Research on Good Practice – Early Help

Context – what works

Early help and support for families can be described as:

> *'...both a style of work and a set of activities which reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary and community and private services and are generally provided to families in their own homes and communities. The primary focus is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families, paying particular attention to those who are vulnerable or at risk.'*
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> Pinkerton et al., 2004[1]

There is a widespread understanding across the UK that effective early help and family support can help to secure two primary goals for councils and their partners:

- Firstly, to reduce the number of children who experience poor outcomes through their childhood because they have experienced abuse, trauma, neglect or exploitation for longer than they needed to.
- Secondly, to meet fiscal responsibilities by minimising expenditure on safeguarding and care by the Council (with, for example, some placements now costing Councils in Wales as much as £15,000 per week).

The evidence base for early help / intervention through family support is continually developing, and 'what works' in one local context may fail in another very different environment. However, there are some things known across the UK about how best to design, organise and deliver targeted family support, and Cardiff Council has drawn on analysis by the Institute of Public Care at Oxford Brookes University to summarise these themes.

Perhaps most significantly, national research emphasises that commissioners and managers of early help services should secure **both** effective services or interventions **and** effective multi-agency assessment and referral systems to optimise impact on families with additional needs with needs greater than one service or agency can address:

[1] Pinkerton, J., Dolan, P & Canavan, J. (2004) Family Support in Ireland A paper for the Department of Health & Children. Dublin: Stationery Office

These areas are overlapping in that:

- Systems often include services/interventions (for example Lead Professional or Key Worker activity can and arguably should include some element of direct work with the family).
- A range of family support services frequently contribute to system arrangements or themselves take the lead role in these arrangements, and so can also be seen as part of the whole family or whole system approach.

Early help for families

When we talk about early help, the research suggests that, although it is certainly best to intervene as early as possible in a child's life to prevent problems from escalating[2], it is important also to attend to early stages of a problem at whatever age, and both can be cost effective[3]. Early help[4] is most effective when it includes:

- Effective team around the family or similar
- Attention to effective engagement of families in change and proactive breaking down of barriers to participation including through being non-judgemental, active listening, practical 'quick wins'
- Whole family approaches
- Multi-component approaches linked to family needs
- Strengths-based and solution-focused interventions
- Targeted approaches (targeting individual families or vulnerable communities)
- Focus on supporting improvements in parent functioning and parenting

[2] The evidence demonstrates how deficiencies in early years' experiences have an enduring impact on the child's subsequent development. The worst and deepest brain damage occurs before birth and in the first 18 months of life when the emotional circuits are forming (Marmot 2010 Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England). Also Field, F (2010) The Foundation Years: preventing poor children becoming poor adults and the recently published cross-party manifesto 'The 1001 Critical Days: The Importance of the Conception to Age Two Period' (2013)

[3] Cost effectiveness is referred to in the DfE/Wave Trust report 'Conception to Age 2 – the age of opportunity' (2013). Returns of between £1.75 and £19 on every £1 invested have been demonstrated by 9 Social Return on Investment studies

[4] Compared to reactive services when problems are complex

- Services and interventions that draw on tested methodologies (that have a strong theoretical or evidence base), and fidelity to specified methodologies in the delivery[5]

The Early Intervention Foundation has recently identified the importance of of programmes which can address, between them, in particular three key (often related) needs:

- Improved attachment security
- Improved child behavioural regulation
- Improved child cognitive development

Examples of evidence-based[6] early help programmes addressing these needs relating to families with younger children include:

- Group parenting programmes such as Triple P (0-16) and Incredible Years Parenting / Webster Stratton (0-12 years)[7]
- Family Nurse Partnership (for children 0-2 and vulnerable first-time mothers)[8]
- Support to address maternal (post-natal) depression[9]
- Programmes that seek to improve parental verbal stimulation and early learning practices with their infants / toddlers

Examples of evidence-based programmes addressing these needs relating to families with older children include:

- Cognitive behaviour therapy (CBT) for young people with behaviour problems, depression, school refusal and other issues
- Group parenting programmes such as Triple P (0-16) or Strengthening Families (10-14).

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[5] Allen G (2011) Early Intervention: the next steps; Centre for Excellence and Outcomes (2010) Early Intervention and prevention in the context of integrated services – evidence from C4EO Narrowing the Gap Reviews; the Munro Review of Child Protection

[6] Note that 'evidence-based' depends on interpretation including in particular whether randomised control trial evidence is required or something different (note RCT is generally considered to be the 'A' standard but other well-conducted studies do also add to our understanding and are often relied upon as 'B' standard evidence

[7] A more extensive list can be found in the DfE and Wave Trust report 'Conception to Age 2 – the age of opportunity: Framework for local areas service commissioners' (2013)

[8] The evidence base is stronger in the USA than in the UK, where the early findings of a randomised control trial involving FNP pilot sites (Robling, M. et al (2016) Effectiveness of a Nurse-Led Intensive Home Visitation Programme for first time teenage mothers (Building Blocks): a pragmatic randomised control trial, The Lancet, Vol 387, No. 10014, January 2016) have been mixed. A further evaluation is now underway and due to report in 2018

[9] See the RRR for Perinatal Support

Support for families with more complex and/or chronic needs and children on the edge of care

Evaluative research shows that there are a number of helping methods that have a good record of reducing the impact of later incidence or complex family needs. The features of more effective support for families with more complex or chronic needs include those outlined above for early stage help, and **in addition:**

- More intensive interventions (but still with broader base of multi-disciplinary support).
- A longer period of intervention is usually required overall – i.e. 12-18 months, but this can include an element of 'step down' to less intensive support after a period of intensive intervention.
- Assertive, persistent Key Workers with lower caseloads and high levels of skill in working with families.
- Even closer attention to helping parents or carers to develop internal motivation to change and to address their issues that are likely to get in the way of considering or making changes for example, substance misuse, domestic abuse or parent mental health issues[10] [11]

It is clearly important to select an evidence-based programme or set of methodology(ies) or approach(es) for intervention with families who have complex needs, however Ofsted's 'Edging Away from Care' report (2011) strongly suggest that fidelity to the chosen methodology is even more important than the actual choice of model.

Programmes of intervention with a high level of evidence base (usually involving a randomised control trial study) are mostly those that are manualised and relate to intensive work with young people and their families, for example: Functional Family Therapy or Multi-Systemic Therapy. However, some other studies are beginning to identify the evidence-based components of effective family support at a higher level of need. For example, a 2016 evaluation of a high level and highly successful family support service working with families with complex or chronic needs in Newport, Wales[12] found that, in addition to working very intensively with the family in the first few weeks of the intervention, effective services provided a 'golden combination' of therapeutic and practical approaches for the duration of the intervention, as illustrated in the table below:

[10] In addition to the references at 11. above, Interface Associates (2011) Troubled Families 'What Works'; and Ofsted (2011) Edging Away from Care

[11] Innovation Programme 'Wave I' findings published by DfE in 2017 including: Burch, K. et al (2017) Social Care Innovations in Hampshire and the Isle of Wight: evaluation report, DfE, March 2017

[12] Successful working with families in the statutory arena: an evaluation of the Newport Family Assessment and Support Service: Summary Findings (May 2016) published by the Institute of Public Care (https://ipc.brookes.ac.uk/publications.html)

Example therapeutic approaches	Example practical approaches
Confident exploration of the past (cycles of behaviour & relationships and impact of childhood experiences & parenting approaches & domestic violence)	Parenting tips –reference to evidence- based programmes that can be delivered 1:1 – including suggesting, 'modelling', 'doubling back' when problems arise. The context for this work is often parent: mental health issues; substance misuse; lack of experience of effective parenting in their own childhood; learning disability.
Theraplay and other playful approaches to strengthening attachment	Providing information e.g. about how inter parental conflict affects children / how to de-escalate conflict
Ongoing support for motivation to change including to reach out to external supports for DV, SM, MH	Basic financial and housing advice and support
Therapeutic work with individual child members of the family – particularly young people engaged in or at risk of sexual exploitation, poor mental health, challenging or aggressive behaviour, non-school attendance	Advice about how to keep children safe
Work with all family members on relationships and how to relate to each other in a positive way	Work with parents around keeping the house sufficiently clean so as not to be a risk to the children

Other key attributes of this successful model included:

- Support provided 'up front' to families to develop internal motivation to change – including through the application of motivational interviewing techniques[13]
- Use of highly visual distance travelled tools (which families interviewed for this evaluation suggested were highly motivational)
- High levels of guidance (toolkit and standards for practice) and ongoing supervision of practitioners providing interventions

[13] The stages and theory of change was first described by James Prochaska and Carlo Diclemente (1982) including reference to: pre-contemplation; contemplation; determination / preparation; action; maintenance leading to lifestyle /behaviour change; possible lapse; contemplation etc. Their work has informed the development of motivational techniques

Finally, in terms of those families with the most complex problems nearing breakdown and on the edge of care, there is also a growing evidence-base on what kind of combination of services work most effectively:

- Rapid response for young people at risk of homelessness / entry into care includes an element of family mediation, practical support and access to appropriate accommodation or supported housing and other services (depending on age).
- Attention to family engagement and 'contracting' – a creative and tenacious family focus at all first points of contact including if appropriate reminding legal guardians of their legal duties to young people.
- Clear, evidence-based model(s) for intervention such as Functional Family Therapy and Multi-Systemic Therapy selected with regard to the presenting characteristics of young people presenting on the edge of care[14]. High levels of fidelity to the chosen programme.
- Assertive, persistent key workers for young people and their families with low caseloads – able to work skilfully with families for extended periods of time including an intensive initial phase. The quality of the key worker relationship with families is the factor most commonly cited as the difference between success and failure.
- Responsive access to broader services including positive activities; Family Group Conferencing; CAMH services.
- Investing to make reconciliations safe and sustainable.

Officers in Cardiff have used the IPC evidence summarised above to inform the outline design of the strategic delivery model for prevention, early help and support described below, particularly in terms of:

- Recognising the importance of good quality information, advice and assistance to all families
- Emphasising the importance of early help for families who need some early help, and of intensive support for those with complex or long-term problems, and that the detailed design of these services needs to be different.
- Ensuring that the right skills, capacity and experience is available to families at different points in the range of services.
- Investing sufficiently and focusing on the right families so that the number of children in Cardiff needing safeguarding or substitute care away from their birth families is reduced, securing better outcomes for them and reduced costs to the Council.

[14] Generally speaking, MST is considered a good fit where the child's behaviour constitutes 'wilful defiance' and is driven more by peer, school or community factors. FFT is considered a better fit where the child's behaviour is driven more by family issues such as high conflict, histories of neglect or psychiatric concerns, or where the caregiver is initially reluctant to participate