Briefing Paper: Intensive Family Support Service – A Blended Model of Delivery.

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The purpose of this brief is to summarise the findings of a review of a family support programme delivered in Belfast, Northern Ireland between 2014 and 2016 by the Extern Organisation. Through a mixed methods critical appraisal, this new model in which disciplines and practices were blended together was analyzed to improve our understanding of 'what works' for families with complex and multi-faceted needs.

Introduction

Across the UK there has been an increasing appetite for implementing programmes that have been rigorously evaluated and come with a strong evidence base. Why? As decision makers and social influencers become more aware of the economic implication of social problems, they are understanding that problematic life-course trajectories correlate closely with increased public expenditure.

Over the last decade a number of investigations such as The Allen Reports (Cabinet Office, 2011) and Munro Review (Munro, 2011) have raised acute concerns regarding child protection and child welfare services. Of the major findings was the absence of decision making underpinned by evidence. The dual development of increased availability of evidence and increased need to improve services at a reasonable cost have created the conditions for a growth in evidence based approaches.

In Northern Ireland, one of the underpinning themes of the previous Strategy for Children and Young People (OFMDFM, 2011) highlighted the interdepartmental objective to ensure that strategies are evidence based. Reducing duplication, improving services, ensuring efficiencies across departments and getting value for money as well as successful outcomes became the linchpin of the Northern Ireland Executive.

In the current Programme for Government, the Stormont Executive has made a commitment to deliver a range of measures to tackle poverty and social exclusion through the Delivering Social Change (DSC) Framework. The framework supported by a fund of £118M aimed to facilitate joined up commissioning across government departments for programmes and activities that have evidence of effectively achieving objectives related to the 5 key priorities of: early years and early intervention; literacy and numeracy; transitions; integrated delivery; & joint planning (CYPSP, 2014). Announced in September 2014 by OFMDFM, a stream of DSC was the Early Intervention Transformation Programme (EITP) that aimed to equip all

parents with the skills needed to give their child the best start in life; support families when problems first emerge, out-with the statutory system positively addressing the impact of adversity on children by intervening both earlier & more effectively to reduce the risk of poor outcomes later in life. The programme was underpinned by a focus on early intervention, the use of best evidence and outcomes based accountability.

In 2014, as part of a coordinated approach in reducing family adversity, the Extern Organization in Northern Ireland developed a new model of practice called the Intensive Family Support Service (IFSS). Building upon decades of learning, the new model was built upon whole family approaches, a range of evidence based and evidence informed practices, low caseloads, 24/7 support and dedicated family workers who provided a flexible and responsive service at times when families were most in need of support for between 12 and 18 months. This new blended design was intended to incorporate a range of practices to meet the varied and multi-faceted needs of families with complex needs. The original model design also involved the coordination with other relevant services or agencies in order to minimise duplication and maximise impact.

A range of evidence based practices and programmes were available to families and within the IFSS programme. In total, 68% of families engaged in at least one evidence based programme or practice. A core feature of IFSS was the Multisystemic Therapy (MST) programme. MST is an intensive community based model that uses evidence-based interventions to address problem behaviours and attempts to mitigate the risks associated with out of home placement by placing the family at the centre of all elements of the work. Since being developed in the 1980's, MST provision has extended beyond the USA where it was first developed and into 15 counties across more than 200 teams (Olsson, 2010). 9 treatment outcome studies (including 3 controlled trials) have been published and for 7 of these follow-up data from 1-4 years have been reported to be effective for those who completed the treatment programmes. By increasing an understanding of the 'fit' of the problems, MST intervenes directly in the systems and processes related to those areas. In Belfast, this was delivered by a standalone team within the programme and accounted for more than 2/3 of the total families supported given the much shorter treatment time (3-5 months). In addition, the programme delivered a broader range of programmes as emerging needs arouse. These included CBT (39%), Incredible Years (15%), Art Therapy (6%), Play Therapy (7%) and Parenting your Teen (5%).

Between June 2014 and March 2016, Extern's IFSS programme supported 158 families. The programme was delivered by a range of staff from across a myriad of professions. These ranged from social work professionals to youth workers to art therapists and psychologists. It was also evident that a significant number of staff were trained in multiple disciplines. The majority of families were supported by those from a social work background (38%) but those with a combined discipline supported more than ¼ of families (26%). Between them, youth work staff and those with a background in psychology supported almost 1/5 of the remaining families (19%). Common reasons for referral included: education (74%) and care (76%) issues as well as managing risk (66%). Almost half of families were referred for mental health support (46%) and anti-social behaviour (42%). 33% were referred due to home conditions and 31% of families were referred for health reasons. 25% of families were referred with known substance abuse issues whilst finances (25%) and employment (14%) were other common reasons for referral. 100% of families were experiencing 2 or more of these complex issues simultaneously at the point of referral and it was clear during the data analysis that further issues were recognised and targeted by the key workers during the service implementation. In fact, 89%of families were supported by IFSS staff across 4 or more issues.

Key Findings

1. The development of a blended design enabled a menu of options to become available for families based on their specific needs.

2. The blended approach means that there are multiple implementations occurring in parallel. This type of design is under-evaluated within human service studies and prevention science

3. There is a need for great clarity around decision making processes within this blended approach to ensure that families are accessing the right support at an appropriate time.

4. Housed under one roof and staffed by a multi-disciplinary team made the design more conducive to implementing a variety of techniques, strategies and models

5. The contextual scaffolding made up of Competency, Process, Organizational and Operational drivers, contributed to improved outcomes for beneficiaries of the IFSS programme.

1. Operational Drivers-Menu of Options

- A central component of the IFSS was the menu of strategies, supports and interventions that were blended within a complex arrangement of internal and external relationships to meet the needs of individual families.
- There is a dearth of information related to the prevalence of blended models as well as their outcomes and impact.
- Within IFSS, the cocktail of support was defined at the outset to include both evidence based programmes and evidence informed practices. It was reviewed continually and appears to have proven successful for those who received the correct blend and dose.
- A central design of the programme pilot involved a partnership with two external agencies who specialized in rights and advocacy (Citizens Advice Bureau) and relationship counselling (RELATE). 25% of all families who engaged in the IFSS programme were referred to CAB for additional specialised support. 15% of families were referred to RELATE for relationship counselling. It appears from the evidence that of those who were referred to the programme for issues related to finances and who accessed CAB services as an integral part of the support, were more likely to achieve their desired outcomes.
- Despite the array of support services available to families, not all families received the same level or categories of support. The menu of options were available to families and were actioned when specific issues presented.
- Service provision appears to be dependent on a variety of variables, one of which was the reason for referral. For instance, families with home conditions, finances and/or employment as a reason for referral were less likely to engage on an evidence based practice or programme.
- In contrast, families who were referred for other reasons such as issues with educational engagement or attainment were more likely to engage in an evidence based practice and/or programme.
- There was a strong statistical relationship between use of evidence

based practices and HLO's being met. 70% (n=57) of those who used an evidence based practice also fully met their target goals. Only 38% (n=24) who did not use an EBP fully met their goals.

- Interestingly, families who received an evidence based practice were more likely to receive less intensive face to face provision by IFSS staff.
- Families who were referred with substance abuse issues and had an evidence based approach or practice as part of their menu of supports were more likely to fully achieve their outcomes. 94% (n=15) of those with goals fully met also had an EBP.
- In contrast, 88% (n=14) of those whose goals were no met, did not engage in an EBP
- In some cases it was not the inclusion or absence of the evidence based practice or programme itself, but the issues facing a family at a point in time, the menu of support available to parents and the blend of interventions tailored to meet those needs. 100% of families who were referred with substance abuse issues and received parenting support along with an evidence based approach (n=16) fully met their target goals.
- Use of an evidence based programme, specific work targeting mental health and risk management appear to be some factors that improved outcomes for families. 100% (n=37) who undertook mental health work also achieved target outcomes by case closure appears logical, it also appears that not all families received mental health support. When families did not specifically access mental health support, 96% (n=21) did not fully achieve their target outcomes.
- Similarly, there was a positive relationship between substance abuse, risk management work and goals being met. 100% (n=27) of those families referred with substance abuse issues and had risk management work also met their goals fully and a large proportion (69%) of those families referred with substance abuse issues but had no risk management work did not meet their goals fully (n=12).
- Emotional support offered to service users enhances the therapeutic alliance (Littell & Tajima 2000) and can be a strong predictor of outcomes. When this type of support was documented by IFSS workers it correlated positively with key programme outcomes.
- 80% (n=8) of those whose goals were met around employment issues also had emotional support and in contrast, 71% (n=22) of those who goals were not met around employment, did not receive documented emotional support.
- Whilst it is clear this was not the intention at the outset, the flexibility of the service, the ability to collect and collate needs, the leadership of the management to react quickly to emerging need and the competency of staff to identify suitable interventions resulted in the evolution of this menu of evidence based practice/programmes.

2. Operational drivers- Multi Implementation Site

- The IFSS model has required the implementation of several evidence based practices and models simultaneously to meet the complex needs of the range of families referred to the programme. The blended design assimilates different approaches within one site and one operating structure. In addition, integrated approaches involve the joining of

disciplines as a conscious and active effort to share best practice.

- Whilst other models such as Integrated Care (Lemmens et al, 2015) provide some empirical basis for the development of such blended programme designs, there are clear distinctions. For instance, whilst integrated approaches seek to improve coordination, this is often across different sites and operating structures. As part of the menu of supports, evidence based practices and programmes were blended together in one site. Therefore implementation took place concurrently with different models being implemented simultaneously within the same programme to meet the needs of individual families.
- Not only did the implementation team find themselves moving forward and backward within the implementation cycle but this study of the IFSS model appears to add to this discourse by illustrating another complexity- travellers are not only on one path but may be on several at any given time. Both in terms of IFSS replication and the evolving study of implementation, future studies should explore in greater detail the mechanism successfully driving a multiple implementation site and complexities around such implementation.

3. Process Drivers-Decision Making

- Work undertaken in the support of families differed within and between families. It was evident from the review of case files that decisions around strategies and /or interventions to implement were dependent upon the presenting needs of the families referred.
- How and when to access each of these categories of support differed between teams. Respondents advised that while each component was available to all members of the programme, decisions around access were often down to several variables including worker confidence, availability of wider professional relationships and management styles within each team as well as worker preference.
- Given the multiple adversities experienced by families within IFSS and indeed the range of issues key work staff were tasked with addressing, there were some recommendations from staff that whilst they acknowledged the benefit of a blended approach, greater understanding around how, why and when to use particular strategies would greatly benefit staff in their decision making.
- The ability to fully test how, why and when families received categories of support was outside the remit of this study but would be an important next step if the model was sustained and/or replicated. Workers suggested that having a more consistent approach around decision making processes would greatly enhance worker confidence in their own delivery and potentially maximise the outcomes experienced by families.

4. Process Drivers: Continual Quality Improvement

- In addition to team and supervisor support, the consensus amongst those interviewed was that a range of tools and resources were accessed to provide evidence based answers to prescribed problems or challenges. This ability to access and then implement strategies based upon the best available evidence appears to be a growing culture within the IFSS programme. This may speak to the complex issues facing families but may also be an indicator of an evolving programme open to change and innovation to solve those complex issues.
- There was a general openness to investigation and improvement across the IFSS programme. This is partly evidenced by the evaluation of the menu of supports available to families. It was clear through the data collection that the blend of interventions had increased dramatically throughout the two year period that the study covered. This may be explained by the issues that emerged during that period, but must also be explained by a cultural openness to new innovations within the programme itself.
- Within this study it appeared that for the most part, the CQI processes were seen as a resource for staff and something that provided security in a complex environment. In an area where uncertainty around decisions being taken can exist, the combination of staff support, organisational policies and procedures and a continual feedback loop can reassure staff.
- Synthesising the IFSS quality assurance processes, it appears the collection of data was designed to increase an understanding of what was working well, what was not working well, provide feedback on those areas, agree targets associated with advancing practice and agree goals to achieve those targets.

5. Structural and Competency Drivers- Contextual Scaffolding

- The IFSS model did not develop within a structural vacuum. Rather it was born from decades of learning and success from within dozens of community based support programmes, developed by the Extern Organisation in real world settings.
- Corporate governance structures allowed practitioners to practice in a safe manner; organisational policies and procedures provided staff with clarity around roles, responsibilities and limitations; and leadership at an organisational level allowed measured risks to take place. In doing so this facilitated new innovations to emerge.
- Getting the right staff at the outset of delivery is a critical phase of programme development and evidence based programme replication. Over a third of the support staff involved in the study (38%) were social work trained; 10% of staff were trained in psychology; almost one in ten staff were youth work trained (9%) and a large proportion (26%) of staff were trained in more than one discipline.
- Evidence from the qualitative data suggests that some staff believed that social workers were more likely to have been exposed to the range of issues during their initial professional training (and therefore better prepared). However the quantitative data suggests that across a number of areas (mental health, emotional support, engagement, parenting), discipline made no statistically significant difference to the outcomes

experienced by families. However, in other areas such as mentoring, group work, practical support and the use of evidence based practices, discipline did matter. In addition to the plethora of experience, approaches and skills with the multi-disciplinary environment came a range of specialisms. Through professional experience and indeed professional interest, some staff had acquired specialist skills such as in working with autism. When colleagues were struggling with areas of specialist concern, this blend of experience enabled supports to be more effectively delivered.

- It is recognised that not all staff will have the requisite skills to deliver all components of the IFSS model at the point of entry. For instance, not all newly appointed workers will have trained in Cognitive Behavioural Therapy (CBT) or Structural or Strategic family Therapy or know effective parenting strategies for children with autism. This is not a pre-condition for staff selection. However, actively recruiting staff from across a range of disciplines who collectively possess great knowledge and can impart great skill appears to have paid dividends in this programme. It also appears to be expected that they are open to training in various methodologies and new innovations.
- Within the context of IFSS initial orientation to the agency and the IFSS model; formal supervision, team meetings; on-site observations; family feedback; and on-going training create the conditions necessary to link theory with practice and ensure the practitioner develops within the model. Specific training included: substance abuse; parenting skills; budgeting; risk management; Incredible Years; MST; mental health awareness; safety planning; and outcome based accountability. Training appears to be an integral component of the model and one which staff appreciated. It was seen as both a mechanism for enhancing skill but also an indicator of organisational appreciation for those delivering the model within the community.
- Throughout the interviews, key work staff labelled three areas of structural supports as enabling them to do their jobs more effectively. (1) Formal staff supervision was consistently cited as an integral support process. As already noted, this was both a recognition of how the organisation valued its staff and a forum in which complex issues were navigated. In general, staff appreciated the time allocated for supervision and the process itself was viewed as a necessary component within a model that dealt with so many complex issues. (2) Staff were trained in a variety of techniques and models as needs arose and issues were identified. Once identified, leadership was available to quickly source the most suitable practice or programme to attend to that need. (3) Solid organisational policies and procedures that were readily available to staff were seen as an asset. The existence of such policies appeared to infer transparency on the part of the organisation and provide reassurance to staff who were better informed of their role at an individual worker, team, programme, directorate and corporate level.

6. Conclusion

The pilot of the Belfast Intensive Family Support Service has demonstrated great potential to support families who experience multiple complexities and significant adversity.

The context in which families are living and the environment in which IFSS staff were supporting those families is very complex and emotionally demanding. Despite this, the IFSS programme has successfully engaged and retained both families and competent staff.

Family interventions, levels of intensity and categories of support offered were needs led and this often required a reflexive response from staff who had access to a range of formal and informal supports as well as a menu of strategies and interventions.

The multi-disciplinary aspect enabled a menu of supports but also enhanced collegiality, informal learning and on-the-job training.

If not a new way of working, the blended approach taken by the IFSS programme is the only known programme to empirically examine and disseminate how this design can potentially improve outcomes for children, young people and families in Northern Ireland. This blending of approaches combined with practice wisdom has demonstrated significant outcomes. There is great potential to understand in greater detail how and why families are selected to engage in specific components of the model to increase the consistency around decision making.

It is increasingly clear that staff characteristics (e.g. prerequisites around level of education, discipline, age, openness to one or more of a variety of working styles, openness to innovation and evidence based practices, tenure etc.) will likely facilitate or impede the delivery of blended models. Examining which (if any) of these characteristics enable greater implementation will be of critical importance to researchers interested in blended approaches, programme managers interested in successful implementation and commissioners interested in bringing to scale approaches that have a strong evidence base.

The development of an adherence measure relative to the specific IFSS principles and operational drivers would go some way to enhance impact and outcomes.

References:

Cabinet Office (2011). Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government. Graham Allen MP. London: Stationary Office.

Carr, A. (2005) Contributions to the Study of Violence and Trauma: Multisystemic Therapy, Exposure Therapy, Attachment Styles and Therapy Process Research. *Journal of Interpersonal Violence, 20.*

Cary, M., Butler, S., Baruch, N., Byford, S. (2013). Economic Evaluation of Multisystemic Therapy for Young People at Risk for Continuing Criminal Activity in the UK. PLoS ONE 8 (4)

CYPSP 2014. The Early Intervention Transformation Programme. Health and Social Care Board. Northern Ireland

Lemmens, L., Molema, C., Versnel, N., Baan, C., De Bruin, S. (2015) Integrated care programs for patients with psychological comorbidity: A systemic review and meta-analysis. Journal of Psychosomatic Research, 79

Littell, J.H., Tajima, E.A. (2000). A multilevel model of client participation in intensive family preservation services. Social Service Review, 74(3), 405-435.

Munro, E (2011). The Munro Review of Child Protection. London: Department of Education Cm 8062

Olsson, T. (2010). MST with Conduct Disordered Youth in Sweden: Costs and Benefits after 2 Years. Research on Social Work Practice, 20

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