pathways: part 2: how well are we doing? *Journal of Integrated Care Pathways* 10 (1) pp 23-27

Middleton S and Roberts A (2000). *Integrated Care Pathways. A Practical Approach to Implementation*. Butterworth-Heinemann. Edinburgh.

Moran P, Ghate D and van der Merwe A (2004) *What Works in Parenting Support? A Review of the International Evidence*. Research Report RR574. Policy Research Bureau/DfES

Morris K, Hughes N, Clarke H, Tew J, Mason P, Galvani S, Lewis A and Loveless L (2008) *Think Family: A Literature Review of Whole Family Approaches*. Cabinet Office.

Price S (2009) *Integrated care pathways for substance misuse treatment – rapid review of the evidence*. National Public Health Service for Wales

Public Service Wales (2010). *New Models of Service Delivery. Team Around the Family Approaches. Key Findings and High Potential Characteristics*.

Robinson M, Atkinson M and Downing D (2008) *Supporting Theory Building in Integrated Services Research*. Slough: NFER.

Rotter T, Kinsman L, James EL, Machotta A, Gothe H, Willis J, Snow P, Kugler J. *Clinical pathways: effects on professional practice, patient outcomes, length of stay and hospital costs*. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD006632.

Statham J and Smith M (2010). *Issues in Earlier Intervention: Identifying and supporting children with additional needs*. Research Report DCSF-RR205.

Thomas Coram Research Unit, Institute of Education, University of London.

Thoburn J (2009) *Effective interventions for complex families where there are concerns about, or evidence of, a child suffering significant harm*. Safeguarding: Briefing 1. C4EO

Tunstall J and Allnock D (2007) *Understanding the Contribution of Sure Start Local Programmes to the Task of Safeguarding Children's Welfare*. Research Report NESS/2007/FR/026. DfES Nottingham

Vanhaecht, K., De Witte, K. Sermeus, W. (2007). *The impact of clinical pathways on the organisation of care processes*.

Welsh Assembly Government (2005) *Designed for Life: Creating world class health and social care for Wales in the 21st century*.

Welsh Assembly Government (2008) *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018*

Zander K (2002) Integrated care pathways: eleven international trends. *Journal of Integrated Care Pathways* 6 pp 101-107

Appendix One: Case materials and resources

1 Developing a care pathway

There is now a considerable amount of material to support the development of integrated pathways. While virtually all of this material has been developed with a health service audience in mind, most contain content that is useful and applicable to other multi-agency settings.

Integrated Care Pathways: A guide to good practice (National Leadership and Innovation Agency for Healthcare 2005) was produced with an explicit intention to ensure *equity in the development of ICPs across Wales and gives the reader helpful suggestions to develop and establish successful and sustainable ICPs.*

The guide addresses definitional issues but includes a number of practical approaches and techniques to support pathway development in a staged approach. The guide can be accessed at

<http://www.wales.nhs.uk/sitesplus/documents/829/integratedcarepathways.pdf>

Other useful resources include the suite of quality and service improvement tools provided by the NHS Institute for Innovation and Improvement and specifically those concerned with process mapping, service analysis and redesign. These can all be accessed via

http://www.institute.nhs.uk/option.com_quality_and_service_improvement_tools/Itemid,5015.html

The ICP users group (ICPUS) in Scotland have also produced a useful and useable guide on developing care pathways in *A Workbook for People Starting to Develop Integrated Care Pathways* (2007). This also uses a staged approach, includes some helpful self-assessment material and can be found at

http://www.icpus.org.uk/wp-content/uploads/2007/08/icpus_workbook_2007.pdf

The guide usefully complements an earlier resource developed by the Effective Interventions Unit in 2003 for substance misuse and published by the Scottish Executive. Both documents include approaches and techniques that are applicable to pathway development more broadly.

Integrated Care Pathways. Guide 1: Definitions and Concepts

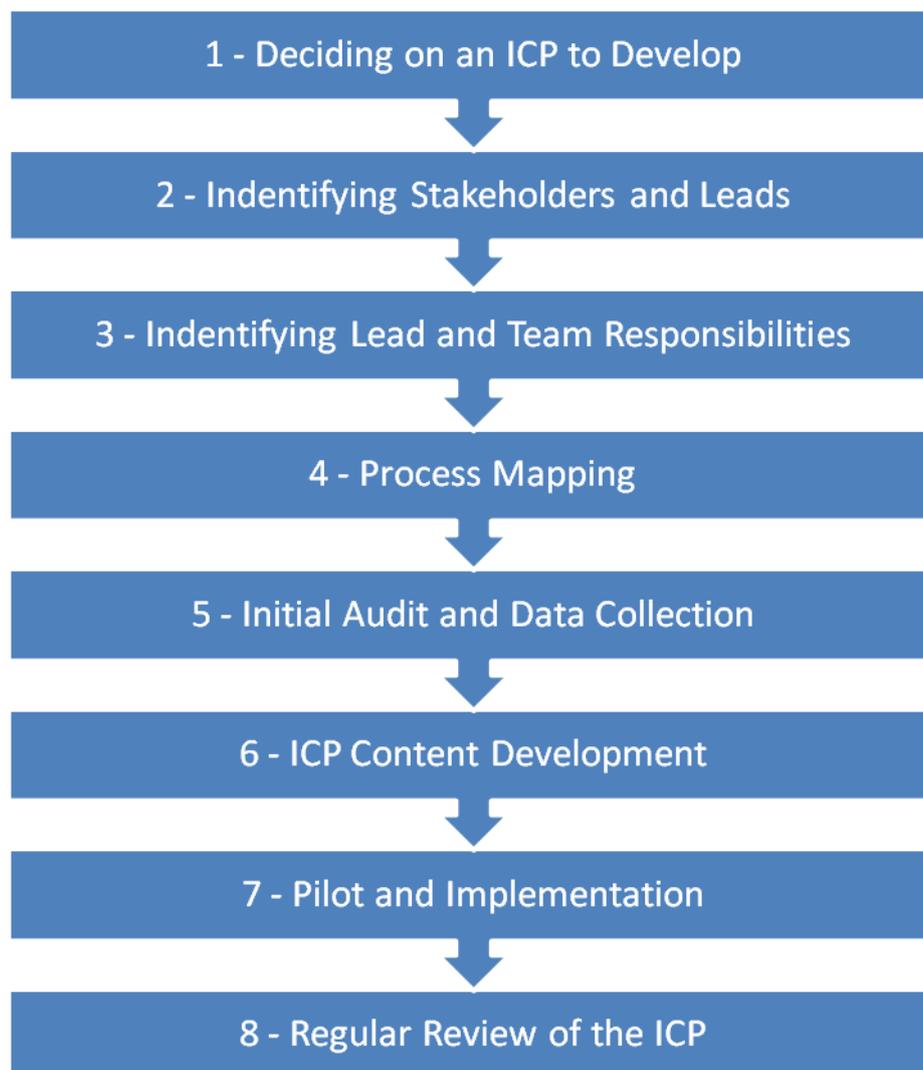
<http://www.scotland.gov.uk/Publications/2003/03/16898/21082>

Developing and implementing integrated care pathways. Guide 2: developing integrated care pathways.

<http://www.scotland.gov.uk/Resource/Doc/46930/0013820.pdf>

Most of this supporting material adopts a staged approach to pathway development with a number of key steps from initial definition to pathway implementation and review. Figure One is drawn from the NLIAH (2005) guide and is provided here by way of example.

Figure One. Developing an ICP – key stages



Source: (NLIAH 2005)

The activities within each of the stages need to be determined and undertaken on a sequential basis. The following comments are adapted from the NLIAH guide but their content is broadly similar within many other best practice guides and toolkits. Having identified and defined the pathway to be scoped and developed the following activities should be undertaken.

Identify stakeholders and lead responsibilities: Stakeholders will include anyone with an interest in the pathway or its outcomes. There are likely to be two types of stakeholder. Firstly those who will be directly involved in the development of the ICP and secondly, those who could be involved in consultation on it.

High-level process mapping: The initial stage needs to be high level and bring together professionals from all agencies involved. It needs to start by defining the start and endpoints of the process. The process map is a list of activities to be performed over time in order to achieve desired outcomes. It may be helpful to use a flow chart with boxes to represent key stages in the treatment process for both the service user and providers. The map at this stage needs to be kept

simple. It might be useful for the different professionals and/or agencies involved to develop the map of their own input and then these can be assembled to document the whole process.

The high-level process map should;

- Define the sequence of activities
- Identify the specific responsibility for those activities
- Define any areas or issues that lie outside the process but will have an impact on it
- Define the relationships that exist between the different professionals and agencies involved in the process
- Define potential problem areas or failure points
- Identify areas where current practice can be improved

The process map or maps should allow the service users progress through the system to be seen as a series of stages. Timescales can be developed and expectations about what will need to happen at each stage of the process to enable the service user to move on to the next. For each box on the map the elements of the process can be clarified, who is responsible for delivering them identified and success/failure and entry/exit criteria can also be defined. The process map can be assessed against the evidence base to ensure that current practice is in line with this.

Developing detailed process maps: Having scoped a high level process map more detailed process maps need to be developed for each of the key stages. Conventionally these form the basis of an ICP. Decision trees can be used to identify the points at which different routes might be taken depending on stage outcomes and so on. If one element of the pathway is provided by a specific agency then this could be developed as a smaller pathway forming a subset of the whole. Each of these will need a starting point on the main pathway and a point of reconnection to it.

Identifying key indicators and measures: Key indicators are the milestones against which a client's progress along the care pathway can be measured. These need to be developed based on agreed standards. Standards might be national or local or a combination of both. Agreement will need to be reached on how and when these indicators will be monitored and how the findings will be presented and used to inform further service improvement and commissioning activity. It is important to emphasise that the purpose of these indicators is to provide data in aggregate form; they are not used to evaluate the performance of individual staff members.

Drafting an integrated care pathway: Most sources suggest that it is important to develop the first integrated care pathways for simpler and more straightforward processes rather than complex ones. This enables those involved to gain experience and it is also thought that an early success will ensure longer-term commitment.

Although ICPs in clinical settings can and do form a single record of care this may not be appropriate for a multi-disciplinary, multi-agency service. Nonetheless, consideration will need to be given as to how and where ICP

documentation is held. For example, will it be an electronic record? If so what are the legal issues around signatures? In any event, where it is agreed that the ICP will form the service user record, the document should ordinarily:

- Replace existing documentation and not duplicate it
- Be easy to use
- Be short and concise
- Reference the guidelines and/or evidence used
- Have service user identification information on each page
- Have space for people completing it to add name, designation and signature
- Assign accountability for completion
- Ensure information on variance can be easily recorded and analysed
- Include information on date developed, date to be reviewed and version number

Implementation and Review: How well a care pathway is implemented is likely to be of at least equal importance to its content and objectives. A pilot stage (for example a specified period of time or number of cases) can often be useful in both disseminating the approach and teasing out issues and areas of difficulty. Formal evaluation of a pilot can also be a useful way of introducing and testing review arrangements likely to be applied following full implementation. In any event, a care pathway should be seen as a dynamic tool and one which will need to be amended in the light of ongoing process of audit and assessment of variance.

2 Representations of care pathways

The following three examples have been provided to illustrate the variety of ways in which care pathways have been represented. While they share a common objective of standardising and integrating processes the approach and 'feel' of each document is distinctive and different. The purpose is here is not to commend one approach above any other but to demonstrate the potential range of possibilities that exist to develop useful and useable information.

Pathway to Provision – Nottinghamshire Children's Trust

This type of multi-agency document will perhaps be most familiar to a children's services audience. It forms part of a suite of materials designed to support the *Pathway to Provision* by enabling practitioners to identify the child, young person and/or family's level of need and to enable the most appropriate referrals to access provision.

The overall operating model for the pathway is represented by a conventional windscreen to demonstrate a continuum of need and provision across four tiers from universal to specialist.

The central part of the document provides definitions and indicators for practitioners to assist in the identification at each level of need together with access thresholds where these apply either within or at the interface of tiers, particularly three and four. Services included within the pathway have mapped their provision against the four levels of need identified in the guidance. This has

enabled the production of straightforward process maps for each stage to indicate what practitioners need to do and the sequence of actions involved. The indicators and maps are also available as an online resource.

A number of appendices are included within the document and provide an overview of the Common Assessment Framework, working arrangements in use by the early intervention Joint Access Team and the 'Step Up' and 'Step Down' process for referrals into Children's Social Care and when support from Children's Social Care is coming to an end.

The document does not make an explicit link between best evidence and pathway stages or content or include a summary of the indicators or measures to be used in evaluating the impact of the pathway at critical points or stages.

The document and further information about *Pathways to Provision* can be found at http://nottinghamshire.familyservicedirectory.org.uk/PathwayBooklet_v8.pdf

Whole Family Pathway – Children's Society

This electronic tool represents best practice guidance in supporting young carers by working within the context of a 'Think Family' approach i.e. it is designed to be used by those working in adult services, children's services, health, education and the voluntary sector. The overall intention is to ensure that whoever or however the family in need first makes contact with an agency, the same process or pathway is followed. The document is described as a 'map' for both families and agencies to follow so they can see what choices, what responsibilities and what lines of accountability for services may be available. It is not intended to be read from the first page to the last but instead includes relevant links from each page to other resources within it. The 'first' page for each practitioner or family then is likely to vary depending on their starting point or point of connection to the pathway.

The document does not include a visual representation of a standard or 'idealised' pathway and the actual description of an assessment, planning and review process occupies only five of the seventy-three pages. Rather the emphasis here is on using best evidence to develop awareness and understanding of young carers across agencies and by raising particular issues for specific professional groups (for example schools-based staff, primary health, CAMHS) to consider in terms of recognising and responding well to young carer needs.

The tool is underpinned by six key principles of practice. These are woven into the narrative content at relevant points and supported by summaries of statutory requirements and additional resources that are likely to be of value both to professionals and families.

The Whole Pathway tool can be accessed at <http://www.youngcarer.com/pdfs/Whole%20Family%20Pathway.pdf>
Further information about the context for development of the pathway can be found at <http://www.youngcarer.com/showPage.php?file=professionals.htm>

Integrated Care Pathway for Children and Young People with Complex Physical and Healthcare Needs. DHSSPS, Northern Ireland

This document provides a good example of a pathway developed using conventional ICP methodology and which also serves as a single record of care and support. It has been designed to guide community services in meeting the needs of families, children and young people with complex physical healthcare needs. This 'whole life' pathway covers four main strands or stages from transition from acute to community services to end of life and bereavement.

The pathway includes a simple process map outlining the elements to each strand and their relationship to each other. This is supported by more detailed information about the content to each strand.

The central part of the document identifies and details the main actions to be taken within each strand and suggests the agency or professional role that either is or could be assigned responsibility for its implementation. These actions reflect current best practice and/or best evidence within research reviews. Key standards have been identified for each stage within the pathway together with anticipated outcomes.

As a single record of care, the actions identified within each strand allow for reporting to be made within the document including the noting of any proposed deviations as well as any omissions or improvements that occur. The intention here is that the document supports effective information sharing across the professional network as well as with families but also contributes to subsequent audit activities and ICP review and potential redesign.

This document can be accessed at

http://www.dhsspsni.gov.uk/integrated_care_pathway-july09.pdf

Appendix Two

Appendix Two – Effective intervention with families: approaches and programmes

1 Introduction

This appendix provides an overview of approaches to and programme interventions for whole family support. The focus here is largely, but not exclusively early and earlier support designed to prevent escalation of needs and difficulties and addresses in particular the protective dimension of services up to an including the interface with remedial provision. It draws on a range of sources but principally the evaluative reviews cited within the main report undertaken by Moran et al (2004), C4EO (2010), Lindsay et al (2010), Allen G (2011) and Mason P (2011).

While the evidence base for effectiveness continues to develop and become more robust, the picture is an evolving one with new approaches and local innovation characteristic of this area of provision. Increasingly, questions of cost-effectiveness and impact are becoming more central to service review and development and are now more routinely accommodated within formal research projects. The recent Allen, Lindsay and C4EO reviews, for example, deal explicitly with issues of cost and scope for savings over at least the medium- to longer-term.

At the same time, the potential number and range of approaches and interventions is extremely large. The Moran et al (2004) review considered 39 programmes for parenting support alone while the Allen paper identified in excess of seventy interventions designed to provide effective early support. While Allen produced a reduced and final list of nineteen 'top' interventions', he conceded that this was very much an interim and to extent arbitrary finding i.e. a different form of classification would in all likelihood have produced a different result in the final analysis.

The approach adopted here has been to include **family-focused** programmes that either have been or are in the process of being trialled in the UK albeit that the origins of the programme may have been developed elsewhere. This does mean that a number of programmes with a strong evidence base but not currently delivered in the UK have not been included here. There is of course a continuing and strong case for looking to import established programmes from elsewhere, a point made by the Allen review and endorsed by recent best evidence reviews of early and later childhood education programmes by Chambers et al (2010).

This is a significant finding and explains, at least in part, why one of the five key strands for future investment identified by C4EO (2010), namely childhood literacy, is relatively poorly represented in terms of established improvement programmes. The other four strands (early years, parenting programmes, targeted family support and young people on the edge of the care system) appear to be more comprehensively covered by the programmes identified in part 3 below. On the face of it, it would seem reasonable to assume that

findings from similar circumstances and challenges elsewhere would generalise to the UK. Nevertheless, there still remains a need for large-scale randomised evaluations of programmes already in use here, and of UK adaptations of programmes that have shown evidence of effectiveness in other countries.

The emphasis on the family also means that a number of interventions designed to address early and childhood literacy have been omitted since these are generally delivered directly to children within school settings albeit that many programmes will have at least some level of parental involvement.

Intervention approaches and programmes have only been included where there is established evidence for effectiveness obtained from randomised control trials with statistically significant post-intervention effects. 'Homestart' for example is an established intervention in the UK but was not identified in an evaluation by the Rowntree Foundation in 2004 as either being cost-effective or sufficiently robust to produce consistently better outcomes. The listing is not intended to represent any sort of prescriptive menu or comprehensive service offer but could perhaps form part of a framework for authority areas to review their existing breadth of provision against best evidence.

2 Overall approaches to family-focused support

Total Place and Community Budgets

The Total Place approach has been piloted in England in Children's Services and recently pilot authorities for the new Community Budgets for families with multiple needs were announced.

Both these approaches look at the total resource available in a local area to provide holistic multi-agency support to families. The drive is to provide new innovative ways to provide services, reduce costs and overlaps and to secure better outcomes with the available resources. The more recent Community Budget pilots include the following approaches:

Approach	Local Authority
<p>Scaling up or expanding existing multi-disciplinary models such as the FIP or the LIFE Programme in Swindon. The latter is billed as 'the next step' to the FIP model – using a multi-disciplinary team approach working with families over two years where families are invited to participate fully from referral and are given the chance to recruit the professionals who will work with them. Linked with this, getting greater buy in and investment from agencies other than the local authority (who effectively contribute in proportion to the savings that they might be expected to accrue from turning around troubled families).</p>	<p>Barnet, Birmingham, Leicestershire, Swindon</p>
<p>Drawing in investment including through the use of Social Impact Bonds (SIBs). A number of sites have submitted requests for advice and support from DLG about how to source investment through vehicles such as SIBs.</p>	<p>Birmingham</p>

Approach	Local Authority
Formal pooling of budgets or at least 'people' to achieve a Think Family Approach.	Blackburn with Darwen, Hull, Kent
'Up front' identification of cohorts of children and families who would benefit from this approach.	Many including Blackpool
Building on previous Total Place pilot to create a multi-disciplinary and co-located Family Resilience Service including a Team around the Family approach and deliver evidence-based interventions.	Croydon
Development of several multi-disciplinary teams based in localities, using a whole family assessment and key worker approach and drawing in substance misuse or other services to contribute to interventions.	Hull and Lincolnshire
Use of payment by results for aspects of provision, for example substance misuse services.	Hull, Islington and Lewisham
Development of a new Family Outreach Support Service at the same time as drawing in a range of budgets for targeted support services (for example including the Pupil Premium from schools) to re-shape targeted services more widely.	Islington
Building up team around the child or team around the family approaches and panels locally.	Lewisham

For more information see

<http://www.localleadership.gov.uk/totalplace/>

<http://www.communities.gov.uk/news/corporate/1748111>

'Think Family'

Research suggests that for 70% of children who enter the care system, the primary cause of need was a difficulty faced by a parent or caregiver (Looking after children: cohort studies, CFCR). Effective support for parents and families is therefore crucial in enabling children to remain with their families.

The 'Think Family' approach call for adults and children's services and health and voluntary sector partners to work more closely together. The focus is a whole family approach in order to secure better outcomes for children from families with complex needs. The 'Think Family' toolkit and protocols for substance misuse, offending, mental health, and young carers are available from <http://www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/>

Research findings concerned with the 'Think Family' approach are now beginning to emerge. York Consulting, have recently published two reports of research funded by the DfE. Their research on the use of whole family assessment to identify the needs of families with complex needs, found a range of positive outcomes linked to intensive family focused assessment and support, such as a reduction in family risk levels which has stopped child protection concerns escalating and earlier/swifter identification of child protection concerns. <http://www.education.gov.uk/research/data/uploadfiles/DFE-RR045.pdf>

Secondly an assessment of the early impact of Family Pathfinders funded by DfE to test family focused models of working with families with multiple problems found a range of positive outcomes. The support provided by the projects lead to improvements in both family level and individual outcomes and nearly half of the families who exited from the support programme showed reduced levels of need. As part of the research an initial Social Return on Investment (SROI) 2 analysis of 53 families was undertaken and this analysis found that focused support generates net programme benefits. One million pounds of investment was estimated to generate savings of £2.5m at a society level by avoiding adverse outcomes for family members, such as custodial sentences or unemployment; a net benefit saving of £1.5m.

<http://www.education.gov.uk/research/data/uploadfiles/DFE-RR046.pdf>

Family Intervention Projects

Family Intervention Projects (FIP) provides the most 'at risk' families with high level, intensive support to help them make positive changes. The projects target families who are responsible for disproportionate amounts of anti-social behavior, families who experience child poverty and those who are at risk of becoming involved in offending behaviors.

More information can be found at the following websites:

http://www.yhn.org.uk/tenancy_services/young_peoples_services/family_intervention_project.aspx

<http://www.education.gov.uk/research/data/uploadfiles/ACF44F.pdf>

<http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00680/>

The approach was strongly promoted by the previous government in England and many local authorities were funded to pilot FIP's. Evaluation reports have generally been positive although the FIP approach as a whole has not been without its critics both in terms of emphasis and validity of findings, see for example Gregg (2010 - *Family Intervention Projects: a classic case of policy-based evidence*). For a copy of this report go to

<http://www.crimeandjustice.org.uk/familyinterventionprojects.html>

3 Family focused programmes

Family Nurse Partnerships (0-2 years)

The Family Nurse Partnership approach was developed in the USA over thirty years ago and is an evidence-based nurse home-visiting programme designed to improve the health, wellbeing and self-sufficiency of young first-time parents and their children. It involves weekly or fortnightly structured home visits by a specially trained nurse from early pregnancy until children are two years old. Forty local areas are now piloting the approach in England supported by a number of Department of Health funded randomised controlled trials which are due to report in 2013. A commitment has recently been made to significantly increase access to the programme.

This programme has been well researched in the USA and has shown consistent short as well as longer-term benefits for children and families. Large scale randomised trials have shown reductions in children's injuries, greater intervals between births, improvement in school readiness and reduction in antisocial

behaviours in children when they reach their teens. Further information about the programme can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118530

Webster-Stratton Incredible Years (0-13 years)

This parent-training intervention has been widely delivered across the UK, including delivery with a focus on the disadvantaged through Welsh Early Years Services. It comprises a series of interlocking programmes for parents, children and teachers, focused on strengthening parenting competences (monitoring, positive discipline, confidence) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competences and reduce conduct problems. The Webster-Stratton programmes have been evaluated in a great number of randomised control trials, including a number carried out in the UK, and which have demonstrated high effectiveness on a range of child and parent outcomes. The intervention has been evaluated by NICE as being cost-effective in reducing conduct disorders and includes other evaluation outcomes, for example, reductions in parenting stress and significantly reduced antisocial and hyperactive behaviour. The intervention has been promoted for use in a large number of authority areas in both England and Wales and is currently subject to further evaluation by Warwick University as part of the PEIP programme across eighteen pathfinders in England. Further information can be found at

www.incredibleyears.com/Program/incredible-years-series-overview.pdf

Triple P (0-16 years)

Originally developed in the 1980s, this is an established and widely used multi-level and multi-disciplinary preventative programme with application in both universal and highly targeted settings. The programme aims to prevent severe emotional, behavioural and developmental problems in children by increasing parental knowledge and capability together with enhanced family environments. Delivery and intensity of the intervention can happen at one of five levels contingent on the assessed severity of problems. The intervention has been evaluated by NICE as being cost-effective in reducing conduct disorders and has been shown to be effective with a range of less significant behavioural problems in children aged 0-16 years. The intervention has been promoted for use in a large number of authority areas in both England and Wales and is currently subject to further evaluation by Warwick University as part of the PEIP programme across eighteen pathfinders in England.

Multi-systemic therapy (MST) (11-17 years)

Multi-Systemic Therapy (MST) is a comprehensive, flexible, and individualised family intervention for treating clinically significant antisocial behaviour in children and young people aged 10 to 17 who are at high risk of entry into the looked after system. It has received the most empirical support as an effective family-based treatment for serious antisocial behaviour. The approach has a focus on promoting the capability of the family as a whole to address offending behaviour and delinquency through improving parenting capacity, increasing young people's engagement with education and training, reducing their offending behaviour and tackling underlying health or mental health problems, including substance misuse. MST is typically delivered at the homes of participating families, however, the setting may vary according to the individual needs of the

family. The therapist is available to the family twenty-four hours a day, seven days a week, however, treatment gradually decreases towards the end of a 3 to 5-month course of MST. The approach, endorsed by NICE, has been trialled across 10 sites in England, and is supported jointly by the DfE, the Youth Justice Board and DH.

The therapy is used with children and young people aged 11-17 years and their families, where young people are at risk of out of home placement in either care or custody, due to delinquent and aggressive behaviour, and anti-social attitudes. Interventions typically last from three to six months.

The 2010 evaluation of a UK based MST pilot by the Brandon Centre in conjunction with UCL found that re-offending in troubled and aggressive young people can be significantly cut by using this pioneering mental health approach. Using the therapy in families with multiple problems was found to reduce the risk of re-offending, particularly among boys. Lower re-offending behavior was evident two years down the line compared to existing service approaches. The approach can be cost effective, because young people are kept out of custody or local authority care, and parents are encouraged to use the voluntary sector and local supports instead.

For more information see

http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_117344

FAST (Families and Schools Together) (3-18 years)

This systemic and ecological early intervention evidence-based programme was partly developed and has been fully tested in the UK. It aims to increase protective factors for the child (and especially the parent-child relationship), increase the family social network of support including the development of social capital, to reduce family conflict and enhance academic achievement. It is delivered via eight weekly school-based sessions followed by two years of parent-led, school supported, monthly booster sessions.

The programme has been subject to considerable research over the past twenty years including randomised controlled trials. Established benefits include improved academic competence, better parent-child relationships and family functioning and reduced rates of externalising behaviours. Evaluations have also identified unanticipated and long-term parent outcomes including increased parent involvement in schools, parental uptake of further education and work opportunities. It is common for a number of parents who complete the programme to volunteer as future leaders.

FAST was one of five programmes chosen for the PEIP initiative in England although the limited number of families involved prevented a comprehensive evaluation of impact by Lindsay et al (2010).

Further information about the FAST programme can be accessed at

<http://www.mdx.ac.uk/aboutus/Schools/hssc/mh-sw/research/fast.aspx>

Functional Family Therapy (FFT) 10-17

This is a structured and brief systemic family intervention that works to enhance protective factors and reduce risk factors in the family. FFT has three phases.

The first phase is designed to motivate the family towards change; the second phase teaches the family how to change a specific critical problem identified in the first phase; and the final phase helps the family to generalise their problem-solving skills. Intervention typically lasts for around three months. Research from the USA indicates cost-effectiveness in a number of areas including reductions in behavioural problems, substance misuse disorders, crime and likelihood of entry to the looked after system. A randomised controlled trial of Functional Family Therapy is currently under way in Brighton as part of the SAFE Project. Further information about the trial can be found at

<http://www.preventionaction.org/node/1331>

Strengthening Families Programme (10-14 years)

Formerly called the Iowa Strengthening Families Programme (ISFP) SFP10-14 was developed in 1992 at Iowa State University in the United States. The long-term aim of the SFP10-14 is reduced alcohol and drug use and behaviour problems during adolescence. This is achieved through improved skills in nurturing and child management by parents, improved family environments and developed interpersonal and personal competencies amongst young people to promote resilience. The programme delivered over a seven-week period consists of three main components: Parent Skills training, Children's Skills training and Family Life Skills training. SFP has been extensively evaluated particularly in the USA but there are also UK based studies (e.g. Coombes et al 2009 and a current 4 year RCT in Wales). A Cochrane Collaborative Systematic Review has endorsed SFP10-14 as a promising prevention of substance abuse. In general there has been good consistency of findings for impact on reduction and prevention of substance abuse, internalised and externalised behavioural problems, conduct disorders, parental depression and improved family cohesion.

Multidimensional Treatment Foster Care (MTFC) (3-16 years)

This intervention for children and young people with complex needs and challenging behaviour, including offending behaviour, was originally developed in the USA as a cost-effective, family-based alternative to group or residential treatment in care. MTFC involves parenting training, for both the foster carers and the biological (or adoptive) parents, which emphasises the use of behaviour management methods in order to provide a structured and a therapeutic living environment. The training is combined with access to a single multi-disciplinary team, providing a combination of mental health, education and social services.

Intervention targets those factors in each young person's social network which contribute to their problems, including challenging behaviour. It combines high levels of supervision with very positive parenting practices. It also seeks to decrease involvement with anti-social peer groups and to enhance involvement in school and positive recreational activities.

Specific treatment techniques used to achieve these outcomes apply previous methods that have already been shown to be effective, including cognitive, behavioural and family therapies.

The DCSF funded three programmes based on this approach: one which piloted its use with adolescents; a second, working with younger children aged three to six, which focused on prevention; and since 2008, a third for children aged seven

to eleven experiencing placement disruption together with complex behavioural and/or emotional difficulties. Current evaluation within the UK indicates significant benefits for this intervention in terms of offending, self-harm, sexual behaviour problems, absconding and fire setting.

The MTFC model has also underpinned the Intensive Fostering programme, funded by the YJB. This programme provides an alternative to custody for children and young people whose home life is felt to have contributed significantly to their offending behaviour. The programme provides highly intensive care for up to 12 months for each individual, as well as a comprehensive programme of support for their family. For more information see <http://www.yjb.gov.uk/en-gb/practitioners/Reducingreoffending/IntensiveFostering/> and www.yjb.gov.uk/publications/Resources/Downloads/A%20Report%20on%20the%20Intensive%20Fostering%20Pilot%20Programme.pdf

Appendix Three

Ten Principles to guide and underpin service development and delivery for families and children.

1. *The uniqueness of children and families is valued and provided for.*
2. *The care that children receive is based on joint assessment, planning and review processes that keep parents and carers at the heart of discussion and decision-making about their child.*
3. *Service delivery for children and families is integrated and experienced by them as holistic, co-ordinated and seamless.*
4. *Families experience continuity of care through different phases of their engagement with services.*
5. *Children's learning and development is monitored and promoted.*
6. *Families are able to make informed decisions.*
7. *Wherever possible, families are able to live 'ordinary lives'.*
8. *Families and children are involved in shaping and developing services.*
9. *Working practices and systems are integrated.*
10. *Families can be confident that the people working with them have the training, skills and experience required to meet their child's needs.*

(Adapted from *Early Support Service Audit Tool 2009*)

<http://media.education.gov.uk/assets/files/pdf/e/early%20support%20service%20audit%20tool%202009.pdf>, using Early Support.