# Practitioners' experiences of using blended models within family support: A proof of concept study involving Cognitive-Behavioural Therapy (CBT), Multisystemic Therapy (MST) and Incredible Years (IY) interventions

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## Introduction

Since the emergence of the violent sectarian conflict in Northern Ireland during the 1960's - commonly referred to as the *'Troubles'* and generally regarded as Europe's longest running violent conflict (Lynch & Joyce, 2018), approximately 3,700 people lost their lives, about 40,000 people sustained physical injuries (McAlinden & Dwyer, 2015) and countless others suffered psychological trauma. Some estimates suggest that 80% of the population knew someone who had been killed or injured during the *Troubles* (Breen-Smith, 2012). Crimes against person and property permeated all aspects of life. Routine tasks such as shopping, travelling and socialising were often affected by conflict-related incidents such as police check-points, bomb scares, car hijacking, protests, parades and mass rioting and this had an significant psychosocial impact on the whole population (McAlister, Scraton & Haydon, 2014). In the context of this, evidence has consistently demonstrated that families living in Northern Ireland experience multiple adversities, particularly in those areas that were characterised as having been exposed to conflict and social deprivation (Davidson, Bunting & Webb, 2012; Bunting & Lazenbatt, 2015). Some of these families, were often referred for, or offered additional supports for their family.

Family support is a familiar term that has been used widely over recent years and yet is a contested concept (Cameron et al., 2007; Devaney & Dolan, 2014) which varies according to context, purpose and underpinning values within specific models (Churchill & Sen, 2016). Rather than illustrating a particular type of intervention, 'family support' refers to a range of interventions or strategies that are delivered across many disciplines to address a well-defined problem (McKeown, 2000) within specific family systems. The emergence of the concept as well as significant increase in interventions defined as 'family support' models in many ways reflects social trends fuelled by concerns around welfare, family functioning, mental health, violence and inequality (Bonoli, 2013). Over recent decades there has been an exponential growth in social, psychological and therapeutic specialisms (Ovretviet, Hansson & Brommels, 2010) in response to the increased complexity of needs presented by service users (Lemmens, Molema, Versnel, Baan & De Bruin, et al., 2015). By some accounts, the figures for primary care centres in the US who also offered behavioural interventions rose from 42%

to 75% between 2000 and 2011 (Padwa et al., 2016) suggestive of a rise in crisis experienced by families and members within those families.

Adversity affects many families but a minority find themselves in crisis following complex and sometimes cumulative adversities such as abuse, poverty, incarceration and ill health (Lee et al., 2017). Within a social ecological framework, these issues impact upon both individuals and wider family members. Often one issue exacerbates other pre-existing issues whilst also contributing to new and more complex challenges. Whilst an array of social programmes and human service interventions are available, accessing those who need them and retaining them in support can be difficult.

The emergence of evidence-based practices (EBPs) and implementation science (Fixsen et al., 2005) provided opportunities for human services to understand what works in improving outcomes as well as the mechanisms to successful (and sustainability) replicate what works (Olsson, 2010; Wiggins et al., 2010). This includes practices to both identify and retain those who are most in need of support so that the potential impact of evidence based practices can be fully achieved.

Depending on the criteria applied and how 'evidence' is defined, there are between 50 and 200 evidence-based programmes (Little, 2010) currently available in the areas of parenting (Furlong et al., 2012), educational attainment (Valdebenito et al., 2018) and violence prevention (Tolan, 2013). In the UK there has been a drive to embed these models into routine practice. Between 2008 and 2011, a UK government sponsored implementation strategy called the Parenting Early Intervention Programme (PEIP) was designed to help facilitate the replication of a range of evidence based parenting models across 150 local government areas in England (Lindsay et al., 2013). And between 2012 and 2017, the Big Lottery, the UK's largest charitable grant making body, funded the *'Realising Ambition'* Programme aimed at improving the evidence base of what works with preventing youth offending and was supported by a financial pot of $32m (Catch 22, 2014). In Northern Ireland too, there has been an increasing focus on integrating evidence into practice and this was built into the previous programme for government (OFMDFM, 2011). Commitments have been made to deliver a range of measures to tackle poverty and social exclusion through a 'Delivering Social Change (DSC) Framework' itself funded to the tune of $150M (CYPSP, 2014). The programme was underpinned by a focus on early intervention, the use of best evidence to inform practice. In an era of increased austerity, successfully implementing such interventions within the context of family support also had the additional value of saving money whilst improving outcomes (Odom, 2009).

However, these are often implemented either sequentially (as one treatment proves ineffective) or in parallel but also in isolation from the other with needs assessment, clinical decision making and reviews taking place.

Given that families' needs are often complex and co-occurring, with different family members requiring different types and levels of support simultaneously, single, specific and targeted programmes may not comprehensively address the complex needs experienced by some families (Guastaferro et al., 2017). In a social, economic and political climate that has demonstrated significant interest and investment in evidence based interventions that seek to improve family outcomes (Batty & Flint, 2012), multiple component interventions that address the distinct needs of family members have been significantly under-evaluated (Aarons, Hulburt & Horwitz, 2011). Few studies have actively sought to explore whether a combination or blending of evidence based models and practices enhance outcomes that families experience, particularly when they experience multiple adversities concurrently. Additionally, there are even fewer studies that have sought to explore the implementation challenges with this type of novel blended approach.

For the purpose of this paper, blended models (Walsh & Doherty, 2016) have been defined as the concurrent implementation of more than one evidence based model or practice facilitated by practitioners within the same programme but to address distinct needs. Using our definition of blended models, family therapy followed by cognitive behavioural therapy (or vice-versa) is not a blended model. Likewise, an individual within a family receiving two interventions, neither of which is integrated or coordinated is not a blended model. In this conceptualisation, a blended model is one in which a family receive more than one intervention which is integrated, coordinated and is also intended to address more than one issue (e.g. CBT for depression and MST for a reduction in violent behaviour).

Given the dearth of primary studies exploring the viability and acceptability of this approach, the aim of this paper is to explore the feasibility of blended approaches within complex family support programmes as a means of addressing these complex and concurrent needs and retaining families in interventions most likely to achieve the best possible outcomes for them. The medical research council provide some guidance around evaluating complex interventions. They suggest that prior to an expensive process evaluation or outcome study, an early stage review could be considered with the aim of answering 'would this be possible to use' (Craig et al., 2008). This proof of concept study aims to highlight the potential feasibility of blending different interventions to meet those concurrent and complex needs that families

experience. Proof of concept (PoC) is a realization of a certain method or idea in order to demonstrate its feasibility or a demonstration in principle with the aim of verifying that some concept or theory has practical potential (Ungar et al., 2017). The studies aim to explore the feasibility of a novel approach (Kush et al. 2007). In health care, PoC studies have been used to understand challenges and reduce inefficiencies in clinical trials serving to prepare the ground for full outcome studies. Within prevention, early intervention and parenting initiatives, PoC studies are increasingly being used to highlight gaps in current practice, the added value of novel approaches and the mechanics of those new practices (Rabinowitz et al., 2013). But given their primary aim is to demonstrate that a programme design has practical potential rather than generate conclusive evidence about their relative efficacy, further studies to determine effectiveness are often required (Cobham et al., 2017).

In this study, a large voluntary organisation implemented three evidence based models and practices within the same service environment.

For the current paper the focus is on the concurrent implementation of three evidence based models and practices implemented concurrently within a family support service: Multisystemic Therapy (MST), Incredible Years (IY), and Cognitive Behaviour Therapy (CBT).

In 2014, as part of a coordinated approach in reducing family adversity and improving outcomes for children and young people in Northern Ireland, the Extern Organization, a large NGO supporting children, young people and families with complex needs, piloted a new model of practice called the Intensive Family Support Service (IFSS). The pilot sought to blend together a range of evidence based, evidence informed and basic needs practices under one roof and to be delivered by a skilled but also multi-disciplinary team. Three evidence based models (Multisystemic Therapy-MST, Cognitive Behavioural Therapy-CBT and Incredible Years) were implemented (see table 1). In addition to the evidence based interventions, a range of evidence informed practices such as person centred counselling and motivational interviewing were implemented.

The aims of the pilot were to engage families who had been known to multiple services but were considered 'hard to reach' either because they had failed to complete interventions or presented with challenges following previous support; to help prevent placement breakdown; to reduce offending and other risk taking behaviours; to improve mental health issues; and to increase academic engagement and attainment.

**Table 1:**
Overview of EBPs within IFSS

| Model or practice | Target group | Desired outcome | N= |
|---|---|---|---|
| Multisystemic Therapy (MST) | Parents of young people 12-18 | Reduced anti-social behaviour and improved family functioning | 56 |
| Cognitive Behavioural Therapy (CBT) | Young people aged 10-18 | Improved mental health symptomatology | 32 |
| Incredible Years | Parents of young children | Improved family functioning | 12 |

A range of evidence based practices and programmes were available to families and within the IFSS programme. Three of these are covered in this article: Multisystemic Therapy (MST); Incredible Years; and Cognitive Behavioral Therapy (CBT).

Incredible Years supports parents of younger children to improve parenting practices and family function; MST supports parents to address adolescent risk factors associated with family breakdown; and CBT provides individual therapeutic support to those with mental health difficulties. It has been proposed that the combined delivery of these three models are both complementary and the potential for improved outcomes is potentially enhanced through the novel blending.

MST is an intensive community based model that uses evidence-based interventions to address problem behaviours and attempts to mitigate the risks associated with out of home placement by placing the family at the centre of all elements of the work. Since being developed in the 1980's, MST provision has extended beyond the USA where it was first developed and into 15 counties across more than 200 teams (Olsson, 2010). Nine treatment outcome studies (including 3 controlled trials) have been published and for seven of these follow-up data from 1-4 years have been reported to be effective for those who completed the treatment programmes (Carr, 2005).

In addition to MST, it was decided to replicate Incredible Years, an evidence based programme that involves parenting and teaching practices that have been shown to positively and effectively reduce conduct problems and strengthen children's social and emotional

competence. The model is guided by the behavioural principles of operant conditioning and social learning, and aim to strengthen parent and teacher skills respectively and ultimately improve child outcomes. The National Institute for Health and Clinical Excellence has published guidelines for parenting programmes for the treatment of conduct disorders and when published, Incredible Years was only 1 of 2 models that met the criteria (NICE, 2006). The programme, aimed at children aged 3 to 12 years, is founded on Social Learning Theory (Bandura and consists of at least 12 weekly, two-hour group sessions delivered by skilled practitioners. Overall, the Incredible Years Programme aims to: promote positive parenting and improve parent-child relationships, reduce critical and physical discipline and increase the use of positive strategies and help parents to identify social learning theory principles for managing behaviour and improve home-school relationships (McDaniel et al., 2009). Reviews of the efficacy of a number of parent training prevention programmes and treatment programmes have shown these programmes to be promising for changing maladaptive parent and child behaviour in younger children (Webster-Stratton & Reid, 2017) and a study in Ireland found that benefits were experienced by families both in the short term and longer term (McGilloway et al., 2009). An additional study (McGilloway, 2012), investigating the impact of incredible years on parenting, educational engagement and childhood functioning found significant reductions in childhood conduct disorder, improved parenting skills and improved academic engagement.

Cognitive approaches to therapy first emerged in the work of Alfred Adler, Albert Ellis and Aaron T. Beck (Beck, 1995). Beck et al (1979: 3) note that cognitive therapy is an "active, directive, time-limited and structured approach used to treat a variety of psychiatric disorders". The therapeutic techniques used within Beckian CBT are designed to identify, test and ultimately correct the dysfunctional schemas that underlie the client's cognitions. CBT is based on the idea that how we think (cognition), how we feel (emotion) and how we act (behavior) all interact together. Specifically, our thoughts determine our feelings and our behaviour (Beck, 2011). Cognitive behavioural approaches use components of Cognitive Behavioural Therapy and are well established psycho-social therapeutic practices, particularly for 'at risk' populations. Largely developed in clinical settings and adapted for a range of populations including those with anxiety, depression, and those who have experienced trauma (Armelius & Andreassen 2007), more recently the approaches have been integrated into preventative practices with the aim of reducing risk taking and/or offending behaviour (Littell & Forsyth, 2005). The practices have been widely used in youth justice and probation environments as a means of addressing offending at an early stage as well as reducing the likelihood of reoffending by engaging clients or service users in reasoning and/or problem solving skills (Joughin, 2006)

The rationale to include these three models is related to both the function and structure of them. All three are evidence based models widely used. All three are implemented for well-defined reasons, with well-defined desired outcomes. A critical feature is that the target populations are also well defined. For instance, MST would not be implemented to address parenting concerns regarding a toddler, but Incredible Years would. Conversely, Incredible Years would not be implemented to prevent further offending by a 17 year old but MST would.

The aim of this proof of concept study is to compare and contrast the experiences of practitioners implementing both blended and non-blended approaches to family support.

The objectives of this study are:

- To explore the experience and perceptions of practitioners who implemented the blended model.
- To explore the novelty of blended approaches
- To examine the extent to which families were engaged in and were retained in this programme;
- To compare the outcomes for families who received blended and non-blended approaches;

## Methods

### Data collection

This exploratory study used qualitative methods as a primary data collection too. This was supplemented by pre-existing quantitative data gathered by the organisation (See below for further details). A mixed methods approach (Bronstein et al., 2013) was employed in the study in which family data (reasons for referral,amount of support received and whether families were engaged in blended or non-blended support), and staff demographic data dovetailed (gender, no. of year's experience, time with the agency, primary discipline), (Bryman, 1998) into semi-structured interviews in order to increase the accuracy of the findings (Creswell, 2009; Moran-Ellis et al., 2013).

The sample were practitioners from the project and included primary date from thirteen individual interviews as well as secondary data from 41 staff.

*Practitioner demographics*

A total of forty one staff completed the initial questionnaires representing 91% of the total staff team. The returns represented the various disciplines (Youth work n=5; Social work n=15; Psychology n=6; Counselling-n=2; Play and art therapy n=3; Health and social care n=4; Combined social work and psychology n=6) (see table 2).

**Table 2:**

Practitioner demographics

| | | M | % | N |
|---|---|---|---|---|
| **Age** | | 25 | | |
| **Gender** | Male | | 14 | 6 |
| | Female | | 86 | 35 |
| | Total | | 100 | 41 |
| **Year's experience** | | 3.5 | | |
| **Months with the organisation** | | 14 | | |
| **Discipline** | Youth work | | 12 | 5 |
| | Social work | | 36 | 15 |
| | Psychology | | 14 | 6 |
| | Counselling | | 4 | 2 |
| | Play therapy | | 7 | 3 |
| | Social care | | 9 | 4 |
| | Combined | | 14 | 6 |

Quantitative data collection tools

The quantitative data included existing information which was designed and collected by the project delivery staff. These were non-standardised measures designed in line with the operational requirements of the project.Data was collected from families who engaged in the pilot was collated and analysed.  This included access to referral forms, case notes and

closure reports. Referral forms were received from a range of referral agents on a standardised programme template which outlined reasons for referrals and contact information for each family. Following receipt of this, the family were allocated a project worker whose initial role it was to undertake an assessment for service. This assessment aimed to understand the strengths and needs of each family, what they wished to receive support with and negotiate how best the programme could serve them. Following this assessment, the project worker, the family and the service manager agreed a family support plan and what that plan would consist of. At this stage, objective and measurable desired outcomes were agreed (e.g. X will return to education and attend daily, consistently for four weeks). During period reviews and at the end of each intervention, these overarching goals were reviewed. Following intervention, a determination around the extent to which those goals were met, partially met, or not met were agreed between the family, the project worker, the programme manager and the referral agent.

Not all families received the same type of intensity of support. Some received single interventions and others received blended interventions. Using this assessment data, comparisons were then made between those who received a blended model of support and those who did not.

Following allocation, work which was undertaken with each family was recorded following each session using routinely collected session template. The data included categorical (such as reasons for referral; models engaged in; completion status; outcomes achieved). Additionally, continuous data was collected (hours of support provided).

In addition to family profile data, all staff (n=41) were invited to engage in the research and complete an initial questionnaire. This questionnaire included demographic details (gender & age); and professional details (discipline, level of education, years of experience and time with the agency).

Qualitative data collection tools

All key work staff within the programme (n=41) were invited to engage in the interview process. Fourteen staff consented and were interviewed. A semi-structured interview schedule was developed (Creswell & Clarke, 2007). Each interview lasted between thirty five and forty five minutes. Interviews were facilitated by two trained investigators with experience in undertaking qualitative studies neither of whom were directly associated with the interventions being studied. Notes were taken by one of the investigators verbatim whilst the other conducted the

interview. Following the interview, participants were given an opportunity to review notes taken during the interview and asked to confirm if they accurately reflected what they said. Following each interview, a de-brief was undertaken. Using more than one interviewer enabled greater access to participants and their experiences, greater understanding of the responses, gaining the trust of the participants and establishing a rapport more quickly and the opportunity to take more detailed notes (Fontana & Fay, 2005). Critically this allowed for a more informed reflection of each interview (Matteson & Lincoln, 2009).  Each interview followed a standard process with key workers asked to confirm that they voluntarily opted into the study; that they were aware of the purpose; and that they understood how the data collected would be used. Following this confirmation key workers were then asked a series of open questions related to their experiences within the project (;their motivation for joining the project; prior experience of evidence based practices; perceived level of support in relation to implementing the work; previous training/discipline/qualifications; challenges with implementing the model; and recommendations moving forward were all explored.

All of the interviews included staff who had delivered a blended approach.


Ethical considerations

Data was collected as part of a service evaluation. As such, no formal ethical approval was sought (NRES, 2009). Despite this, ethical issues were addressed. Participants were provided with information about the study and an opportunity to opt in. the information sheet outlined what would be involved if they chose to be involved and how the data would be used. They were provided with one week between receiving the initial information and being provided with a consent form to engage. No paper copies of personal information was held by the researchers.  Confidentiality of participant's personal data was be ensured by not collecting individual names on the enrolment or measurement forms. All data will be stored in a pseudonymised manner. During enrolment participants were issued an identification code. Consent forms were held securely on the premises in a locked filing cabinet. For qualitative data, transcripts were anonymised (names, places, services) and no identifying information was used in dissemination.


Data Analysis

The analysis was undertaken sequentially. Secondary analysis was undertaken using existing data routinely collected within the project. This data was analysed prior to the interviews and helped inform that interview schedule that was undertaken with project staff. That quantitative data was analysed using SPSS Version 22 (SPSS, 2013). Independent samples t-tests were used to compare means between variables of interest. Crosstabulations were used to compare categorical data (reasons for referral, engagement in the three evidence based models and outcomes attained) and Chi-square tests of independence were used to explore statistical relationships between them.

Qualitative data was captured during the semi-structured interviews. Notes were taken by the researcher during the interview, reviewed immediately following the interview, typed and uploaded onto the NVivo version 10 qualitative software programme. Each interview was coded within NVivo, nodes were created and a process of thematic analysis was facilitated to interrogate the data in order to explore themes emerging from the interviews. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within the data (Braun & Clarke, 2006). Themes that emerged from the informants stories were pieced together to form a comprehensive picture of the collective experience. Given the dearth of empirical or theoretical evidence for this type of approach, themes emerged inductively (Miles & Huberman, 1994). That is to say, the themes were data driven and not confined to pre-specified coding systems.

## Results

**Quantitative results**

*Reasons for referral*

Families were referred for a number of complex psychosocial issues (see table 3) and allll families were being supported with at least 2 of these complex issues simultaneously at the point of referral. In fact, 89% of families were being supported with 4 or more issues.

**Table 3**
Overview of reasons for referral

| Reason for referral | % of total families referred | N= | % of families referred blended | N= | % of families referred-non-blended | N= |
|---|---|---|---|---|---|---|
| *Safety, risk and aggression* | 66 | 104 | 84 | 26 | 61 | 78 |
| *Education* | 74 | 116 | 74 | 23 | 73 | 93 |
| *Mental health* | 46 | 73 | 81 | 25 | 38 | 48 |
| *Substance use* | 25 | 39 | 19 | 6 | 26 | 33 |
| *Health* | 31 | 49 | 29 | 9 | 32 | 40 |
| *Finances* | 25 | 39 | 7 | 2 | 29 | 37 |
| *Home conditions* | 33 | 52 | 13 | 4 | 38 | 48 |
| *Employment* | 14 | 22 | 0 | 0 | 100 | 22 |

The intensity with which families were supported varied depending on need at various points in the programme journey. The average number of face to face hours families were afforded was 11.5 per month. However, the range was a huge 56 hours per month and the standard deviation was more than 7 hours per month.

*Blended approaches*

Not all families received the same intensity or type of support. Some families received a blended approaches and others did not. Families were supported from staff from a range of professional backgrounds. Interestingly, only those from youth work (3%), social work (29%) psychology (10%) or combined social work/psychology (58%) backgrounds implemented a blended model approach.

Families who were referred to the programme for issues around safety, risk and/or aggression (34%) were more likely than other families to undertake risk management work and safety planning. Those families were also more likely to achieve positive outcomes ($X^2$, 2, n=86= 21.29, p=.00, phi=.50). Interestingly 66% (n=21) of those who were not referred with safety concerns also undertook risk management work suggesting that more families experienced issues related to risk than statutory services were aware of at the point of referral. Families referred with finance (n=29) and/or home conditions issues were more likely to engage in more practical supports (80%, n=23).

A range of evidence based practices and programmes were available to families. In total, 68% of families engaged in at least one evidence based programme or practice.

There was a strong relationship between use of evidence based practices and outcomes being met ($X^2$, 2, n=158= 26, p=.00, phi=.41) suggesting that those with more complex needs were better served by evidence based models or approaches. 70% (n=57) of those who used an evidence based practice also fully met their target goals compared with 38% (n=24) who did not use an EBP fully met their goals. But then families with basic needs issues (such as finances or employment were less likely

38% (N=31) of those who engaged in an EBP had access to more than 1 evidence based practice or intervention. Within this group, families had access to an increased number of hours (m=16.13, sd=6.46) compared to families who did not engage in a blended intervention (m=10.43, sd=6.82). This may partly be because families who engaged in a blended approach were also those who more likely to experience multiple and higher risk issues (See table 4). The more intensive nature of the support was statistically significant (t (156)=4.21, p=<.01).

**Table 4:**
Overview of reasons for referral and outcomes by blended/not blended

| Population | Reason for referral | % | Outcome (% fully met) | Complete? |
|---|---|---|---|---|
| **Blended** | Safety, risk or aggression | 84% (n=26) | 81% (n=21)_ | 100% (n=31) |
| | Mental Health | 81% (n=25) | 80% (n=20) | 100% (n=25) |
| | Employment | 0% (n=0) | 0% (n=0) | 0% (n=0) |
| | Finances | 7% (n=2) | 100% (n=2) | 100% (n=2) |
| **Non-blended** | Safety, risk or aggression | 61% (n=78) | 41% (n=32)_ | 81% (n=63) |
| | Mental Health | 38% (n=48) | 35% (n=17) | 83% (n=40) |
| | Employment | 100% (n=22) | 46% (n=10) | 96% (n=21) |
| | Finances | 29% (n=37) | 57% (n=21) | 97% (n=36) |

And whilst it appears that those who engaged in multiple EBPs were families who were more likely to experience more significant and risky challenges, they were also more likely to

achieve their outcomes. 81% of those who engaged in a blended approach (n=25) had their goals fully met compared with only 48% (n=61) of those who did not engage in a blended approach. Likewise, only 3% (n=1) of those within the blended approach met none of their goals whilst 28% (n=36) of those who did not engage in a blended approach met none of their goals. These were at the point of statistical significance ($X^2$, 2, n=158= 12.22, p=.002). When specific reasons for referral are explored in more detail, it seems that families with complex and risky issues who engaged in blended approaches were more likely to achieve their outcomes compared with non-blended families

In addition to achieving positive outcomes, those who engaged in a blended approach were more likely to fully complete the programme than those who engaged in a non-blended intervention. 100% (n=31) of families who engaged in blended approaches fully completed the programme compared to 87% of those who did not ($X^2$,1, n=158= 4.35, p=.04).

### *Qualitative results*

#### *Benefits of blended approaches*

It was clear from interviews with staff that the complexities families face were not underestimated.

> *Some of my families are so vulnerable, I would be better moving in with them. I'm not joking. It's not always the case but there are some families I could be with in the morning, on the phone to them in the afternoon and back out with them in the evening. That could be the pattern for weeks depending on what's happening. But then as time goes on, you expect to see intensity reduce and intervention approaches change (Social Worker 2: 1.5 years' experience)*

The intensity of support was echoed during all interviews. Practitioners felt that a thorough assessment enabled them to make sense of the variety of issues affecting families and prioritise in some way the challenges being presented. Most staff believed that given the complexities, single responses were often not what was required.

> *Families don't come to IFSS because they have a few issues. They usually get referred in after years, maybe generations of support from services. They usually have loads of issues and they take time to methodically address all of these. The benefit of IFSS is we can target multiple things at once. We help coordinate services. We are in the family's homes, we see what they see and we can provide a birds' eye perspective on what is going on. That means we can target support where it needs to go to get the biggest bang for our buck! (Youth Worker 1: 3.5 years' experience)*

And yet, despite the complexities that practitioners described in great detail, many of the staff reported seeing significant change taking place with their families. Practitioners reported something unique about this type of blende approach. Even those more seasoned practitioners with experience in a variety of other support services indicated that the blended approach was contributing to change that was tangible.

> *I've been involved in a range of projects and to be honest, I've seen and heard about many of the same families coming through IFSS. There's families that have been through loads of different programmes. But something different has happened here. I know one family who's kids are now off the child protection register. That says loads. It says that they're in a place to manage things themselves-after years of support. (Psychologist 3: 2 years' experience)*

Having a variety of interventions that could be implemented with different members of a family to address their specific needs was seen not only as a resource for the family but also for the practitioner. So often, practitioners described uncertainty about what to implement, how and when. The combination of evidence based and manualised approaches enabled practitioners to provide support in an evidence based way with the understanding that these interventions have been rigorously tested.

> *I think because we have some many resources at our disposal, you can draw on one model for this and another for that so you don't need loads of different services as long as you know how to prioritise (Psychologist 1: 3 years' experience).*

> *This model incorporates all family members and so isn't solely behaviour modification work. Because there are so many issues, we have a menu of work that is growing. We can draw on practical expertise and evidence based theoretical interventions sometimes at the same time. (Counsellor 1: 2 years' experience)*

*Implementation Challenges with blended approaches*

Implementation can be defined as a series of measurable steps towards full and competent delivery. Within this process of implementation, different actors play different but complimentary roles. Whilst the focus of service evaluations is often on the competence and delivery of practitioners, during interviews, staff were keenly aware of the role that the organisation had to achieve implementation of this type of approach

> *The managers here have invested a lot in us as staff. There is loads of training that we need to take part in. you see, if you are delivering Incredible Years, you need to know how to deliver it. So you need trained in it. It's the same with other types of intervention.*

In addition to the resource implications (time and financial), practitioners also described the role that the organisation had in other areas of implementation

*Because we deliver evidence based models, there is a strong focus on fidelity. You need to deliver the model as it was intended to be delivered. So there's a lot of systems in place that the organisation had to develop and then stay on top of. They monitor how close we are delivering to the model and give us feedback (Social worker 1: 1 years' experience)*

Organisational systems and supports appeared to be critical for practitioners to engage in a blended approach. For others however, regardless of the type of support provided and training afforded, some staff struggled to engage in the blended approaches.

*They [the organisation] expect us to do everything. I think this is a way of cutting down on costs and just expecting us to do all the work that 3 or 4 organisations would have done before (Youth worker 1: 5 years' experience)*

And whilst this was echoed several times, others had a different perspective on reducing the amount of service providers involved with families

*My families don't know where they are from day to day, who's coming out and even when they're out, it's a struggle for the families to remember what their role is. They need one service that can do a whole lot of things for them. You can build up a relationship and they know where they're at. (Social worker 3: 7 years' experience)*

But despite the opportunities with blended intervention, for some, the combination of interventions and approaches created a more complex working environment. This was particularly the case for staff who had not previously implemented a manualised model and for those who had concerns around prioritising what to implement and when. There are some indications that particular disciplines are more likely to be open to evidence based practice in general and this may in part be explained by their exposure to EBP during initial professional training

*Using evidence based models wasn't that new to me. I covered it in uni and then when I was on placement, we got to implement a model called Strengthening Families. (Social worker 1: 1 years' experience)*

But whether practitioners felt the approach was useful or not, there was a general consensus that too little information was available to them on the mechanics of implementation. There were real concerns around how decisions were taken and the consistency around those decisions.

*I look to my manager for some guidance on what a family should receive. We have so much here but that can be overwhelming (Social worker 3: 7 years' experience)*

Indeed, it appeared that the programme lacked a coherence around decision making process, particularly when it came to which family would receive which type of service and which family would engage in which component/s of the blended model. In the absence of a coherent framework, preference filled the vacuum.

> *There could be better guidance around what options to choose to handle certain difficulties. I think it depends on the staff member and the team they are in at the minute what options are available and what options are suggested (Psychologist 3: 2 years' experience)*

## Discussion

### The viability of the blended model

A central design feature of the IFSS service were the range of supports that families had access to- a menu of strategies, supports and interventions that were blended within a complex arrangement of internal and external relationships to meet the needs of individual families. Interventions that were actioned when specific issues presented. These issues only became visible as the relationship developed. This suggests that some adversities were often unknown to statutory agencies but when made aware, IFSS keyworkers were able to implement appropriate interventions. This adds weight to the benefit families achieved by engaging in an environment where a menu of interventions is available.

There exists a dearth of information related to outcomes of blended models, their frequency and their impact. Whilst other models such as Integrated Care provide some empirical basis for the development of blended programme designs, there are clear distinctions. For instance, whilst integrated approaches seek to improve coordination, this is often across different sites and operating structures. Within the IFSS model, the blended design assimilates different approaches within one site and one operating structure. In addition, integrated approaches involve the joining of disciplines as a conscious and active effort to share best practice. In contrast, whilst the IFSS model did actively seek to recruit staff from across various disciplines, the blended approach requires that staff, from whatever sector, fully implement a range of evidence based practices and interventions.

Findings from the quantitative analysis appears to show a link between the use of a blended approach and improved outcomes for children, young people and families and despite limitations with the measures used, there are indications that this novel design did contribute

towards improved outcomes for families with complex needs and multiple risks factors. As noted, despite the array of support services available to families, not all families received the same level or categories of support. Interestingly, not every family needed an evidence based programme to achieve their desired outcomes. This suggests that not every family would receive an additional benefit from a blended approach but for others, with more complex needs, a blended approach could contribute towards enhanced outcomes. However, further investigation is needed.

## The challenges

Given the multiple adversities experienced by families within IFSS, greater understanding is needed around how, why and when to use particular strategies and/or an evidence based practice or programme would greatly benefit staff in their decision making. Decision making processes were overwhelmingly unclear and inconsistent. However, during the interviews in was clear that some key considerations around which intervention or strategy to use included:

> - Is there any immediate risk to family, community or worker?
> - Based on the up to date assessment of need, what are the immediate issues facing the family?
> - Based on this up to date assessment of need, does the intensity of support need to be increased/decreased?
> - How do these priorities relate to the short and longer term family goals?
> - Is there a need for revision of goals?
> - Based on these identified priorities, what model, intervention or strategy is best suited and proven to address this identified issues or need?
> - Is there consensus on all the above (family, referral agents, other key organisations, team)?

## Conclusion

The implementation of evidence based models has been a growing phenomenon within human services. However, evidence based models have tended to be developed and proven effective for specific populations and for addressing well defined, albeit complex issues. Within some environments, this limits the extent to which specific models can successfully address concurrent issues within complex social systems, such as the family.

This proof of concept study has demonstrated some potential to support families who experience multiple complexities and significant adversity simultaneously. Despite the limitations noted, families with such complex needs experienced positive outcomes. Additionally, practitioners described in detail the acceptability of this type of approach.

## Limitations and Future Directions

The concept of blending distinct interventions to improve outcomes for children and families has practical implications for professionals and front line services. Despite the potential of the blended model approach to supporting families with complex and concurrent needs, the authors acknowledge the current limitations.

Measures used within this study were non-standardised.. Whilst they were based upon the mutual concerns of the family, the project worker and the project manager, there is a need to enhance the objectivity of such findings by incorporating validated measures. .

Both in terms of IFSS replication and the evolving study of implementation, future studies could explore in greater detail the mechanism/s successfully driving a multiple implementation site and complexities around such implementation including defining core components across multiple interventions and fidelity issues.

However, given the novelty of the blended model approach, there are few other empirical studies to anchor this article onto. As such, further investigation is needed using larger sample sizes and explore the feasibility of this approach using a wider set of interventions.

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