The ATLANTIC Philanthropies

Early Intervention Transformation Programme

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

A rapid review of evidence – for Workstream 2 of EITP

Final report

September 2014

Contents

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

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

1. Introduction

Background

The Early Intervention Transformation Programme (EITP) represents the coming together of six Government departments and private philanthropy, as part of the Delivering Social Change (DSC) initiative, to jointly fund a programme of early intervention. The focus of the EITP is on achieving transformative change in how mainstream services are delivered to children and families, including both universal and targeted provision. This will ensure that improvements in outcomes for children and families are sustained far beyond the lifetime of the Programme.

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

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

NCB NI has been asked to provide the following technical support services across the EITP work stream teams:

- Undertaking evidence reviews to inform the development of project proposals;
- Developing effective performance management processes to monitor project impact; and
- Providing implementation support for project delivery and sustainability.

This document presents the findings of a rapid review of evidence to inform the development of a new Early Intervention Service (EIS) for Northern Ireland.

The proposed Early Intervention Service[1]

This proposed new service sits within work stream 2 of EITP and is led by the Public Health Agency. Its overall aim is to work with families with 'Tier 2' level needs based on the Hardiker model, i.e. vulnerable children and their families, who require additional support to:

- Promote social inclusion;
- Reduce levels of vulnerability within the family; and/or
- Minimise risk-taking behaviours.

[1] Information presented on the EIS in this review is taken from the draft EIS proposal

The EIS will deliver and coordinate personalised, evidence based early interventions for children, young people and their families with the aims of de-escalating issues of concern, achieving sustainable change, promoting capability and capacity within families to problem solve difficulties they are or may experience in the future and diverting them from statutory intervention services using the combined expertise of participating agencies.

The operational parameters of the proposed EIS are as follows:

- It will consist of approximately 20 multi-disciplinary teams across NI which will be developed between 2015 and 2018. Whilst it is envisaged that teams will have some staff with skills and experience relating to children and young people of particular age-groups, it is anticipated that the majority of staff will be able to provide interventions to support children, young people and their families across the age-range.

- The EIS teams will operate within defined geographic areas to provide a more integrated approach and better coordination of services. The service will represent integrated working with community; voluntary and statutory sectors through the development of a multi-agency network of organisations within each locality.

- The EIS teams will be aligned to Family Support Hubs (FSHs) and will work together with existing services to ensure the right services are engaged with the family resulting in the development of multi-agency working. The overarching model will be replicated across all FSHs to a greater or lesser extent to meet local needs allowing for the model to be modified and built upon.

- Each team will be led by a professional with a qualification in a health/education related discipline who will be supported by a number of family support workers. A key worker will be provided for each family with whom they will work on an individual basis in providing a range of time-limited interventions as well providing access to evidence based/evidence informed parenting programmes. The service will stay involved with a family until the family can be returned to the usual single agency.

- The service will respond to requests for support from FSH coordinators. Requests for support from the EIS may also be from a number of sources including community, voluntary and statutory organisations e.g. service users; health visitors; school nurses; school principals; EWO's; Early Years Providers; Gateway; GP's; PSNI.

- The progress and effectiveness of EIS will be monitored using the Outcomes Based Accountability approach to performance management.

What is a rapid review of evidence?

According to the Government Social Research Service[2] used by the Civil Service when undertaking research to inform policy development:

'A Rapid Evidence Assessment (REA) is a tool for getting on top of the available research evidence on a policy issue, as comprehensively as possible, within the constraints of a given timetable.'

A REA is an effective method for undertaking a quick overview of existing research on a topic and a synthesis of the evidence provided by these studies to answer a specific question or set of questions. An REA can take anywhere from 2 to 6 months to complete and provides a balanced assessment of what is already known about a policy or practice issue, by using systematic review methods to search and critically appraise existing research. This type of rapid assessment limits a number of aspects within the full systematic review process in order to shorten the timescale e.g. using less developed search strings and limiting sources searched to those available electronically.

In shortening the traditional systematic review process REAs risk introducing bias, however, when a policy decision is required within months and policy makers want to make decisions based on the best available evidence within that time, an REA is the best option.

Given the short time scale for establishing the Early Intervention Service, it was decided that this rapid assessment approach be used to inform the development of EIS and hence NCB has adhered to the principles underpinning a rapid review of evidence as set out in the GSR guidelines [see foot note 2 below].

The specific objectives of this rapid review

In undertaking this review, NCB NI was specifically asked to:

- Identify the evidence base for the following interventions which may from part of the proposed EIS delivery model using a key worker:

  — Family Group Conferencing;
  — Motivational Interviewing;
  — Video Interactive Guidance;
  — Solihull; and
  — Brief Intervention Therapy.

- Identify and recommend other appropriate evidence based family support interventions appropriate to the proposed EIS i.e. those that target Tier 2 families and are delivered using a key worker.

- Provide learning from similar approaches to early intervention elsewhere that use a key worker approach.

[2] http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance

The remaining chapters of this review present the methodology used followed by the findings in relation to each of the above tasks and the resulting implications for the proposed Early Intervention Service. The final chapter draws these implications together into a set of key messages and suggestions for informing the EIS development going forward.

2. Review methodology

This chapter presents the methodology used to generate, analyse and appraise the information contained in this review.

Literature and information search

NCB's library and information service conducted a comprehensive literature search using the following search terms (keywords):

- Early intervention;
- Practice;
- Key worker;
- Family support;
- Video Interactive Guidance;
- Solihull;
- Motivational Interviewing;
- Brief Intervention Therapy; and
- Family Group Conferences.

Since all databases searched have different indexing systems using their own keywords, the above keywords were 'translated' to fit with the databases searched. For example, instead of only using the keyword Family Support when searching the NCB Database, terms such as Families AND Intervention Programmes were used in addition to Family Support in order to capture all information.

The following databases and sources were searched:

- **NCB Database:** NCB's Information Centre's online database contains over 85,000 records of books, reports, journal articles and grey literature on policy, legislation, practice and research - from current thinking to background and historical work - on the social care, education, health and welfare of children and young people. The database is unique in its comprehensive and multi-disciplinary coverage. Subjects include children in care, child protection, early years, play, disability and special educational needs, family and parenting, law, education, health, poverty, crime and youth justice.

- **Social Care Online:** Social Care Online is produced by the Social Care Institute for Excellence (SCIE) and is the UK's largest database of information on all aspects of social care and social work.

- **General and specialist early intervention web searches:** Advanced web searches were conducted by NCB's Information Centre and the NCB NI team to capture any information left out by the above databases. These included searches of specialist early intervention websites such as www.investinginchildren.eu, www.blueprintprograms.com (see appendix A for more details of about the Graham Allen's rating system for interventions).

In total, c. 140 documents were consulted and, of these, 103 documents were deemed to be directly relevant to the focus of this review. Please note, that in the interest of making the content of this review easier to navigate, no references or citations are included within the tables or the main text of this document. However, the full list of references is included near the end of this document.

Consultation with early intervention specialists

In addition, the methodology also involved consultation with key NCB staff and their partner organisations involved in delivering similar early intervention services in the UK. The learning presented draws heavily on the approaches being used in the Lambeth borough of London and Greater Manchester which include elements similar to the proposed EIS model and illustrate what could be achieved working across Local Authority boundaries when faced with fiscal pressures and the need to deliver systemic transformational change in public services.

Analysis of information and presentation of findings

A content analysis approach was used to examine the information generated from the searching and consultation activities. From this, key themes were identified under which information relating to each early intervention approach and/or programmes is summarised.

For ease of interpretation, the summarised information on the various early intervention approaches and/or programmes is presented in tabular format throughout the review. Each chapter of the review concludes with a set of implications for the new EIS.

3. Evidence base for specified potential EIS interventions

Introduction

As stated in the introductory chapter, the first task of this review is to identify the evidence base for a number of potential family support interventions delivered through EIS using a key worker. These potential interventions are as follows:

- Family Group Conferencing;
- Motivational Interviewing;
- Video Interactive Guidance;
- Solihull; and
- Brief Intervention Therapy.

Before examining the findings relating to each of the above interventions, it is important understand the concept of key working and explore what the literature tell us about the approach in practice. The following paragraphs present a summary of the literature on the key worker approach including the role of the key worker; the experience and skills required of a key worker; and the support required to enable effective key worker practice.

What is a key worker approach?

A key worker is a single point of contact that a parent approaches for advice about any problems related to their child. The key worker has responsibility for collaborating with professionals from their own and other services. Where a key worker system is in place, the quality of life of families with children engaged in services is improved. Having a key worker to lead coordination means that other practitioners' and the family's time is freed up, potentially leading to a more efficient and effective system. Families with key workers have better relationships with services, better and quicker access to services and reduced levels of stress. The key worker approach has been most commonly implemented in services that engage with disabled children and their families.

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

The role of a key worker, the characteristics and skills necessary to fulfil this role and supporting factors are listed below:

The role of a key worker

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

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

The skills and experience required of a key worker

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

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

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

Supporting key worker practice

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

- Local key workers should have access to a central administrative resource. This would ensure that key workers can focus the majority of their time on working with children and young people whilst the administrative support is able to follow-up appointments, for example;
- The provision of a key worker to all children and young people aged between 0-25 years would ensure that the benefits can be reaped across the difficult period of transition from child to adult services; and

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

Evidence base for the potential interventions for EIS

The remainder of this chapter presents the review findings in relation to each of the potential specified interventions being explored for EIS, namely:

- Family Group Conferencing;
- Motivational Interviewing;
- Video Interactive Guidance;
- Solihull; and
- Brief Intervention.

As a useful starting point, it is worthwhile drawing attention to the type of 'intervention' each of the above five represents. Family Group Conferencing, Motivational Interviewing, Video Interactive Guidance and Solihull are all practice approaches that seek to actively engage and encourage families to identify the need for change and be actively involved in bringing about that change. Brief Intervention is, for the most part, a general concept that can be applied to any type of early intervention which, as implied in the title, operates over a short period of time.

These both differ to the more commonly known types of early intervention programmes such as Incredible Years, Strengthening families and Family Nurse Partnership which are more structured in design, follow a set curriculum over a fixed period of time and target specific areas of need. These intervention programmes and their supporting evidence base have been the underlying focus of many of the leading initiatives in the UK and USA such as the Early Intervention Foundation, the Investing in Children database within Dartington's Social Research Unit, the Blueprints programme in Colorado and the Washington State Institute for Public Policy's database. These initiatives/organisations have given a wide range of programmes (e.g. Incredible Years) the stamp of approval following a rigourous review of their evidence base and cost-effectiveness. The presence of these initiatives makes it relatively straightforward for researchers and policy makers to obtain all the necessary information required to appraise the interventions and make subsequent decisions regarding their commissioning. However, this is in stark contrast to the practice approaches to early intervention listed above, which to date have not been the subject of such scrutiny and which require extensive searching techniques to both identify and appraise their evidence base.

The table overleaf summarises key information on each of the five interventions under the following headings:

- A brief description of what the intervention is;
- When and where is it used (including local use in NI);
- Qualifications and skills required to deliver;
- Delivery structure (i.e. in group format or one-to-one);
- Training and related costs;

- Cost benefit evidence; and
- Evidence of impact (i.e. whether or not the intervention is subject to experimental design such as a Randomised Controlled Trial which involves the use of treatment[3] and control[4] group and which is deemed to be the gold standard for assessing programme effectiveness).

[3] A treatment group comprises all of those individuals who have received a particular programme.

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

Table 1: Potential specified interventions for EIS

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	**Motivational interviewing (MI)**	**Video Interactive Guidance (VIG)**	**Solihull approach**	**Brief Intervention**
1. What is it?	• Family Group Conferences (FGCs) are gatherings that integrate families into the decision making process to help ensure child safety. They are based on the underlying presumption that by involving families in the resolution of difficulties, the outcomes for children will be improved. It is a model of practice that recognizes the value of extended family support and promotes service providers and families working together.	• Motivational Interviewing (MI) is a client-centred method that aims to enhance a person or family's motivation to change a problematic behaviour by exploring and resolving their ambivalence about change without evoking resistance to change. • The overarching goals of MI are to: enhance internal motivation to change; reinforce this motivation; develop a plan to achieve change. • It is based on three key concepts: (i) Collaboration - implementing a partnership that honours the family's expertise and perspectives. The key worker provides an atmosphere that is conducive rather than coercive to change. (ii) Evocation - the resources and motivation for change are presumed to reside	• Interactions between an adult (usually a parent or carer) and a child are recorded using AV equipment. This is later viewed and discussed, typically between a health/ social care work professional and a parent/carer. • The aim of VIG is to give individuals an opportunity to reflect on their interactions, drawing attention to elements that are successful and supporting clients to make changes where desired.	• The Solihull Approach employs a theoretical model that integrates psychotherapeutic, child development and behavioural concepts. It was originally designed to be used as a brief intervention (5 sessions or less) for practitioners working with infants and young children and their families. It aims to give these practitioners the knowledge and skills to help them work with parents to solve various behaviour problems in children. • The approach has been further developed and can now be used by a range of professionals working with children and young people up to the age of 18.	• Brief intervention is a generic term referring to a variety of encounters with a client/patient that require relatively little time. It is a suite of interventions of varying content, target groups and providers. • Brief interventions can range from a single 5 minute session providing information and advice to 15-30 minutes of brief counselling to several sessions of counselling. • Common elements of effective brief intervention are captured in the acronym FRAMES: Feedback on behaviour and its consequences, Responsibility for change as responsibility of the individual, Advice for change, Menu of options for change, Empathy and Self-efficacy for change.

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
		within the family. Intrinsic motivation for change is enhanced by drawing on the family's own perceptions, goals and values. (III) Autonomy - the key worker affirms the family's right and capacity for self-direction and facilitates informed choice.			
2. When and where is it used?	• FGC can be used in any serious situation where a plan and decision needs to be made about a vulnerable adult or child. • In the UK FGCs are mainly used in child welfare cases, particularly when a child is at risk of going into care, although some local areas are using the approach to prevent school exclusions, tackle anti-social behaviour, address youth offending and in planning for vulnerable adults. • In Northern Ireland, the approach is used by each of the five Health and Social Care Trusts, Barnardo's and Action for Children. • In England and Wales, c.75%	• MI is used to address a variety of issues and is provided directly to parents/ caregivers/families. • MI is used across the HSCTs in Northern Ireland by nurses, midwives, health visitors, social workers, outreach support workers, psychologists, occupational therapy condition management teams and self-harm practitioners. • Approximately 170 HSCT practitioners have received MI training through the Clinical Education Centre in the last 7 years. • Staff from BELB use MI techniques in order to involve parents more in school life.	• VIG is used to help parents develop better relationships with their child by improving communication. • It is used by at least 4000 practitioners in more than 15 countries, including Northern Ireland and England. • It is used by NSPCC in Northern Ireland.	• The Solihull Approach is mostly used in situations where parents require support in solving various behaviour problems in their children. • It is used mainly by health visitors in their engagement with parents during home visits. Can also be used by school nurses, midwives, and antenatal practitioners. • Thousands of practitioners have been trained across the UK. • To date, 120 practitioners have been trained in the Solihull Approach Foundation programme across the 5 HSCTs, and in the community and voluntary sector in Northern	• HSCT professionals, including staff within primary care and A&E are trained and encouraged to undertake brief alcohol intervention programmes in Northern Ireland. • Brief Interventions are available in Alcohol Clinics across the South-eastern HSCT. • Practitioners (n=24) from across the 5 HSCTs were trained in Steps to Cope, a brief intervention for children and young people living with parental substance misuse and/or parental mental health problems. More recently Steps to Cope has been introduced to the Down

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
	of local authorities have implemented or commissioned FGC for children in their area or are planning to do so. • FGC has been implemented in over 20 other countries worldwide.	• MI was incorporated into the PHA Active Belfast project. • It is also used by the community and voluntary sector in Northern Ireland, e.g. the Together For You mental well being project which is a partnership of 9 different organisations, Extern, Council for the Homeless in Northern Ireland and Breakthrough, Addiction NI. • MI is also used by the Probation Board for Northern Ireland in its work with offenders.		Ireland.	District Council area. • Given the generic nature of brief interventions they are used widely by health professionals on a worldwide basis and most commonly in the treatment of substance misuse, dietary habits, weight reduction, smoking cessation and risky behaviours. • The most commonly cited models of specific brief intervention in practice are Solution Focused Brief Therapy (SFBT) and Brief Encounters. • Brief Encounters is a model used where problems in family relationships exist - over 3,000 practitioners have been trained in the UK and c. 400 practitioners have been trained in Ireland. • SFBT is used as an intervention across all age groups and a whole range of problems, including adult mental health, behavioural problems in school, eating disorders, child abuse, family breakdown homelessness,

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
					drug use, relationship problems and psychiatric problems. SFBT is used globally and in NI.
3. Qualifications and skill set required to deliver	• Those who wish to become trained as a Family Group Conferencing co-ordinator must hold a social work qualification.	• Research suggests that it is possible to train professionals and lay people to offer the simplest components of MI during routine clinical practice. However, developers of MI recommend considerable training and support in order to develop the skills necessary for the technique. • Training for MI appears to be most effective when it begins early in professionals' careers, when it explores the philosophy underpinning the approach rather than being implemented as an isolated skill.	• VIG been used by a wide range of staff including educational and clinical psychologists, social workers, CAMHS workers, health visitors, residential care staff, teachers, speech and language therapists, and children's centre workers. • Training is required to deliver the approach.	• Those who typically receive training in Solihull include health visitors, midwives, school nurses, nursery nurses, doctors, psychologists, speech and language therapists, midwives, Sure Start teams, social workers and teachers.	• Brief Encounters ca be delivered by: Health practitioners, family support workers and all staff and volunteers working in the frontline with families. Adapted training has been produced for volunteers. • SFBT can be delivered by: all health and social care professionals, outreach workers, housing support staff, probation officers, and youth workers.
4. Delivery Structure (delivered 1-1, in home settings etc; time required to implement)	• Families receive guidance and supervision from an independent FGC coordinator. • The organisation of an FGC takes a considerable amount of time. For example, in order to set-up a FGC, co-	• MI sessions can be delivered as a one-off. However, evidence suggests that 2-3 sessions are more effective than a single session. • The recommended duration of a single session is 30-50 minutes. • MI mostly requires one to	• The process begins by helping the parent/carer to negotiate their own goals. • Adult-child interactions are then filmed and edited to produce a short film. • In the video review sessions that follow, the family and professional reflect	• It is largely based on one to one delivery between the professional and the parent. • Solihull can also be delivered to groups of parents and carers- usually to groups of 12 over 10 weekly sessions. • Parents can also receive training through an online	• SFBT: Can be delivered to groups or individuals. • Brief Encounters is usually delivered in a one to one situation between a practitioner and client.

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
	ordinators, alongside the young person and immediate carers, must identify potential participants from the family network. Co-ordinators must then meet with these family members individually in order to prepare them for the meeting. The time required for this process will depend on the number of family members identified. The actual FGC meeting is likely to take several hours and at the end of the meeting families will have developed a plan. A review FGC meeting is usually arranged to review how the plan is working and to make new plans if necessary.	one interaction between the practitioner and family members. • MI sessions are captured by the acronym OARS: Open-ended questions; Affirmations; Reflective Listening; and Summaries.	collaboratively on what they are doing that is contributing towards the achievement of their goals, celebrate success and then make further goals for change. • Feelings, thoughts, wishes and intentions are explored. • Typically four separate filming and reviewing sessions will take place over eight weeks. • Filming sessions normally last for 10-15 minutes. • A considerable period of time should be set aside to analyse the film and prepare for the review.	course.	
5. Training and costs	• Training is available through the University of Ulster (UU) in partnership with The Family Group Conference Forum (NI). • The programme combines	• HSC Clinical Education Centre run 2 MI training courses: MI and Stages of Health Behaviour Change (2 days £164) and MI within Midwifery care (1 day £82).	• Training is delivered by AVIG-UK and spans over 18 months consisting of 3 stages. • Stage 1: 2-day initial course (£375) and 7 X 1 hour	The HSC Clinical Education Centre (HSC CEC) and Public Health Agency offers 5 training courses to health and social care practitioners in the Solihull Approach:	• Ascert offers 2 training courses on using brief interventions for substance misuse practitioners. These are 2-day courses and are free of charge for Belfast and

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
	an introductory session and three taught days for skills development. The cost of training at UU is £500.	These courses are free if organisations have a Service Level Agreement with HSC CEC. • MI is a modular option in degree programmes offered by the School of Nursing and Midwifery at Queen's University Belfast and the School of Nursing in the University of Ulster. • Private training provided by Glenn Hinds Level 1 Skills Development (2 days £220 for statutory organisations, £200 for voluntary organisations).	supervisions; Stage 2: 1 hour introduction and 8 X 1 hour supervisions; Stage 3: 1 hour introduction and 8 X 1 hour supervisions. • Each trainee is allocated a personal supervisor for regular supervision sessions • Video capture equipment is required. This might include a tripod mounted video camera and software to allow for film editing.	• Solihull Approach Foundation Programme (2 days, £160). • Solihull Approach Programme for Health and Social Care, Voluntary and Community Staff (2 days followed by 2 weeks practice and 4 mandatory practice sessions. No direct cost if organization has service level agreement with CEC). • Solihull Approach workshop for managers (1 day £82). • Solihull Regional Trainers Forum (1 day £82). • Solihull Train the Trainer (1 day, no direct cost if organisation has service level agreement). • Each practitioner that attends the above training is provided with a Solihull Approach Manual specific to their service area. • CEC does not currently deliver training on the Solihull Approach Parenting Course, but this training may become	South Eastern HSCT staff. • Brief intervention for smoking cessation is offered by the Northern HSCT, North Eastern and South Eastern ELB youth service. These courses are free. • Brief Encounters: Ag Eisteacht in the Republic of Ireland offers the 3 Day Brief Encounters® Course at a cost of €300. It also offered by Oneplusone in UK (costs not available). • SFBT: HSC Clinical Education Centre run a one day course £160. Free if organisation has Service Level Agreement with HSC CEC.

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
				available in 2015-2016. • The online parenting course costs £39.	
6. Cost benefit	• The Barnardo's Bristol family Intervention Project found that the cost of FGCs vary from £840-£2,200, with an average cost of £1,700. • Research suggests that FGC result in substantial savings since they are likely to reduce the use and costs of court proceedings. This is supported by a more recent survey by Family Rights Group (2010) which shows that for every £1 spent on delivering FGCs the savings to the state are £11.	• No information identified	• No information identified	• No information identified	• No information identified
7. Evidence of impact	**The most common sources of evidence for FCG are based on non-experimental evaluation designs which focus on the short-term impacts and largely conclude positive results. These results include its popularity amongst families and practitioners, its impact on improving working relationships between families**	**Results from several RCTs and 4 meta analyses have identified positive short and long term effects of MI on a number of outcome areas including substance misuse, diet and exercise, adherence to medication plans, mental illness, eating disorders and risky behaviours. It was also found to be effective in increasing client engagement in treatments for conduct**	**Results from several RCTs have identified positive short and long term impacts of VIG on a range of areas including maternal sensitivity to their children, attachment, internalising behaviours (i.e. behaviour that impacts negatively on self), externalising behaviour (i.e. directed at others such as aggression, delinquency, and hyperactivity). It is important**	**The majority of evidence found on Solihull focuses on its short term impact and is drawn from non-experimental evaluation designs. This evidence reports that the approach improved consistency of practice between health visitors; improved relations with other health professionals; increased job satisfaction; reduced the**	**Due to its wide application on varied range of outcome areas, there is extensive evidence reporting on the effectiveness of brief interventions. This evidence comes from evaluations using both experimental and non-experimental designs. The most compelling evidence relates to the positive impact of brief intervention on alcohol misuse and it is**

	Practice-based approaches				Broad concept/theory
	Family Group Conferencing (FGC)	Motivational interviewing (MI)	Video Interactive Guidance (VIG)	Solihull approach	Brief Intervention
	and practitioners, and its effectiveness in engaging the wider family in issues impacting on children. Some inconsistencies in the evidence were found in relation to its longer term impact on preventing future care proceedings and returning children in care to their family settings.	problem children.	to note that much of this evidence is based on VIG's use alongside home visiting programmes.	need for children with less complex behavioural issues to be referred to psychology and psychotherapy services; and reduced general parental anxiety and anxiety relating to problem child behaviour.	therefore recommended as a tool by the WHO for this purpose. There is a strong evidence base for SFBT (the specific and commonly used model of brief intervention referred to above) in that numerous high quality experimental evaluations report positive impacts on the outcome areas targeted e.g. behavioural problems in school, eating disorders, child abuse, family breakdown and relationship breakdown. Brief Encounters (the other specific model identified in this review) has a very limited evidence base and the one RCT study conducted on it dates back to 1999.

Summary and implications for the proposed EIS

The information presented on the interventions in the above table needs considered interpretation when being used to inform the development of such an important service as the EIS. The crucial first step in the process must focus on appraising the strength of the evidence base in terms of the intervention's impact on both families and practitioners.

In taking this first step, it becomes clear that the evidence base for Motivational Interviewing, Video Interactive Guidance and Brief Intervention is stronger than that for Family Group Conferencing and Solihull due to the better standard of evaluation methods used to evaluate their effectiveness i.e. experimental designs such as RCTs.

The next steps in the appraisal process focus on examining the 'fit' of the various interventions to the proposed EIS delivery model. The most sensible means of beginning this assessment lies in the coverage of the various interventions. The proposed EIS model seeks to work with families that have children across the 0-18 range and also seeks to provide support to meet a broad range of low risk needs within families. With this knowledge in mind:

- Motivational Interviewing stands out as the approach most suited to the EIS delivery model as it can be used to address a wide variety of issues among families including several lower risk areas such as diet, exercise, risky behaviours and problem behaviour among children. The approach's breadth of coverage, combined with its strong evidence of impact across these areas and the availability of local, low cost training suited to a variety of professionals makes a compelling argument for its inclusion it the EIS suite of interventions.

- Solihull and Video Interactive Guidance are not as suited to the EIS model as they tend to focus on addressing fewer areas of need such as child behaviour problems and parent/child relationships. Furthermore, Solihull is more grounded in practice with young children.

- Brief intervention in general is also not particularly suited to the EIS model as it is most commonly used in the area of alcohol abuse and the majority of its evidence base relates to its use for this purpose. The exception to this is the specific Solution Focused Brief Therapy model (SFBT) identified which targets many areas of need, including some low level issues, and can be used across all age groups. The evidence base for the model is strong and training in its delivery is both low cost and available locally. Should there be sufficient need across Tier Two families in Northern Ireland for this therapeutic type support, this model warrants consideration for inclusion in the EIS delivery model.

- Family Group Conferencing is the least suited intervention to the EIS delivery model as not only is its evidence based on less robust evaluation designs than that of other approaches but it is also predominantly a single purpose intervention for the prevention and resettlement of children who are either in or at risk of entering care.

Notwithstanding the implications above, each of the above approaches have their place in providing support to either specific age groups or to meeting specific needs. The assessment of their fit to the new Early Intervention Service is based on the current proposed delivery model which spans all age groups and all variety of low level need – the suitability of this model however is explored in later chapters of this review and is a particular focus of the conclusions.

4. Evidence base for other potential EIS interventions

Introduction

In Chapter 3, the evidence base for a range of practice-based family support interventions was explored. These interventions were specified for inclusion in this review by the PHA and have been appraised for their suitability to the current proposed EIS delivery model.

The purpose of this chapter is to present information on other interventions identified in the searches undertaken in this review that are suited to the proposed EIS delivery model.

Identification of other potential evidence-based practice *approach(es)*

In terms of practice based approaches most of the literature searches uncovered information relating to the four interventions identified in Chapter 3 above. Beyond this, only one further approach was identified in this review that had a strong evidence base to suggest that it is effective, namely the Family Partnership Model (FPM). Further details of this approach are contained in Table 2 below.

Table 2: Family Partnership Model description

Family Partnership Model (FPM)	
1. What is it?	• The Family Partnership Model (FPM) is an evidence-based (manualised) approach to promote effective partnership working and service user-centred practice in health services. • The theory underlying FPM emphasises the need for highly skilled communication and a respectful partnership between practitioners and parents. • This partnership is considered a powerful support tool in its own right, which enables parents to extend their problem-solving abilities, self-esteem, self-efficacy and interactions with their children, thereby fostering parental development and well-being. • Much research on the implementation of FPM focuses on its use with parents of newborns.
2. When and where is it used?	• FPM is used in the UK for a range of preventative and early intervention services and initiatives, as well as in Australia, several European countries and New Zealand • Not currently delivered in NI
3. Qualifications and skill set required to deliver	• FPM is aimed at a wide range of practitioners who work with families: — *Skills set:* effective interpersonal skills based on counselling skills such as communication and listening, enabling change in feelings, ideas and actions and problem management. — Essential qualities of the helper (as the practitioner is called in this model): respect, genuineness, empathy, humility, quiet enthusiasm, personal strength and integrity and intellectual and emotional attunement.
4. Delivery Structure	• Given the importance of the practitioner-parent relationship, those incorporating the Family Partnership Model into their practice need to allow for sufficient time

Family Partnership Model (FPM)	
(delivered 1-1, in home settings etc)	for the relationship to develop. • Delivered 1:1 in a range of multi-agency settings. • Any individual or organisation can receive training in FPM.
5. Training and costs	• A range of training course options are available from a Foundation level course (accredited at OCN 2 and 3) to supervision training, Family Partnership Facilitator Course and Family Partnership Trainers Course. • Costs: £1250 for Foundation level course. • Also costs associated with manuals, e.g. Facilitator Training Manuals £90 approx – 2 manuals required. • Currently delivered at Centre for Parent and Child Support, Maudsley Hospital, Michael Rutter Centre in London. • Training is not currently available in Northern Ireland.
6. Cost benefit	• The mean incremental cost per infant of a home visiting intervention using the Family Partnership Model approach is £3,246.
7. Evidence of impact	**The majority of evidence found on the Family Partnership Model focuses on its short term impact. Results from RCTs have identified positive impacts including benefits to the developmental progress of children, more positive parent-child interactions, improved maternal sensitivity, improved infant cooperativeness, and improvements in the psychological functioning of parents, families and children.** **Evidence from non-experimental research studies found that parents viewed the approach as highly valuable and identified a number of benefits including increased confidence, improved mental health, better parenting and changes in their attitudes towards professionals. Practitioners reported that the approach was highly valuable for their practice.**

Identification of other potential evidence-based early intervention *programmes*

The first stage in identifying suitable early intervention programmes involved consulting both the Graham Allen report entitled 'Early Intervention, the Next Steps' and the Investing in Children websites. The initial search was restricted intervention programmes that have a family focus in line with the EIS model. In total, 29 programmes were identified through these sources. The full list of early intervention programmes is contained in Appendix B.

From this initial list of 29, further short-listing was undertaken based on whether or not each of the specified programmes could be delivered on a one-to-one[5] basis as per the current EIS model.

[5] One-to-one is defined as delivery to either one individual in a family or one family unit.

Applying this criterion reduced the list significantly and only five programmes remained viable for further screening, namely:

- Bright Bodies;
- Family Nurse Partnership;
- Functional Family Therapy;
- Multisystemic therapy; and
- Parent Child Interaction Therapy.

It is worthwhile noting that many programmes exist that have been proven to prevent or address low risk issues in families, such as Incredible Years and Strengthening Families. However, these programmes are delivered in community or school settings utilising a group based format and are therefore not deemed to have an appropriate fit with the Early Intervention model being used by EIS.

The next stage of the process was to shortlist the programmes above according to the following criteria based on the current EIS model of covering a wide range of low risk issues across the 0-18 age range, and delivered within a short timescale:

- Programme focus (i.e. those focused on a broader range of areas were shortlisted over those programmes that focused on single issues such as behaviour);
- Programmes targeted at tier two families (i.e. those programme that focus on families addressing lower risk issues/needs were shortlisted over those programmes that deal with complex needs where families are already likely to be involved with one or more statutory agencies); and
- The duration of the programme – only those that can be delivered over the period of a few months or less were shortlisted.

Applying the above criteria, the following two programmes were shortlisted:

- Functional Family Therapy; and
- Parent Child Interaction Therapy.

Table 3 below provides detailed information on each of the above shortlisted programmes.

Table 3: Potential evidence-based programmes for consideration by EIS

Description	Programmes	
	Functional Family Therapy (FFT)	**Parent Child Interaction Therapy (PCIT)**
1. What is it?	• Functional Family Therapy (FFT) is a short-term, family-based therapeutic programme for young people (12-18 years) involved in offending behaviour and at risk of institutionalisation. It is designed to improve family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behaviour. Parenting skills, youth compliance, and the complete range of behaviour domains are targeted for change.	• Parent-Child Interaction Therapy (PCIT) is an empirically-supported treatment for young children (aged 2-8) with emotional and behavioural disorders that places emphasis on improving the quality of the parent/carer-child relationship and changing parent/carer-child interaction patterns. • During PCIT, therapists coach parents while they interact with their children, teaching caregivers strategies that will promote positive behaviours in children who have disruptive or externalising behaviour problems.
2. When and where is it used?	• FFT is used with families who have a young person (12-18 years) engaging in persistent antisocial behaviour, substance misuse and/ or youth offending. • FFT has been implemented in 45 US states, Norway, the Netherlands, Belgium, Denmark, New Zealand, Ireland, UK, Singapore and Sweden. • FFT is used in NI e.g. in the Northern HSCT area – and is delivered by Action for Children.	• PCIT is used in families were a child (aged 2-8) is experiencing emotional and behavioural disorders. • PCIT is mainly implemented in the US where almost all of the RCTs have been conducted. Outside of the United States, it has been implemented in Australia, Germany, Japan, Hong Kong, Norway, The Netherlands, South Korea, Taiwan and New Zealand. • Not currently delivered in NI.
3. Qualifications and skill set required to deliver	• FFT should be implemented with a team of master's level therapists, with oversight by a licensed clinical therapist. • Practitioners need to have a wide range of knowledge and skills, including, for example: — Knowledge of systemic principles that inform the therapeutic approach; — Knowledge of problem behaviours in relation to FFT; — Knowledge of the FFT approaches that enable therapeutic change (i.e. the three phases outlined below); and — Ability to initiate contact and undertake an FFT assessment. • Ability to promote engagement and motivation.	• Practitioners are expected to have a firm understanding of behavioural principles and adequate prior training in cognitive-behaviour therapy, child behaviour therapy, and therapy process skills (e.g., facilitative listening) are required. • For training in this treatment protocol outside an established graduate clinical training programme, the equivalent of a master's degree and licensure as a mental health provider is required.

Description	Programmes	
	Functional Family Therapy (FFT)	Parent Child Interaction Therapy (PCIT)
4. Delivery Structure (delivered 1-1, in home settings etc)	• FFT is designed to be delivered over approximately 30 hours across 3-4 months and practitioners work with families on a one-to-one basis. • FFT is a phasic programme with steps which build upon each other. These phases consist of: — Engagement; — Motivation; — Assessment; — Behaviour Change; and — Generalisation. • The programme can be delivered in a range of settings, including: • Juvenile Justice; Mental Health Centres; and Social Services.	• It can be delivered to individual parents and children or can be delivered in a group format. When done so, small groups of 3 or 4 families in 90-minute sessions are recommended. • PCIT is time-unlimited; families remain in treatment until parents have demonstrated that their skill set has developed sufficiently and rate their child's behaviour as within normal limits on a standardised measure of child-behaviour. Therefore treatment length varies, but averages about 14 weeks, with hour-long weekly sessions. • Therapists can see 15-25 PCIT cases per week. • The programme is generally administered in an outpatient clinic or home setting.
5. Training and costs	• Phase one training (i.e. full set-up) takes approximately one year. • Training is team based with an optimal team size of 5-6 therapists. • The cost of phase one training and technical assistance is £22,000, plus an estimated £10,000 for travel a total of £32,000. • Some of these costs will be incurred after the programme staff are trained and seeing clients.	• Initial training for therapists runs from (£1,875-£2,500) per participant, depending upon the size of the group. • It is recommended that at least two therapists from an agency be trained together. It is also suggested that a supervisor or administrator be trained. • The model often requires modification of space, with the addition of a one-way mirror to adjacent rooms, sound equipment and toys at an estimated cost of £600-£950.
6. Cost benefit	For every £1 invested in the programme, the monetary benefit is estimated to be £12.32. The risk of loss from investing in the programme is 0%.	• For every £1 invested in the programme, the monetary benefit is estimated to be £2.37. The risk of loss from investing in the programme is 0%.

Description	Programmes	
	Functional Family Therapy (FFT)	Parent Child Interaction Therapy (PCIT)
7. Evidence of impact	**Results from RCTs have identified positive short and long term impacts of FFT on a number of areas including reductions in recidivism (the act of repeating an undesirable behaviour), reducing the likelihood of entry into the care system and treating adolescents with alcohol and other drug misuse disorders who are delinquent and/or violent.** **Functional Family Therapy is one of the Blueprints model programmes and was identified as a Level 1[6] Programme in the Graham Allen report.**	**Results from RCTs have identified positive short and long term impacts on a number of areas including better parenting skills, improved child behaviour, reduced parental stress and reduced abuse and neglect.** **Parent Child Interaction Therapy has been identified as a Level 2 (i.e. promising) programme in the Graham Allen report[7].**

[6] Blueprints is also commonly used to determine the evidence base for programmes. Programmes are rated as either Promising or Model. Promising programs meet the minimum standard of evidence (i.e. requires a minimum of (a) one high quality randomised control trials or (b) two high quality quasi-experimental evaluations that demonstrate effectiveness). Model programmes meet a higher standard of evidence and provide greater confidence in the program's capacity to change behaviour and achieve positive outcomes. A level 1 programme rating indicates that the programme has scored the highest in terms of evaluation quality and/or impact criteria and is considered to have the highest levels of robustness. For more details on programme ratings, see Appendix A.

[7] Promising programs meet the minimum standard of evidence (i.e. requires a minimum of (a) one high quality randomised control trials or (b) two high quality quasi-experimental evaluations that demonstrate effectiveness).

Summary and implications for the proposed EIS

Looking first of all at the information in Table 2 on the practice-based Family Partnership Model, whilst it has a strong evidence base and is indeed a viable intervention in its own right, it does not represent as close a fit to the current proposed EIS model as Motivational Interviewing. In terms of suitability to the current EIS model, the main distinctions between the two approaches are that Motivational Interviewing spans a broader range of issues and age ranges whereas the Family Partnership Model is specific to improving parent child interactions, self esteem and problem solving skills and focuses primarily on young children.

Moving onto the identified intervention programmes presented in Table 3 above, based on the strength of their evidence base, their relatively short-term delivery times and favourable cost benefit ratio both Functional Family Therapy and Parent Child Interaction Therapy are viable options for the current EIS model.

However, both programmes are delivered by highly qualified specialist staff and both programmes also require significant up-front investment in training. The viability of these programmes within the current EIS model must therefore hinge upon basic supply and demand considerations:

1. FFT – are there enough Tier 2 families across NI that have young people aged 12-18 who are presenting with persistent anti-social behaviour, substance misuse and/or youth offending?

2. PCIT – are there enough Tier 2 families across NI that have young children aged 2-8 who are presenting with emotional and behavioural disorders?

If the answer to both (or either) of the questions above is yes, and is based on robust evidence (e.g. accurate assessments of need) then indeed both (or either) programmes warrant serious consideration for delivery via EIS teams.

However, as referred to previously in this chapter, many very effective short-term intervention programmes exist for preventing or reducing issues in Tier Two type families and indeed many of these are delivered across Northern Ireland such as Incredible Years and Strengthening Families. However, because they are delivered in community or school settings and in group formats they are not suitable for the 1:1 delivery model in the proposed EIS.

5. Implementation learning from elsewhere

This chapter presents some valuable learning from the implementation of early intervention approaches elsewhere in the UK. It particularly draws upon approaches being used in the Lambeth borough of London which has similarities to the proposed EIS model and the Greater Manchester area which illustrates what can be achieved when working across local authority boundaries, when faced with fiscal pressures and the need to deliver systemic transformational change in public services.

Early Intervention in Lambeth - a case study of specific approaches to early intervention

Introduction

Lambeth is a London borough with a population of just over 300,000 and almost one-quarter of the population (22%) are children and young people. Almost one-third (31.6%) of young people who are under the age of 16 live in poverty compared to an average of 20.6% for England, whilst teenage pregnancy also compares unfavourably to the English national average - 33.2 per 1,000 females aged 15-17 in Lambeth vs. 27.7 for England.[8]

There are a number of Early Intervention approaches being implemented in Lambeth, including:

- Aspirational Lambeth Families Team (ALF - Lambeth's Troubled Families programme) - led by Lambeth Council.
- Two locality based Early Intervention Multi-Agency Teams (MATs) led by Lambeth Council.

Each of the above approaches are additional to existing services in the borough and do not replace any.

This short case study draws together some key information on the development and implementation of these initiatives and is based on a review of both internal documentation and publically available information on the initiatives, as well as interviews with key staff members.

[8] http://www.apho.org.uk/resource/item.aspx?RID=142318

Background information on approaches

Aspirational Lambeth Families (ALF) Team: In December 2011, central government instigated a new initiative designed to address the complex issues facing families who have been identified as 'troubled'. The 'Troubled Families' initiative is designed to 'turn around' families where members either experience poor school attendance; are involved in crime or anti-social behaviour or where families are workless. In Lambeth, a troubled family is defined as those that:

- are involved in crime and anti-social behaviour (ASB) -national criteria;
- have children not in school or with significant school absence – national criteria;
- have an adult on out of work benefits- national criteria; and
- cause high cost to the public purse (local filter).[9]

The ALF team comprises a number of intensive family support workers. As part of ALF, Multi-systemic Therapy is commissioned from an external provider. SHP (a preventing homelessness and social inclusion charity) is also commissioned to work with a certain amount of cases.

MATs: The MATs were established to provide support to Tier 2 families across the borough. In reality the teams became involved in supporting Tier 3 issues with these families in conjunction with other specialist teams as very often having initially engaged with families, more complex needs were identified that required specialist input. As a result the Social Care team within Lambeth Council are doing a review of 'children in need' to define more clearly what constitutes a Tier 2 and Tier 3 family so a more integrated process is developed across the Council's social care 'children in need' team, the Early Intervention MATs and the ALF teams.

The MATs teams comprise early intervention social workers, early intervention youth advisors and early intervention family support workers. The teams have been operating for 8 years across the Borough. The idea behind the MATs is that they adopt a whole family approach and work with the family on a wide range of issues. For example, recently a team worked with a family who had been experiencing difficulties on a number of issues including: one child who had experienced bullying; another child had a weight management problem; and another child had difficulties in engaging in further education.

Referrals and identifying need

MATs: Needs are identified through extensive analysis of local data and of resources and support needed to meet these needs. Referrals are via the Common Assessment Framework (CAF) and the CAF process enables a single professional to decide whether additional support is needed from the MATs. Depending on the level of need identified, families are directed to either an early intervention family support worker (low level need) or an early intervention social worker (high level need). Regardless of the level of support required, clients must give their consent to avail of it.

ALF: This is a large data driven government initiative where a central identification process took place using available data relating to the 3 national criteria (e.g. school attendance). As part of this

[9] https://moderngov.lambeth.gov.uk/documents/s58391/03%20-%20Troubled%20Familes%20Report.pdf

process, central government allocated the various Local Authorities a particular number of families based on this process. Lambeth then began their own data warehousing project, amalgamating the national data with data on a few additional local criteria e.g. domestic violence and mental health prevalence. ALF is also consent based support.

We know from the background information presented at the beginning of this case study that the potential for duplication in service provision to both the MATs and ALF families existed as often lines were blurred in identifying families as either low risk and suitable for MATs or higher risk/more complex and suitable for ALF. This duplication of effort was unavoidable given that both services were working independently of each other and providing separate support to families and hence efforts are now underway to integrate the services given the difficulty in placing families in either a Tier 2 or Tier 3 category via an initial assessment.

Engaging with families

MATS: An initial phone call is made from the MATs member to set up an initial family home visit where they will jointly develop a family action plan and then provide continued support to deliver on this.

ALF: The key worker makes contact with identified families through an initial scripted phone call. This is then followed by a face-to-face visit and an interview. A support plan is subsequently agreed and delivered; the intensive family support worker is the lead worker except in cases where the family already has a social worker in place in which case the social worker remains the key contact.

Caseloads

MATs: Each worker works with up to 20 clients.

ALF: Those working with families with most complex issues that require visits 2 to 3 times per week have a caseload of between 6 and 10 clients. Those working with the lesser complex families have a caseload of up to 20 clients.

Table 4: Experience, skills and qualifications required for team members

Early intervention initiative/ job role	Details of role/ responsibilities/ skills and experience required
MATs – *Early Intervention Support Worker*	
Role • To provide a comprehensive area based family support service to children with additional need in liaison with the school. To undertake assessments using the Common Assessment Framework (CAF). • To work in partnership with a range of professionals, both community and school based, to provide support to children and young people to ensure their social, educational and health needs are well met.	

Early intervention initiative/ job role	Details of role/ responsibilities/ skills and experience required
	Responsibilities In addition to undertaking home visits, the role include a wide-ranging set of responsibilities including, for example: • To undertake assessments of children with additional needs and planning, delivering and reviewing activity; • To support parent/carer to accompany children to appointments if required; • To develop, implement and review case work plans in accordance with legislation, best practice and Council policies and procedures; and • To liaise and work with, SENCOs (Special Educational Needs Coordinators), inclusion managers in schools and other professionals across the partnership, in relation to individual children and young people. **Skills/experience required** A wide range of knowledge, experience and competencies are required including, for example: • Knowledge of government legislation and standards relevant to children with additional needs; • Evidence of further qualifications or equivalent (ideally to degree level) in Psychology; Social Work; Child Development; Nursing; or a subject relevant to children's workforce; • Previous experience of working with children and families within a statutory or voluntary setting, particularly schools and experience of working within a multi-disciplinary team; and • Planning and co-ordinating to establish clear targets; define plans and co-ordinate resources in order to meet them.
ALF - Intensive Family Support Worker	
	Role • To provide intensive casework support to families with multiple problems and to provide and co-ordinate intensive and structured support and intervention to families to help them change their behaviour; and • To deliver evidence based parenting programmes to support families with multiple problems. **Responsibilities** A wide range of responsibilities are required including, for example: • To hold a caseload of 6-10 families with multiple needs as directed by line manager; • To carry out assessments on families; • To plan, deliver and review support packages designed to assist families, to act as the lead professional as required; • To provide advice and support to appropriate agencies in dealing with anti-social behaviour and cases of neighbour nuisance; and • To work proactively with Children's Centres and early years settings to identify and support the most vulnerable families who would benefit from intensive packages of support.

Early intervention initiative/ job role	Details of role/ responsibilities/ skills and experience required
Skills/experience required A wide range of knowledge, experience and competencies are required including, for example: • Specific experience of working with the target groups (e.g. families, children or adults with additional needs, young people at risk of offending); • A relevant professional qualification or equivalent experience. Recognised disciplines include: social work, teaching, youth work, health work, police and probation work; • Experience in using the CAF and the Lead Professional role; • Training and experience in delivering evidence based parenting programmes; and • Wide range of key competencies in a range of areas including: team working; developing productive relationships; effective written and oral communication skills, analysing and evaluating data, and planning and co-ordinating.	

Approaches to family support practice

Motivational interviewing (MI) is currently used for both MATs and ALF. Evaluations of its use within MATs have been very positive, and MI has been identified as being particularly successful in enabling the family support workers to empower families to develop with their own solutions to issues.

In terms of professional development and based on identified need, managers across teams for both programmes are also being trained in reflective supervision to embed a better challenge and questioning approach when in multi-agency meetings.

Across all early intervention work a key factor of practice is making sure workers have access to and are properly trained in using risk assessment (e.g. for domestic violence) and parenting assessment tools. A new performance management framework is now being developed across all early intervention work to gather data on impact, and various tools and standardised measures will be used for this as well as a new tool which is being developed for family satisfaction feedback.

Early Intervention in Greater Manchester - a case study of specific approaches to early intervention

Introduction

Greater Manchester (GM) has a population of 2.7million and comprises of ten local authorities and the cities of Manchester and Salford. Over one-fifth (21.4%) of school age children are on free schools which is higher than the average for England at 16.8% and amongst their child population, more than 150,000 live in poverty. In addition, over 40% of children in GM are assessed in reception class each year as not being ready for school.

There has been significant investment in recent years across GM in Early Years provision which has resulted in a patchwork of different approaches across the 10 local authority areas. There are some commonalities – but largely driven by national policy, rather than as a result of any Association of Greater Manchester Authorities (AGMA) activity. According to the Early years business case for GM

"Despite the abundance of dedicated people striving towards achieving better outcomes within their own organisations, there was little evidence to show outcomes for children and their families. 40% of children in Greater Manchester were still being assessed in reception class each year as not being ready for school."

Hence an new Early Years delivery plan for GM was developed in 2013/1014 with two strategic priorities- economic growth, and ensuring that all residents can benefit from that growth. This required a Public Sector Reform (PSR) programme, intervening early and connecting people and neighbourhoods to the growth, supporting independence and self reliance.

The overall objective of the GM Early Years delivery model is;

"To increase the number of children who are ready for school"

The long term objective is to equip more GM residents with the skills they need to access the labour market, to increase productivity and economic growth, recognising that work is the most sustainable route out of poverty.

This programme of PSR outlined the need for a transformational reduction on demand, away from unplanned, expensive reactive spend moving towards the most challenging places and people, with early intervention a central theme.

This transformational change was needed to save money and improve outcomes hence the PSR approach focused on reducing mainstream budgets with a commitment to robust evaluation. The PSR principles applied in Greater Manchester included;

- The selection of interventions chosen on strength of evidence base;
- Effective integration, coordination and sequence packages of interventions; and
- Taking a family/household approach.

Developing the new Greater Manchester model

A significant amount of time and effort was invested to co-design and develop the GM new service delivery model for early years. The current "business as usual" approach to early intervention was examined to determine what exactly needed to change; data was examined to uncover real need for targeted interventions and parents were engaged to ensure their direct experiences informed the new delivery model.

In addition, a thorough assessment of the actual needs of tier two families was undertaken and a comprehensive review of evidence was conducted by an expert reference group taking due cognisance of contemporary policy developments such as the Graham Allen review as well as research on "what works".

As a result the new delivery model for early years in GM consists of:

- A shared outcomes framework across all local partners;
- A common assessment pathway across GM;
- Evidence based assessment tools (primarily ages and stages)to identify families reaching clinically diagnosable thresholds for intervention or having multiple risk factors as early as possible;
- Needs assessment triggers referral into an appropriate evidence based targeted intervention;
- A focussed suite of evidence based interventions has been introduced;
- Existing day care is used more effectively with a consistent drive for improvement and new contract with parents;
- A new workforce approach driving a shift in culture enabling frontline practitioners to work in a more integrated way in support of the real family;
- Better data systems to ensure the lead professional has access to the relevant data to see the whole picture, reducing duplication and confusion and to track children's progress; and
- Long term evaluation to ensure families' needs are being addressed and add to national evidence for effective early intervention.

Implementing the new model

The new GM early years model assumes that 100% of new births (40,000) will receive improved universal services and thereafter 50% (20,000) will require no further support. A further 25% (10,000) of children will have some difficulties identified via assessment and these needs will be addressed through improved /progressive universal services. This includes the following:

- Baby express newsletter;
- Healthy child programme;
- Every child a talker;
- Newborn behaviour observation; and
- Use of the Solihull approach.

The remaining 25% of children will require targeted interventions, including the following:

- Family Nurse Partnership (approx 2000 children);
- Video Interactive Guidance;
- Incredible Years;
- It takes two to talk (the Hanen programme); and
- Targeted 2's daycare.

In addition the new model allows for the decommissioning of reactive services that are no longer required as potential demand reduces.

The Greater Manchester Early Years service is now one of the pilot intervention sites working with the Early Intervention Foundation to share learning and continually embed evidence and evaluate impact using and outcome based approach.

Summary and implications for the proposed EIS

Both of the case studies above provide much valuable learning that can inform thinking around the further development of the EIS. The following points draw attention to some of the most important considerations that should be borne in mind as planning for the implementation of the new EIS continues.

- Establishing multi-agency teams that have combined experience across a range of areas e.g. social work, early years development and learning, youth work and family support so that teams are equipped as much as possible to work across the whole family unit in a life cycle approach.

- The need for ongoing professional development of the early intervention workforce to ensure that they are (a) adequately skilled to implement the selected evidence based approaches /programmes within the EIS delivery model and (b) are also adequately skilled in the use of the most effective tools for assessing family needs and progress.

- Having clear and specific criteria for what constitutes Tier Two and Tier Three needs within families to minimise the number of Tier Three families that may be referred to EIS only to be referred elsewhere as their needs cannot be met within the service.
- The use of pilot sites to test models of working and inform EIS scaling up decisions based on evidence of what is and is not working.

- The need to decommission services that should no longer be required as an effective Tier Two service, like EIS, is rolled out and prevents the escalation of issues that require Tier 3 or 4 services. In the first instance there will be a time lag as the EIS becomes established and scaled up across Northern Ireland, the decommissioning of services will therefore require a phased approach.

6. Conclusions and suggestions for the way forward in developing a EIS for NI

Undertaking this rapid review of evidence within the available timescale was not without its challenges. Specifically, drawing together the evidence base for the five specified interventions (Motivational Interviewing Family Group Conferencing etc) required extensive searching techniques to gather sufficient information to facilitate a meaningful appraisal of their suitability to the current proposed EIS delivery model.

Chapter two concludes by suggesting that of the 5 specified intervention approaches under review, Motivational Interviewing is most suited to the current proposed EIS delivery model as it spans multiple outcome areas and can be delivered on a 1:1 basis within the family unit. Should the proposed model for EIS delivery remain as it currently stands, Motivational Interviewing should definitely be considered as a core approach to the provision of family support.

Furthermore, it is worthwhile noting that the most contemporary piece of in-depth research into Families facing Multiple Adversities in Northern Ireland[10] (completed by NCB NI, Barnardos, NSPCC and QUB) suggests both key working and motivational interviewing as two ways in which the delivery of services to families could be improved. The use of motivational interviewing is being suggested to encourage and empower parents to seek help at an earlier stage of experiencing an issue, before it gets to crisis stage. In the research many participants did not often see the adversity they were faced with as a problem, until it resulted in a crisis, when they were then compelled to seek help.

Chapter 3 is less conclusive in terms of suggesting specific evidence based intervention programmes for inclusion in the EIS delivery model and this is due to a number of factors.

- Firstly, the majority of proven effective early intervention and prevention programmes for Tier Two type families are delivered in community or school settings and in group format. This is in contrast to the proposed EIL model of delivery using a 1:1 delivery format. It is therefore very encouraging to note that operationally the EIS will act as an access point for families to these various proven programmes that are being delivered across NI.

- Secondly, the few proven programmes that do meet the 1:1 criteria (FFT and PCIT) are focussed on meeting specific areas of need among specific age groups. There is not enough information in the current EIS proposal to suggest that there will be enough demand for these services across NI to warrant the required level of investment required to deliver them.

It is therefore recommended that before going any further with the EIS development, a more robust picture of the needs of Tier Two families across NI is understood. Given the fundamental role that Family Support Hubs currently play in referrals for Tier Two families across NI, they are therefore the

[10] This research is due for publication in early October 2014

most obvious place to source this information. We recommend that the EIS development team works with Hub coordinators to generate aggregated data for NI geographies on the following:

1. The presenting issues of Tier Two families based on the results of the various needs assessments undertaken of these families UNOCINI A1, FS1 forms etc.
2. The extent to which suitable services were found to meet these identified needs i.e. therefore identifying the level of unmet need in geographies

Having this information is crucial to building up a clearer and more robust picture of what the level of unmet need is across Tier Two families in NI and will ensure that the EIS will contribute successfully to meeting the needs of families across NI, minimising duplicating with current provision and contributing to the EITP overall goal of achieving systemic transformational change in the delivery of early intervention services. Indeed, once this information is known, some of the intervention approaches and programmes referred to throughout this document may need to be revisited for potential inclusion in the EIS suite of interventions.

Chapter 4 of this review concluded with some key learning points for implementation of EIS based on approaches to early intervention being delivered elsewhere in the UK. This key learning summarised again below provides further information to help refine the EIS model and acts as a useful starting point to inform the development of implementation plans going forward.

- Establishing multi-agency teams that have combined experience across a range of areas e.g. social work, early years development and learning, youth work and family support so that teams are equipped as much as possible to work across the whole family unit in a life cycle approach.

- The need for ongoing professional development of the early intervention workforce to ensure that they are (a) adequately skilled to implement the selected evidence based approaches /programmes within the EIS delivery model and (b) are also adequately skilled in the use of the most effective tools for assessing family needs and progress

- Having clear and specific criteria for what constitutes Tier Two and Tier Three needs within families to minimise the number of Tier Three families that may be referred to EIS only to be referred elsewhere as their needs cannot be met within the service

- The use of pilot sites to test models of working and inform EIS scaling up decisions based on evidence of what is and is not working

- The need to decommission services that should no longer be required as an effective Tier Two service, like EIS, is rolled out and prevents the escalation of issues that require Tier 3 or 4 services. In the first instance there will be a time lag as the EIS becomes established and scaled up across Northern Ireland, the decommissioning of services will therefore require a phased approach.

Next steps in the provision of technical support:

- Upon considering the evidence in this review and the resultant suggestions for further developing EIS, we anticipate that the EIS development team may wish to meet to discuss implications and to identify any areas within the review that require further clarification before the next version of the EIS proposal and delivery model is completed.

- Once completed and the EIS model is agreed, the next stage of technical support lies in taking a closer look at some of the potential tools the EIS teams may use to undertake a thorough assessment of family need before either providing a service directly to families or signposting them onwards to a more relevant service.

7. References consulted

Abrahamse, M., Junger, M., Chavannes, E., Coelman, F., Frits, B. & Lindauer, R. (2012) Parent–child interaction therapy for preschool children with disruptive behaviour problems in the Netherlands. In Child Adolescent Psychiatry & Mental Health, 6(24).

Ag Eisteacht (2014) *Brief Encounters Training Courses* webpage. Available online at: http://www.ageisteacht.com/briefencounters.html [Accessed: 19 September 2014].

Alcohol and you (2014) *Brief intervention Clinics*. Available online at: http://www.alcoholandyouni.com/brief-intervention-clinics/

Alcohol Research UK (2013) *Steps to Cope: A brief intervention for children and young people (CYP) living with parental substance misuse and/or parental mental health problems.* Available online at: http://alcoholresearchuk.org/alcohol-insights/steps-to-cope-a-brief-intervention-for-children-and-young-people-cyp-living-with-parental-substance-misuse-andor-parental-mental-health-problems/

Ascert (2012) *Steps to Cope: Supporting Young People affected by Parental Substance Misuse and/or Parental Mental Health Problems in Northern Ireland: Evaluation of the pilot study.* Available online at: http://www.ascert.biz/uploads/files/Steps%20to%20Cope%20Study%20full%20report%202012.pdf

Ascert (2014) *Drug and Alcohol Workforce Development Programme 2014*. Available online at: http://www.ascert.biz/uploads/files/ASCERT%20WFD%20brochure%20-%20April%202014%20%283%29.pdf

Association for Video Interactive Guidance UK (2014) *AVIGuk website*. Available online at: http://www.videointeractionguidance.net [Accessed: 19 September 2014].

Association of Greater Manchester Authorities (2012) GM Early Years business case. Available online at: http://www.agma.gov.uk/cms_media/files/121031_ey2_business_case.pdf?static=1

Avon Premature Infant Project (APIP) (1998) Randomised trial of parental support for families with very preterm children. In *Archives of Disease in Childhood Foetal and Neonatal Edition*, 79, pp. 4–11.

Barlow, J., Davies, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007a) Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. In *Care Health & Development*, 33(4), 505-505.164.

Barlow, J., Davis, H., McIntosh, E., Jarrett, P., Mockford, C., & Stewart-Brown, S. (2007b) Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation. In *Archives of Disease in Childhood*, 92(3), pp. 229-233.

Barnardos (2006) *The Wexford Family Welfare Conference Project Evaluation Report Synopsis.* Available online at: http://www.barnardos.ie/assets/files/pdf/Wexford-FWC-Executive-Summary.pdf

Barnsdale, L. & Walker, M. (2007) *Examining the use and impact of family group conferencing.* Edinburgh: The Scottish Executive Social Research. Available online at: http://www.scotland.gov.uk/Resource/Doc/172475/0048191.pdf [Accessed: 19 September 2014].

Blueprints (2014) *Parent-child Interaction Therapy.* Available online at: http://www.blueprintsprograms.com/programCosts.php?pid=50336bc687eb161ee9fb0ddb8cf2b7e65bad865f

Bond, C., Woods, K., Humphrey, N., Symes, W., & Green, L. (2013) Practitioner review: The effectiveness of solution focused brief therapy with children and families: a systematic and critical evaluation of the literature from 1990-2010. In *Journal of Child Psychology and Psychiatry*, 54(7), pp. 707-23.

Breakthru (2014) *Help and support webpage.* Available online at: http://www.breakthru.co.uk/index.php?option=com_content&view=category&layout=blog&id=21&Itemid=128

Brown, E.A.,& Dillenburger, K. (2004) An evaluation of the effectiveness of intervention in families with children with behavioural problems within the context of a Sure Start Programme. In *Child Care in Practice*, 10(1), pp. 63-77.

Cardiff Motivational Interviewing Workshops (2013) *Cardiff Motivational Interviewing workshops*. Available online at: http://www.micardiff.co.uk [Accessed: 19 September 2014].

Care Co-ordination Network UK (2004) *Key Worker Standards* York: Care Co-ordination Network. Available online at http://www.anglesey.gov.uk/upload/public/attachments/133/CCNUK_StandardsEnglish.pdf [Accessed 19 September 2014].

Carney, T., Myers, B., Louw, J. & Okwundu, C. (2014) Brief school-based interventions and behavioural outcomes for substance-using adolescents. In *Cochrane Database of Systematic Reviews*, 2.

Cavet, J. (2007) *Best practice in key working: what do research and policy have to say. Working in partnership through early support: distance learning text*. London: Care Co-ordination Network. Available online at: http://www.ncb.org.uk/media/513338/best_practice_in_key_working.pdf [Accessed 19 September 2014].

Cavill, N., Hillsdon, M., & Anstiss, T. (2011) *Brief interventions for weight management*. Oxford: National Obesity Observatory.

Center for Evidence-Based Practices (2014) *Motivational Interviewing website*. Available online at: http://www.centerforebp.case.edu/practices/mi [Accessed: 19 September 2014].

Child Welfare Information Gateway (2013) *Parent-child interaction therapy with at-risk families.* Washington DC: U.S. Department of Health and Human Services, Children's Bureau. Available online at https://www.childwelfare.gov/pubs/f_interactbulletin/f_interactbulletin.pdf [Accessed: 19 September 2014].

CWDC (2011) *Providing intense support for families with multiple and complex needs*. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193509/Managers_Guide_Refreshed.pdf [Accessed: 19 September 2014].

Civil Service (2014) *The need for reviewing evidence.* Available online at: http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment/what-is

Clewett, N., Slowely, M. & Glover, J. (2010) *Making plans: Using Family Group Conferencing to reduce the impact of caring on young people.* Essex: Barnardos.

Council for the Homeless Northern Ireland (2013) *2012/13 Annual Report.* Belfast: Council for the Homeless. Available online at: http://www.chni.org.uk/ANN_rep12-13ppp.pdf

Davis, H. & Day, C. (2009a) *Family Partnership Model Foundation course: Facilitator training manual Part 1. Second Edition.* London: Pearson.

Davis, H & Day, C. (2009b) *Family Partnership Model Foundation course: Facilitator training manual Part 2*. *Second Edition*. London: Pearson.

Davis, H. & Rushton, R. (1991) Counselling and supporting parents of children with developmental delay: A research evaluation. In *Journal of Mental Deficiency Research*, 35, pp. 89-112.

Davis, H. & Spurr, P. (1998) Parent counselling: an evaluation of a community child mental health service. In *Journal of Child Psychology & Psychiatry*, 39, pp. 365-376.

Davis, H. & Rushton, R. (1991) Counselling and supporting parents of children with developmental delay: A research evaluation. In *Journal of Mental Deficiency Research*, 35, 89–112.

Day, C. & Davis, H. (2009) *The Family Partnership Reflective Practice Handbook*. London: CPCS.

Davis, H. & Meltzer, L. (2007) *Working in Partnership through Early Support: distance learning text.* London: Department for Education and Skills.

Department for Education (2014) *Commissioning Toolkit: The Strengthening Families Programme 10 – 14 (SFP 10 – 14)*. Available online at: http://www.education.gov.uk/commissioning-toolkit/Content/PDF/The%20Strengthening%20Families%20Programme%20SFP%2010-14.pdf [Accessed: 19 September 2014].

Department of Culture, Arts and Leisure (2011) *Sport Matters – Implementation group progress report (2)*. Belfast: Department of Culture, Arts and Leisure.

Department for Health, Social Services and Public Safety (2011) New Strategic Direction for Alcohol and Drugs 2011-2016. Belfast: DHSSPS.

Down District Council (2014) *Tackling alcohol misuse together in the Down Council area.* Available online at: http://www.downdc.gov.uk/Home/News/Tackling-alcohol-misuse-together-in-the-Down-Counc.aspx

Early Support (2006) *Working in partnership through early support: training programme - Participant's pre-course handout on the Family Partnership model*. Available online at: http://www.ncb.org.uk/media/509718/participants_pre_course_handout_on_the_family_partnership_model.pdf [Accessed: 19 September 2014].

Early Support (undated) *Key working: improving outcomes for all evidence, provision, systems and structures.* Available online at: http://www.ncb.org.uk/media/847692/key_working_position_paper_final_november_2012comp.pdf [Accessed: 19 September 2014].

Eastern Drugs and Alcohol Coordination Team (2009) *Directory of services: for Substance Misuse in the Eastern Area 2009—11.* Available online at: http://www.ascert.biz/uploads/files/EDACT%20Directory%20of%20substance%20misuse%20services.pdf

Effective Child Therapy (2014) *Specific evidence-Based treatment programmes*. Available online at: http://www.effectivechildtherapy.com/content/specific-evidence-based-treatment-programs#14 [Accessed: 19 September 2014].

Extern (Date of publication not available) *Working in partnership: Extern adult services.* Belfast: DPM Solutions. Available online at: http://extern-www.incontrol-cms.net/Branches/Extern/Extern/Files/Documents/Adult%20Services.pdf

Family Group Conference Northern Ireland (2014) *Action for Children website.* Available online at: http://www.fgcni.org/Action-for-Children.php [Accessed: 19 September 2014].

Family Rights Group (2004) *Duties on Children's Services when children are in the care system.* Available online at: http://www.frg.org.uk/images/Advice_Sheets/11-powers-and-duties-of-local-authorities.pdf [Accessed, 19 September 2014].

Family Rights Group (2004) *Family Group Conferences website.* Available online at: http://www.frg.org.uk/where-and-how-are-family-group-conferences-used [Accessed: 19 September 2014].

Fox, D. (2008) Family Group Conferencing and evidence-based practice: what works? In *Research, Policy and Planning*, 26(3), pp. 157-167.

Functional Family Therapy (2014) *Functional Family Therapy website.* Available online at: http://www.fftllc.com/ [Accessed: 19 September 2014].

Greco, V., Sloper, P., Webb, R. & Beecham, J. (2005) *An exploration of different models of multiagency partnership in key worker services for disabled children: effectiveness and costs.* Nottingham: Department for Education and Skills.

Hartney, E.P. (2014) What Is Motivational Interviewing? Available online at: http://addictions.about.com/od/overcomingaddiction/a/MI.htm [Accessed: 19 September 2014].

Hinds, G. (2014) Motivational Interviewing: Level 1 Belfast. Available online at: http://www.glennhinds.com/events/motivational-interviewing-level-1-belfast-2/ [Accessed: 19 September 2014].

Holland, S. & O'Neill, S. (2006) We had to make sure it was what we wanted. Enabling children's participation in family decision-making through the family group conference. In *Childhood*, 13(1), pp. 91-111.

Holland, S., Aziz, Q. & Robinson, A. (2007) *The development of an all-Wales evaluation tool for family group conferences: Final research report*. Cardiff: Cardiff University.

Huntsman, L. (2006) *Family Group Conferencing in a Child Welfare Context: a review of the literature.* New South Wales: Centre for Parenting and Research, Funding and Business Analysis Division.

Investing in Children (2014) *Functional Family Therapy (FFT) webpage*. Available online at: http://investinginchildren.eu/interventions/functional-family-therapy-fft [Accessed: 19 September 2014].

Investing in Children (2014) *Strengthening Families (10-14) webpage.* Available online at: http://investinginchildren.eu/node/67 [Accessed: 19 September 2014].

Iveson, C. (2002) Solution-focused Brief Therapy. In *Advances in Psychiatric Treatment*, 8, pp. 149-156.

Johnson, R., and Wilson, H. (2012) Parents' evaluation of 'Understanding your child's behaviour', a Solihull approach group for parents. In *Community Practitioner*, 85(5), pp. 29-33.

Joseph Rowntree Foundation (1999) *Findings: Implementing key worker services: a case study of promoting evidence-based practice* [online]. Available online at: http://www.jrf.org.uk/sites/files/jrf/d39.pdf [Accessed: 19 September 2014].

Kiely, P. & Bussey, K. (2001) *Family Group Conferencing: A longitudinal evaluation*. Sydney: Macquarie University.

Kumpfer, K., Cofrin, K., Xie, J., Whiteside, M. & Whiteside, H. (2012) *The Derry, Northern Ireland Strengthening Families Program for Teens and Parents – Evaluation Report*. Utah: LutraGroup.

Lambeth Children and Young People's Service Scrutiny Sub-Committee (2013) *Aspirational Lambeth Families - Troubled Families Programme*. Available online at: https://moderngov.lambeth.gov.uk/documents/s58391/03%20-%20Troubled%20Familes%20Report.pdf [Accessed: 19 September 2014].

Levensky, E., Forcehimes, A., O'Donohue, W. & Beitz, K. (2007) Motivational Interviewing: An evidence-based approach to counselling helps patients follow treatment recommendations. In *American Journal of Nursing*, 107(10), pp. 50-58.

Liabo, K., Newman, T., Stephens, J. and Lowe, K. (2001) *A Review of key worker systems for disabled children and the development of information guides for parents, children and professionals.* Cardiff: Wales Office for Research and Development.

Lundahl, B. & Burke L. (2009) The effectiveness and applicability of Motivational Interviewing: A practice-friendly review of four meta-analyses. In *Journal Of Clinical Psychology.* In *Session*, Vol. 65(11), pp. 1232-1245.

Lundahl, B., Tollefson, D., Gambles, C., & Burke, B. (2010) A meta-analysis of Motivational Interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice,* 20, pp. 137-160.

Mansfield, P. (2009). Intervening early: Helping couples manage relationship issues when they first arise. In Benson, H & Callan, S. (Eds.) *What works in relationship education: Lessons from academics and service deliverers in the United States and Europe* (pp. 87 - 97). Doha, Qatar: Doha International Institute for Family Studies and Development.

McNab, C. & Purcell, D. (2009) *Evidence summary: The effectiveness of Motivational Interviewing for young people with substance use and mental health disorders.* Available online at: file:///U:/Downloads/ev_motivationalinterviewing_v2.pdf [Accessed: 19 September 2014].

Mengoni, S., Oates, J. & Bardsley, J. (2014) *Developing Key Working Council for Disabled Children:* Available online at: http://www.councilfordisabledchildren.org.uk/media/554082/developingkeyworkingfinal.pdf [Accessed: 19 September 2014].

Milford, R., Kleve, L., Lea, J. & Greenwood, R. (2006) A pilot evaluation study of the Solihull Approach. In *Community Practitioner*, 79(11), pp. 358-362.

Miller, M., Champassak, S., Goggin, K., Kelly, P., Dowd, D., Mollen, C., Humiston, S., Linebarger, J. & Apodaca, T. (2014) A brief intervention to reduce adolescent sexual risk behaviours: feasibility and impact. In *Journal of Adolescent Health,* 54(2), S11.

Mukherjee, S., Sloper, P., Beresford, B. & Lund, P. (2000) *A resource pack: developing a Key Worker Service for families with a disabled child.* York: University of York.

National Institute for Health and Care Excellence (2014) *Social and emotional wellbeing: early years webpage.* Available online at: http://www.nice.org.uk/guidance/ph40/chapter/glossary#video-interaction-guidance [Accessed: 19 September 2014].

New Zealand Family and Community Services (2014) *Family Services-Family Partnership Model webpage*. Available online at: http://www.familyservices.govt.nz/working-with-us/programmes-services/connected-services/ngo-capacity-building/family-partnerships-model.html [Accessed: 19 September 2014].

Newton, A., Dong, K., Mabood, N., Ata, N., Ali, S., Gokiert, R., Vandermeer, B., Tjosvold, L., Hartling, L. & Wild, T. (2013) Brief emergency department interventions for youth who use alcohol and other drugs: a systematic review. In *Pediatric Emergency Care*, 29(5), pp. 673-684.

NHS National Services for Mental Health Professionals (2014) *Centre for Parent and Child Support webpage.* Available online at: http://www.national.slam.nhs.uk/services/camhs/camhs-cpcs/ [Accessed: 19 September 2014].

Nilsen, P., Kaner, E. & Babor, T. (2008) Brief intervention, three decades on. In *Nordic studies on alcohol and drugs*, 25(6), pp. 453-467.

Noonan, W. C. & Moyers, T. B. (1997) Motivational interviewing: A review. In *Journal of Substance Misuse*, 2, pp. 8-16.

North Eastern Education and Library Board (2014) *Training Calendar April 2014 to March 2015.* Available online at: http://www.neelb.org.uk/EasysiteWeb/getresource.axd?AssetID=15443&type=full&servicetype=Attachment

Northern Health and Social Care Trust (2013) *Health Improvement Training Directory 2013 – 2014.* Available online at: http://southantrimcommunitynetwork.org/wp-content/uploads/2013/12/NHSCT-Training-Directory-2013-14-HICD.pdf

NREEP (2014) *Intervention Summary, Parent Child Interaction Therapy.* Available online at: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=23 [Accessed: 19 September 2014].

NREEP (2014) *Intervention Summary, Motivational Interviewing.* Available online at: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=346 [Accessed: 19 September 2014].

NSCAP (2014) *Video and Interactive Guidance Training Application form.* Available online at: http://www.nscap.org.uk/assets/news/38-na_link_file VIG%20Training%20Flyer%20and%20Application.pdf [Accessed: 19 September 2014].

PBNI (2012) *Best practice framework incorporating Northern Ireland standards.* Belfast: PBNI. Available online at: http://www.pbni.org.uk/archive/Guide%20to%20Information/What%20are%20our%20priorities/Service Standards/PBNIstandards_v1%2004.10.12.pdf

PCIT (2014) *About PCIT.* Available online at: http://www.pcit.org/about/

Public Health England (2014) *Lambeth unitary authority public health profile 2014.* Available online at: file:///U:/Downloads/HealthProfile2014Lambeth00AY.pdf [Accessed: 19 September 2014].

Puura, K., Davis, H., Cox, A., Tsiantis, J., Tamminen, T., Ispanovic-Radojkovic, V., Paradisiotou, A., Mäntymaa, M., Roberts, R., Dragonas, T. and others (2005) The European Early Promotion Project: description of the service and evaluation study. In *International Journal of Mental Health Promotion*, 7(1), pp. 17-31.

Queen's University Belfast (2014) *School or Nursing and Midwifery - Continuing Professional Development.* Available online at: http://www.qub.ac.uk/schools/SchoolofNursingandMidwifery/StudyattheSchool/OurCourses/ContinuingProfessionalDevelopment/

Sawyer, R. & Lohrbach, S. (2008) Olmstead county child and family services: Family involvement strategies. Rochester: Olmstead County Child and Family services.

Schrader-McMillan, A., Barnes, J & Barlow, J (2011) *Primary study evidence on effectiveness of interventions (home, early education, child care) in promoting social and emotional wellbeing of vulnerable children under 5.* London: National Institute for Clinical Excellence. Available online at: http://www.nice.org.uk/guidance/ph40/resources/ph40-social-and-emotional-wellbeing-early-years-expert-report-12.

Scott, S. and Dadds, M. (2009) Practitioner review: when parent training doesn't work: theory-driven clinical strategies. In *Journal of Child Psychology and Psychiatry*, 50(12), pp. 1441-1450.

Shropshire Council (2014) *Understanding your child - the Solihull approach*. Available online at: http://shropshire.gov.uk/early-help/training-and-events/understanding-your-child-the-solihull-approach/

Skills Development UK (2014) Motivational Interviewing & Beyond (CRBT - Module 2). Available online at: http://skillsdevelopment.co.uk/seminars.php?courseid=5 [Accessed: 19 September 2014].

Skills Development UK (2014) Solution Focused Brief Therapy (2 day course). Available online at: http://skillsdevelopment.co.uk/seminars.php?courseid=117 [Accessed: 19 September 2014].

Solihull Approach Parenting (2014). *Solihull Approach - Understanding your child* webpage [online] Available at: http://www.solihullapproachparenting.com/ [Accessed 19 Sep. 2014]

Solihull Community Services (2014) *What is the Solihull Approach* webpage [online] Available at http://communityservices.heartofengland.nhs.uk/default.asp?page=376

Strengthening Families Program (2014) *Program descriptions webpage.* Available online at: http://www.strengtheningfamiliesprogram.org/about.html [Accessed: 19 September 2014].

Sundell, K & Vinnerljung , B (2004) Outcomes of family group conferencing in Sweden: a 3-year follow-up. In *Child Abuse & Neglect,* 28, pp. 267–287.

The Centre for Parent and Child Support (2014) *Centre for Child and Parent Support* website. Available online at: http://www.cpcs.org.uk/index.php?page=about-family-partnership-model [Accessed: 19 September 2014].

Together for You (2014) *Together we can help improve your mental well-being.* Belfast: Together for You. Available online at:
http://www.togetherforyou.org.uk/media/files/Together_For_You_Brochure_Final_March_2014.pdf

Tooten, A., Hoffenkamp, H., Hall, R., Winkel, F., Eliëns, M., Vingerhoets, A. & van Bakel, H. (2012) *The effectiveness of video interaction guidance in parents of premature infants: A multicenter randomised controlled trial*. BMC Paediatrics, 12(1), p.76.

University of Ulster (2014) *Master of Science Professional Development in Social Work.* Available online at: http://www.socsci.ulster.ac.uk/sociology/prof-dev.html

Woods, K., Bond, C., Humphery, N., Symes, W. & Green, L. (2011) *Systematic Review of Solution Focused Brief Therapy (SFBT) with children and families.* London: Department for Education.

World Health Organisation (2003) Brief intervention for Substance use: A manual for use in primary care. [Draft version 1.1 for Field testing] Geneva: World Health Organisation.

Appendix A: Programme effectiveness scales

A Graham Allen review published in 2011 examined the evidence base for early intervention programmes. The review categorises programmes on a scale (level 1-3) according to the strength of evidence available on the programme's effectiveness. An explanation for the ratings is provided below:

Level 3

All of the following must apply:

- programme has one randomised controlled trial (RCT) or two quasi-experimental designs (QEDs);
- programme has a positive impact on an Allen Review outcome;
- programme has no iatrogenic effect; and
- there are no obvious concerns about intervention specificity or system readiness.

Level 2

All of the Level 3 criteria must apply plus:

- programme meets all evaluation quality criteria

Level 1 (highest rating)

All of the Level 2 criteria must apply plus:

- programme gets a 'best' on evaluation quality and/or impact criteria. In the case of evaluation quality this means that any of the 'best' criteria must apply, while in the case of impact criteria both of the 'best' criteria must apply.

Blueprints is also commonly used to determine the evidence base for programmes. Programmes are rated as either Promising or Model. Promising programs meet the minimum standard of evidence (i.e. requires a minimum of (a) one high quality randomised control trials or (b) two high quality quasi-experimental evaluations that demonstrate effectiveness). Model programmes meet a higher standard of evidence and provide greater confidence in the program's capacity to change behaviour and achieve positive outcomes.

Appendix B: Long-list of evidence-based early intervention programmes

Adolescents Coping With Depression
Big Brothers Big Sisters
Brief Alcohol Screening and Intervention for College Students (BASICS)
Bright Bodies
Coping Power
Early Learning and Literacy Model
EFFEKT
Family Nurse Partnership
Functional Family Therapy (FFT)
Guiding Good Choices
High Scope Preschool / Perry Preschool
Incredible Years- Child Treatment
Incredible Years- Parent Training
Incredible Years- Teacher / Classroom Management
Life Skills Training
Multidimensional Treatment Foster Care
New Beginnings
Olweus Bullying Prevention Programme
Parent-Child Interaction Therapy (PCIT) for Disruptive Behaviour
Parent-Child Interaction Therapy (PCIT) for Families in the Child Welfare System
Positive Action
Positive Family Support- Family Check-Up (formerly Adolescent Transitions)
Project Northland
Promoting Alternative Thinking Strategies (PATHS)
Raising Healthy Children
Safe Dates
Strengthening Families (10-14)
Success for All
Triple P Positive Parenting Programme (All Levels)

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