Health Related Work in Family Intervention Projects

Final report from the Thomas Coram Research Unit, Institute of Education, University of London

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April 2012
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Acknowledgements and disclaimer

The research reported here was funded by the Department of Health, and benefited greatly from the support and advice of colleagues including Zoltan Bozoky, Claire Phillips, Andie Michael, Ben Robins, Tania Celani and Alison Elderfield, to whom we express our thanks. However, the views contained in this report are our own and not those of the Department.

Thanks are also due to the research advisory group, including Caroline Prichard, Andie Taylor, Helen Bedford, Clarissa White and Val Gillies. Special thanks go to Clarissa White and Cheryl Lloyd of the National Centre for Social Research for carrying out secondary analysis of data from the FIPs Information System to complement the qualitative work reported here, and for contributing such collegial and valuable insights into the development and analysis of the study.

We are particularly grateful to Michelle Cage, at the Thomas Coram Research Unit, for providing administrative support to the project, and for her patience and lynchpin role within the project team. Felicity Thomas was involved in the first stages of fieldwork in this study, interviewing parents and young people, and the work benefited greatly from her skill and insights at this early stage. We also thank Denise Odell, who joined the project as a student intern during the summer of 2011, and made valuable contributions to analytic discussions.

Special thanks are due to the families and professional stakeholders who gave so generously in sharing their experiences for the benefit of research, including staff in the four case study areas for their support of the evaluation process, often through difficult times for their local projects.

Finally, thanks also go to Professor Ann Phoenix at the Thomas Coram Research Unit for her valuable comments on an earlier draft of this report, and to the anonymous peer reviewers for such careful and constructive advice.
Executive Summary

Introduction

The research reported here has been carried out in the context of a strong policy emphasis on developing work with families with multiple problems in England. It was commissioned by the Department of Health as an evaluation of health related work by intensive family intervention services (formerly Family Intervention Projects, or FIPs), with the over-arching aim of helping intensive family intervention services develop their health-related work, and of informing policy in relation to intervention with families with multiple problems. This study built on (but has been separate from) an ongoing national monitoring of FIPs being carried out by the National Centre for Social Research.

In introducing this project report, it is important to note that the research did not comprise a substantive evaluation of family health outcomes. Rather, it was concerned to examine the relationship between processes and outcomes associated with health-related work in FIPs, and to learn from relatively well-developed practice in supporting the health and wellbeing of family members. Specifically, the study examined:

i. the work of family intervention services with family mental and physical health needs, in relation to assessment, support planning, and intervention;
ii. family members’ own priorities and perceived needs in relation to physical and mental health;
iii. multi-disciplinary approaches to work with child and family health needs in family intervention services;
iv. the extent to which family intervention services could achieve change in relation to family health, and the barriers and facilitators of that change; and
v. the extent to which change in key aspects of family health was maintained over time.

Methods

The study involved over 100 in-depth interviews with a variety of stakeholders, conducted in two phases:

1. A national picture
   Telephone interviews with FIP specialists and regional leads (n=11) were followed by telephone interviews with FIPs coordinators in 18 local authorities. Projects sampled covered urban and rural areas, large and small local authorities, and ranged from small projects (2-4 key workers) to large programmes (up to 25 key workers) operating several different types of family intervention service.

2. In-depth case studies
   Four of the 18 FIP services studied in Phase 1 were asked to participate in in-depth case studies. This phase of work involved: individual and group interviews with family intervention service key workers and specialist health workers; telephone interviews with professionals in local health agencies (primary care and specialist services); and interviews with 40 parents and young people, sampled from 20 families across the four areas. Family members were interviewed soon
after they had finished the FIP intervention, or when their case was close to being completed, and again, seven months later.

Phase 2 case study areas were selected as examples of well-developed practice in relation to health, and to incorporate variation in relation to geographical spread; urban and rural areas; local authority types; and variation in types of FIP delivered. An additional criterion was that the case study FIPs all had a specialist health worker in situ, employed or seconded using DH funding. The four areas were sampled to represent variation in the health professional employed, to illuminate the potential contribution of different health professional roles.

**Key findings**

The research aimed to complement the national quantitative monitoring of outcomes for families supported by FIPs, by offering an in-depth analysis of process and progress in relation to work with families, with a particular focus on their health needs. Despite the relatively large number of interviews (for a qualitative study) and the range of perspectives encompassed in those interviews, there was strong consistency in themes emerging from different data sources across the study.

**Health needs**

- Families referred to FIPs had significant but diverse health needs, including basic family and child health issues, and an apparently high prevalence of major chronic physical and mental health conditions.

- Underlying health problems were often a key influence on families' wider difficulties, for example in relation to anti-social behaviour or parenting problems.

- Health problems were often unidentified or unaddressed, because of:
  - lack of awareness or recognition of health issues or needs;
  - difficulties with management of health problems and with accessing and engaging with health services; and
  - priority given to more immediate concerns.

**Work with health**

- Health was a core focus for intensive family intervention, and FIP workers evidently played a key role in:
  - identifying family health needs, and enabling family members to recognise and prioritise health issues;
  - signposting and referring to health and related agencies;
  - coordinating multi-agency involvement; and
  - accompanying and advocating for families to secure engagement with health and related services.

- FIP projects across the country were highly consistent in their approach, and the research indicated that there were distinctive benefits from the FIP approach in
identifying and addressing health needs. Specifically, the duration and flexibility of the intervention enabled:

- the disclosure of health problems, through the development of trust and engagement between the worker and family member;
- staged and responsive approaches to the management of health needs; and
- intensive work in relation to the development of sustained and manageable change in health behaviour.

- FIP health specialists, seconded or recruited with Department of Health funding, were seen to play a key role in all aspects of work with health, but particularly in relation to key worker training and assessment of needs.

Health outcomes

- The study provided consistent evidence that FIP intervention was associated with sustained health gains for many families across many aspects of health need identified, including success in addressing complex inter-related health and social problems:
  - For some case study families, positive changes in health were marked, including resolution of long-standing drug or alcohol dependency, and concrete change in capacity to meet children’s basic health needs (e.g. nutrition).
  - For others, chronic or entrenched problems were not resolved, but there was evidence that families had gained competency and agency in management of chronic problems.

- Positive outcomes from work with the family may not be stable if outcomes are influenced by factors – such as physical health – which are beyond the immediate scope of the FIP.

Implications for policy

(1) **Families receiving intensive interventions often have significant unmet health needs**

The extent and complexity of families’ health needs, along with evidence that unmet and poorly managed health needs often underpin or contribute to families’ wider social difficulties, indicates that work with health is central to the task of intensive family intervention, and is critical to enable wider change in families’ lives.

(2) **An explicit theoretical base for intensive family intervention**

Policy and services in relation to intensive family intervention would benefit from an explicit articulation of the theoretical rationale for the principles which underpin the approach. Characteristics such as the duration and intensity of intervention, within a flexible and relational approach, had evidently played a key role in work on family members’ health. A clearly articulated theoretical base would be valuable in order to:
• inform the design of services and training of workers within a service with a diverse professional base; and

• facilitate the articulation of a logic model for intensive family interventions, which would develop the potential to demonstrate future social returns on investment and so provide a rationale for future funding.

(3) A strategic and operational role for primary care services

The research indicates a potentially valuable strategic and operational role for primary care services – and particularly general practitioners – in joint work with intensive family intervention services, to identify and address the complex health needs of families with multiple problems. Ad hoc relationships between GPs and intensive family intervention services are unlikely to be sufficient to address the challenges of meeting family health needs, and to achieve the potential benefits of joint working on a systematic basis.

(4) Embedding health expertise in intensive intervention services

Families with multiple problems face particular challenges in accessing specialist health services (e.g., adult and child mental health services; tertiary health services). There are likely to be distinct benefits in basing specialist health expertise within intensive family intervention services, specifically to support:

• assessment and training for assessment in relation to specific health needs;

• onward referral and access to specialist health services; and

• training for and/or direct work with families in relation to key health needs.

(5) The potential benefits of intensive intervention for family health

In-depth case studies in the present study were focused on well-developed practice, and cannot be assumed to be typical of intensive family intervention services across the country. The research does, however, clearly indicate the potential of intensive family intervention to improve health practices and outcomes in families living in extremely challenging circumstances, who have often not previously engaged with health services.

(6) Defining, monitoring and evaluating health outcomes

Definition, monitoring and evaluation of work with health in intensive family intervention services should take account of the following key points:

• **Stability of outcomes:** Positive outcomes from work with the family may not be stable if outcomes are influenced by factors – such as physical health – which are beyond the immediate scope of the intensive family intervention service.
• **Emergence of health issues:** Health needs may not be identified at initial referral, but may emerge over the course of the intervention, such that it could appear that the incidence of health problems has increased in association with intensive family intervention.

• **Service use and costs:** Use of specialist and universal health services may increase as a consequence of FIP involvement, because of the worker’s role in supporting access and engagement with health. This increase in service use may have implications for the calculation of cost effectiveness. The research does indicate, however, that addressing families’ underlying health needs can potentially result in longer term savings in relation to risks such as crime, anti-social behaviour, or child placement.

• **Expectations of change:** It is not realistic to expect that chronic physical and mental health problems will be wholly resolved as a result of intensive family intervention, and other problems (such as anti-social behaviour) may recur for families where underlying health problems recur or deteriorate.

The financial and social costs of ‘family troubles’ to society indicate the potential value of intervening with families with multiple problems. The research reported here demonstrates that health must be central to that intervention. Health problems, broadly defined, were clearly both a cause and consequence of wider social problems for families in the present study. Intensive family intervention – based on common, consistent principles, but customised to families’ diverse needs – can make a substantial contribution to improving the identification and management of significant and complex health problems, with concomitant benefits for wider social problems that intersect with health.
Health Related Work in Family Intervention Projects

1. Introduction

The research reported here has been carried out in the context of a strong policy emphasis on developing work with families with multiple problems in England. It was commissioned by the Department of Health as an evaluation of health related work by intensive family intervention services (formerly Family Intervention Projects, or FIPs), with the over-arching aim of helping intensive family intervention services develop their health-related work, and of informing policy in relation to intervention with families with multiple problems. This study built on (but has been separate from) an ongoing national monitoring of FIPs being carried out by the National Centre for Social Research.

In introducing this project report, it is important to note that the research did not comprise a substantive evaluation of family health outcomes. Rather, it was concerned to examine the relationship between process and outcomes from health-related work in FIPs, and to learn from relatively well-developed practice, in relation to support for health issues. Specifically, the study examined:

i. the work of family intervention services with family health needs, in relation to assessment, support planning, and intervention;
ii. families' own priorities and perceived needs in relation to health;
iii. multi-disciplinary approaches to work with child and family health needs in family intervention services;
iv. the extent to which family intervention services could achieve change in relation to family health, and the barriers and facilitators of that change; and
v. the extent to which change in key aspects of family health was maintained over time.

In this opening chapter, we provide a contextual overview of the background to the work. This overview does not seek systematically to review the evidence on intervention with families with multiple problems, but rather aims to situate the FIP approach – and hence the research reported here – within a broader conceptual understanding of 'troubled' families.

1.1 Background

1.1.1 Families with multiple problems

Families who experience multiple problems pose specific challenges for policy makers and service providers, because of the extent and complexity of their needs. Matos and Sousa (2004, p66) described the concept of a 'multi-problem' family as follows:

‘families that do not hold a particular symptom, but instead are characterized by a chaotic style of interaction and the presence of a chain of problems affecting an indeterminate number of members, varying in quality and quantity across a wide range’.
Such families can be seen as ‘troubled’, in relation to the problems they face, but also as ‘troubling’ to society, in terms of the costs and consequences of the difficulties they face (Ribbens McCarthy, Hooper and Gillies, in press). In this sense, the complex disadvantages faced by families with multiple problems are often positioned within academic and policy discourses about ‘social exclusion’ and/or ‘social capital’, multi-dimensional concepts which share a concern with social relationships and with active participation in society and in customary ways of life. Both concepts are contested in the academic literature (e.g., Daly and Silver, 2008), but in the context of a practical concern with policy and services, the key point – which is common to the different theoretical constructions of social exclusion and social capital – relates to Matos and Sousa’s (op.cit.) description of a ‘chain of problems’. Complex, multi-faceted disadvantage is:

‘associated both in the short term and into adulthood with a range of adverse outcomes: social, educational, relational, health and crime .... These problems have costs to both the child and society generally.’

Buchanan (2007, p191)

In a similar vein, Devaney and Spratt (2009 p639) argued that there is a particular need for policy makers and professionals to attend to children exposed to multiple adversities in childhood:

‘it is the multiplicity of issues that increases the risk to the child of experiencing social exclusion in adulthood ... rather than any one overriding factor, although some factors may be more significant than others. Therefore child welfare professionals should become more focused on identifying and prioritising responses to these particular children.’

This imperative does not only apply to child welfare professionals, however. The costs to society of complex child and family problems are well-established, and can include costs associated with involvement in crime as well as the need for additional educational provision, or for placement in residential or foster care (e.g., Scott et al, 2001).

There is evidence that health services have a particularly important role to play in addressing problems associated with social exclusion, and more specifically, in identification and support of families with multiple problems (e.g. Wilson and Mullin, 2010; Chase et al., 2010). At the same time, a body of literature indicates that families with multiple problems incur particular costs for health services. For example, Romeo and colleagues’ (2006) analysed the costs of supporting children with severe anti-social behaviour, in a sample of 80 three to eight year old children referred to Child and Adolescent Mental Health Services (CAMHS) in England. They reported that the greatest cost burden was borne by the children’s families, for example, in terms of the need for additional time spent on household tasks as a result of children’s behaviour, or in relation to material damage to the home caused by the child. However, these authors also noted that the most significant service costs were incurred by health services, including GP visits related to child behaviour, but also because the children had high rates of Accident and Emergency attendance and/or hospital admissions, often related to accidents.

Complex childhood adversity has also been shown to affect children’s physical health. Flaherty and colleagues’ (2006) analysis of data from the US Longitudinal Studies of Child Abuse and Neglect examined links between children’s exposure to adverse
experiences in childhood (e.g. caregiver depression; caregiver experience of violence; criminal activity or problem drinking by a member of the household) and illnesses requiring medical attention. Notably, in the context of the present study’s focus on the health needs of ‘multiple problem’ families, children with exposure to four or more such adverse experiences were almost three times more likely to have an illness requiring medical treatment.

In considering the needs and characteristics of families with multiple problems, Bronfenbrenner’s ecological systems model of child development provides a useful theoretical framework (see Figure 1), indicating the relationship between multi-dimensional risks and later outcomes. This theoretical framework attends to the context for an individual’s development, with levels of analysis ranging from culture and society (the macro-system) to proximal influences such as family functioning (the micro-system). In the context of understanding families with multiple problems, the model is particularly valuable in emphasising the inter-relationships between different sub-systems, whilst also recognising the individual as an active influence within those systems (see, for example, Bronfenbrenner, 2005). Thus, for example, Kotch and colleagues’ (2008) prospective study of links between early neglect and later aggressive behaviour demonstrated a cumulative interaction, such that risk of developing aggressive behaviour was predicted by gender (boys were at higher risk), age at which neglect began (with higher risk from neglect in the first two years), caregiver depression, and living in an unsafe neighbourhood.

Figure 1. Bronfenbrenner’s (e.g., 2005) ecological model of child development

Kotch and colleagues’ (2008) findings about the risks associated with early neglect indicate the importance of attending to experiences of child maltreatment in families with multiple problems. Neglect is the most common form of child maltreatment in the UK. National data on children who became the subject of a child protection plan in the year to 31 March 2010 show a high prevalence of neglect (43.5%) and emotional abuse (27.9%) (DfE 2010). At the same time, it is likely that a significant minority in the UK population have experienced neglect or emotional abuse, but not had formal social services involvement. May-Chahal and Cawson’s (2005) UK study of a random general population sample of almost 3000 adults reported that 6% had experienced serious absence of physical care and 5% serious lack of supervision, and 6% were defined as emotionally maltreated.
Of course, not all children in families with multiple problems will have experienced maltreatment, but these prevalence figures suggest a need to attend to this facet of complex disadvantage. Studies of child maltreatment also provide a valuable illustration of the ways in which problems of parenting are often intertwined with other indicators of disadvantage, including parental poverty and unemployment, poor maternal mental health, and alcohol or substance misuse (e.g. Berry et al. 2003).

1.1.2 Intervention for families with multiple problems

The research summarised above indicates a particular need to identify and intervene with families with multiple problems, raising a question about the most effective approaches to intervention. An international body of literature has highlighted the potential value of intensive whole family approaches to intervention in families with multiple problems, for example: Berry and colleagues’ (e.g., 2000, 2003) research in the US; Sousa and colleagues’ studies in Portugal (e.g., Matos and Sousa 2004; Sousa and Eusébio 2005; Sousa and Costa 2010); research by Knot-Dickscheit and Tausendfreund in the Netherlands (e.g. Knot-Dickscheit and Tausendfreund 2010; Knot-Dickscheit et al. 2010); cross-European research for DfE on work with families of young people at the ‘edges’ of care (Boddy et al. 2008, 2009a); and of course, evaluations of Family Intervention Projects and other intensive family intervention services in the UK, as discussed below (e.g. White et al., 2008; Dixon et al., 2010; Ofsted 2011).

This international body of literature raises a fundamental question about the extent to which there are commonalities across different approaches to intensive family intervention. What does the work actually involve? Looking across different studies, consistent features of intensive family intervention can be found.

Foremost, is an emphasis on family-centred, ‘whole family’, or family systems approaches, consistent with a growing literature that highlights the interaction of mutual influences across family subsystems (e.g., Kuczynski, 2003; Bronfennbrenner 2005; Smith 2010; Sturge-Apple et al. 2010). In a similar vein, a holistic family-focused approach is consistently described in the literature cited above as necessary to address complex, dynamic and inter-related difficulties within the family system.

In this context, it is interesting to note that policy and legislation in Denmark, Germany and Italy stipulates ‘whole family’ approaches to intervention (Boddy et al., 2008, 2009b). In Danish law, for example, the helhedsprincip (unity principle) in the 1998 Service Act specifies that intervention should address the whole family (and not merely its component parts). Similarly, in Italy, debate about the meaning and implementation of ‘essential levels of care’ (Innocenti and Vecchiato 2007, cited in Canali 2008) has highlighted the concept of a care pathway (percorso assistenziale), concerned with the well-being of the family as a whole (and not merely its individual components).

In a study of work at the ‘edges’ of care (where placement was being planned or considered) in Germany, Denmark, France and England, interviews were conducted with practitioners involved in providing support and intervention services for young people (aged 10-15) and their families (Boddy et al. 2009a). Workers in this study consistently emphasised the need for family-focused approaches. For example, the manager of social care services in one local authority district commented that a Hilfeplan (the
statutory plan for social services intervention) is a plan for the family, not just for the child.

Within family-focused approaches, research has also highlighted the need for practical help to enable families to achieve concrete change. Thus, one German practitioner in the ‘edges of care’ study (op.cit.) spoke of doing ‘very close work with family’, explaining that this approach was necessary to ‘motivate them, help them to see what it is possible to achieve with the child’ (op. cit. p114). This emphasis was echoed by interviewees across countries in the study. As one service manager in England observed:

‘When you go into a family the worst thing you can say is “We’ll do an assessment” or “We’ll talk again”. They need something concrete.’

(op. cit. p54)

Berry and colleagues’ (2003) review of US research on interventions with child neglect placed similar emphasis on concrete, realistic steps within family-focused approaches:

‘In viewing the family as the focus of attention, the caseworker’s goal becomes to support and assist families in their roles as caregivers. Parents deserve to be made aware of what is expected of them and what needs to change’.

(p17)

Within this over-arching frame, these authors highlighted the following key components of successful intervention, within a focus on the family: involvement of mental health services; treatment for substance misuse; concrete services; and in-home services.

In England, intervention for families with multiple problems have also emphasised whole-family approaches, within the framework of an assertive and persistent approach to intervention. For example, a recent report from Ofsted (2011, p7) highlighted the key characteristics of successful engagement with young people at risk of entering care, and their families, including:

- approaches which built on the strengths of the family;
- persistence, reliability and flexibility including the speed of response;
- open and honest communication, including in relation to what was and was not acceptable behaviour;
- an approach which valued family members, listening to, respecting and understanding the family’s perspective;
- clarity about expectations and what needed to be done;
- improvements and the consequences for the family of not doing so;
- identifying and addressing the needs of all family members;
- working alongside the family to achieve shared goals; and
- a clear plan to sustain progress when the involvement of the service ceased.

These characteristics have much in common with the principles underpinning Family Intervention Projects, which have been characterised as using an ‘assertive’ and ‘persistent’ style of working to challenge and support families to address the causes of their anti-social behaviour (e.g., White et al. 2008).
1.2 Family Intervention Projects

1.2.1 The development of Family Intervention Projects

Family Intervention Projects (FIPs) were first established in England in 2006, as part of the Respect Action Plan (Respect Task Force 2006), as a model of intensive intervention targeting families who were at risk of eviction and potentially homelessness, as a result of anti-social behaviour (ASB) (see Parr 2009). The model of intensive intervention on which they were based drew on the Dundee Families Project, established in 1996 to work with families who were homeless, or at risk of becoming homeless, as a result of anti-social behaviour. Following Dillane and colleagues’ (2001) positive evaluation of the Dundee Families Project, similar programmes of intensive family intervention were developed in England and Scotland (see White et al. 2008; Parr 2009; Pawson et al 2009).

In England, a network of 53 projects was established by April 2007, representing a shift away from enforcement approaches, towards ‘whole family’ support aimed at addressing the underlying causes of anti-social behaviour (Nixon et al., 2010). The intervention model was framed within the former Labour government’s Respect Agenda as ‘a ‘twin track’ approach where support measures to address the underlying causes of problem behaviour are combined with the threat of disciplinary sanctions if families fail to fully engage’ (Nixon et al., 2010, p306).

The focus of intensive family intervention services has also developed since FIPs were first established. From April 2009 to March 2011, all local authorities received central government funding for intensive family intervention, under a number of different funding schemes which led to the development of a variety of family intervention services, working with different target groups, including:

- **Anti-social behaviour FIPs**, including those first established in 2007 under the Respect Action Plan, as well as projects established later, with a broader remit of supporting and challenging families who may not be involved in criminality or anti-social behaviour, but who have other significant problems such as drug and alcohol misuse, mental health problems, and domestic violence.

- **Child Poverty FIPs**, established with the aim of supporting the poorest families, who are not anti-social, but who experience multiple problems that make it more difficult for them to secure and maintain employment.

- **Youth Crime Action Plan FIPs**, working with families with children and young people at risk of offending.

- **Housing Challenge FIPs**, again targeting families at risk of eviction.
At the same time, a programme of **Intensive Intervention Projects** was developed as an extension to FIPs, aiming to ‘turn around the lives of up to 1,000 of the most challenging and problematic young people each year’ (see Flint et al. 2011).

FIP services can be delivered in a number of ways: through outreach support to families in their own homes coordinated by a key worker for each family; through support in temporary accommodation (‘dispersed tenancies’) in the community; or through 24-hour support in a residential care unit where the family live with project staff (see for example, White et al. 2008). While modes of delivery can vary, the approach to intensive family intervention has been described in guidance for service managers as having the following critical features (CWDC 2011, p15):

i. recruitment and retention of high quality staff, including a range of experiences and backgrounds;

ii. a key worker model to ensure families’ engagement and trust and enable the family to feel responsible to the worker;

iii. small case loads of five or six families at one time, reflecting the intensity and complexity of the intervention, to enable the development of trust and rapport, and a persistent and tenacious approach to working with families and coordinating other agencies;

iv. a whole family approach, described in the guidance as collaborative and empathetic;

v. the ability to stay involved as long as necessary, seen as essential for tackling deeply entrenched issues;

vi. the use of sanctions with support to encourage families to agree to work with the family intervention service;

vii. the scope to use resources creatively, for example to buy in services and goods, to enable positive lifestyle change and reward engagement; and

viii. effective multi-agency relationships to ensure families get the services and interventions needed.

As this summary indicates, guidance on intensive family intervention services in England corresponds to findings from the broader international literature noted above, particularly in its emphasis on family-focused relational work, and in persistent intervention based on concrete steps towards change.

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1 For a detailed description of Family Intervention Project services, see, for example, Dillane et al. (2001); White et al. (2008). Projects vary in size and structure, but share common elements. Key workers have small case loads (on average 5-6 families per full-time worker) and diverse professional backgrounds, providing a mix of expertise and experience within the team.
1.2.2 Evaluation of Family Intervention Projects

Dillane and colleagues’ (2001) evaluation of the original Dundee Families Project concluded that the model had the potential to deliver long-term benefits for families who engaged well, in:
- avoiding high cost options including children becoming looked after;
- reducing the incidence of behaviours (including crime) with potential long-term cost implications for society; and
- promoting the quality of life of family members.

Similar positive findings have been reported in subsequent evaluations of intensive family intervention services in England and Scotland (e.g. White et al. 2008; Pawson et al., 2009; Dixon et al. 2010; Flint et al., 2011). In England, Family Intervention Projects have been evaluated at a national level by the National Centre for Social Research (NatCen). This work is ongoing, following the continuing development of the FIPs as outlined above. It has included the development of an Information System, a computerised database in which key workers employed in FIPs record information about the families with whom they work, at particular time points in the intervention (referral, support planning, case reviews, and exit planning). The system allows for longitudinal analysis of change in key measures, with the caveat that it is based on worker report rather than independent measurement. Consequently, data relate primarily to those families who have engaged with FIP services (although some information is available on those who were referred but did not engage); there is no comparison group, and monitoring data do not provide an independent assessment of quantitative impact (e.g., Warrener and Ireland 2008; Gregg 2010).

Whilst bearing in mind those caveats, it is of note that findings from the ongoing evaluation of FIPs – and of similar models of intensive family intervention (e.g., Flint et al. 2011) – have been very consistent, and consistently positive. White and colleagues’ (2008) mixed methods study focused on the work of the first 53 Family Intervention Projects, and indicated that FIPs were successful in improving a range of outcomes for families with significant and complex needs, although the study also highlighted some areas of variation, including projects’ assessment of families’ needs, and parenting interventions on offer. Warrener and Ireland (2008) reported on the first 90 families for whom data were available from the FIPs Information System, and noted significant improvements in a range of outcomes, including anti-social behaviour problems, housing enforcement actions, and risk factors including health, domestic violence, and child protection issues.

1.3 Meeting families’ health needs

The FIPs Information System has recorded some health information about families involved with FIP services: for the family as a whole and for individual family members. In line with the broader academic literature outlined above, these data have consistently indicated that families have significant and complex health needs. For example, White and colleagues’ (2008) evaluation indicated a high prevalence (63%) of significant health problems among both parents and young people. Problems reported included, for example, alcohol and substance misuse, domestic violence, lack of care for the physical health needs of children in the family, and mental health problems. Depression was
reported among 50% of family members (69% of those aged more than 16 years). More recent data published by the NatCen team, on families supported to March 2010 (Dixon et al. 2010), show a similarly high prevalence of health problems: approximately one third of families referred for intensive family intervention were described as facing issues associated with mental health, and/or alcohol and substance misuse, and one fifth were reported to have problems involving domestic violence.

Intensive family intervention has been linked to improvements in health outcomes. Ofsted’s inspection of 11 local authorities in England (Ofsted, 2011) examined the experiences of 43 families involved with intensive support services and suggested that, as a result of intensive family intervention:

‘Many of the young people and parents reported improved confidence, self esteem and mental and physical health related to the support they had received. This included supporting their access to appropriate health care for the diagnosis and treatment of physical or mental health conditions.’ (p14)

This finding of amelioration is supported by NatCen’s national monitoring, which reported significant improvements in health domains according to workers’ report. Dixon and colleagues (2010) noted that 56 per cent of families who engaged with FIPs had experienced a reduction in the number of health risks, including mental or physical health and drug or alcohol problems, between the Support Plan stages and leaving the family intervention. However, the NatCen series of evaluations has also found that work in relation to health can be particularly challenging. White and colleagues’ (2008) interviews with families suggested that family members often felt they had not received much help with health issues, and that:

‘where key workers had been unable to arrange for a parent or child to access a particular health service then this had resulted in families feeling let down by a FIP’.

(op.cit., p 87)

Although improvements in health measures were reported, addressing health was one of the less successful areas of FIP intervention with families. Much greater success was reported in other areas such as crime and anti-social behaviour, and family functioning. Health gains were also more difficult for families to maintain after the intervention than other areas of improvement. Of 283 families followed up by the NatCen team nine to 14 months after they had exited the FIP intervention, less than two-thirds had maintained reported gains in measures of their health (compared with 84% maintaining improvements in relation to family functioning) (Dixon et al., 2010).

A number of potential factors could underpin these findings in relation to health. First, it should be noted that FIP workers involved in White and colleagues (2008) evaluation often reported some difficulties in cross-agency working with health services. Second, Dixon and colleagues’ (2010) analysis illuminated factors that influenced the likelihood of achieving positive change in relation to health. Notably, the research showed that the
longer the family intervention, the better the chances of achieving both ‘some’ and ‘full’ success with health problems such as poor mental health, lack of exercise, poor diet and drug or alcohol misuse. There was further evidence that families from black and minority ethnic communities were less likely to achieve full success\(^2\) with health problems, and that families with at least one child subject to a child protection plan were less than half as likely to achieve some or full success with health problems.

### 1.4 Aims and objectives

The NatCen evaluations indicate the importance for FIPs of attention to families’ health needs – emphasis that is wholly consistent with the evidence from a wider international literature on families with multiple problems, described above. The potential value of long-term intervention to support families’ health has also been demonstrated through evaluations of Family Nurse Partnership, a model of long term intervention for young parents, developed in the US and successfully implemented in England (e.g. Olds et al., 1986; Barnes et al. 2011). However, the research reviewed above has also indicated the challenges for Family Intervention Projects in achieving improvements in relation to family health. Considered as a whole, these findings raise a critical question about how – and how well – FIPs work in relation to families’ health needs.

At the time the research reported here was commissioned, the Department of Health invested £6 million to improve the health contribution to FIPs (£3 million in 09/10 and £3 million in 10/11). The present study was not commissioned to evaluate that investment, rather it reflected a growing recognition of the need for research (a) to consider the ways in which FIP services work with health and (b) to identify models of good practice in overcoming barriers to work with family health.

For example, White and colleagues’ (2008) account of the challenges for FIPs of working with health agencies raised questions about how FIPs teams define, assess, and intervene with families’ health needs. While the NatCen FIPs Information System records the judgements and factual evidence available to FIPs workers at different stages of the intervention project, there is a need for further work to consider the processes by which the work is carried out, and the relationship between workers’ judgements (and related intervention strategies) and families’ perceptions of their own health needs, and of the extent to which these are met.

In considering how FIPs work with families’ health needs, it is also relevant to consider how those needs are prioritised in the context of the perceived focus and emphasis of intervention through FIPs. In discussing assessment, White and colleagues’ noted variation across projects in the extent to which the methods used were focused on criminologic or child welfare assessment. Arguably – given the early emphasis of FIPs on addressing anti-social behaviour – this variability in emphasis could be seen to reflect a historic dichotomy in England between youth justice and child welfare systems (e.g. Held

\(^2\)‘Full success’ was defined as no longer having a problem identified in the initial Support Plan when leaving the FIP, and ‘some success’ as having partially addressed a problem.
2006). However, as Goldson (2007) observed – and as is vividly illustrated by the characteristics of families referred to FIPs – the conceptual distinction between the child as victim (troubled and in need of protection) and the child as threat (in need of control, correction and punishment) is rarely so clearly defined in practice.

Against this background, the research reported here focused specifically on FIPs’ work in relation to health. ‘Health’ was broadly defined to ensure that, within the frame of this qualitative study, workers’ and family members’ conceptualisations of health were not constrained by researcher-led definitions, and as such, ‘health’ was taken to include not only physical, mental and emotional health, but also issues such as the ability to manage interpersonal and familial relationships.

The study aimed to investigate both process and outcome of FIPs on key aspects of family health in order to understand the mechanisms and context in which outcomes are achieved. The overarching aim was to inform the development of policy and practice for intensive family support services, with regard to health-related work and inter-agency working in relation to health. The specific objectives were to determine:

i. FIPs workers’ perceptions of family health needs, and the extent to which these are emphasised in intervention and support planning;

ii. the extent to which FIPs account for and respond to families’ own priorities and perceived needs in relation to their health;

iii. the extent to which FIPs take a multi-disciplinary approach to determining child and family needs;

iv. the extent to which FIPs achieve change in relation to key aspects of family health and the barriers and facilitators of that change; and

v. the extent to which change in relation to key aspects of family health is maintained over time.

Within this framework, the project was not intended as a formal evaluation based on quantitative assessment of change in health outcomes for families participating in FIPs. Rather, the project comprised an in-depth semi-longitudinal qualitative study, offering detailed insights concerning the barriers and facilitators of health-related work in FIPs, the relative emphasis on health issues in work with families, and the extent to which the intervention was associated with perceived health benefits for family members. As such, it offers a valuable complement to the quantitative data on health outcomes reported in the NatCen monitoring exercise. The current study provides detailed insights into the experiences of families supported by FIP projects, and an analysis of the processes and mechanisms by which change is achieved.
2. Methods

The research was conducted in two phases over a 24 month period (see Figure 2).

(i) First, to gain a national picture, interviews were conducted with FIP specialist advisors and regional leads, and with FIP managers/coordinators in 18 local authorities.

(ii) Subsequently, in-depth case studies were carried out in four local authorities, involving interviews with FIP workers, parents and children, and workers in health agencies that had involvement with the case study FIPs.

Given that the financial and temporal constraints of the research did not permit large-scale evaluation of health outcomes, and in light of the study’s broad aim of informing the development of guidance for health-related work in FIPs, the second phase of research was focused on examples of relatively well-developed practice, in relation to support for health issues. Thus, the four case study FIPs were selected on the basis of preliminary analysis of Phase 1 interviews with project managers.

Figure 2. Research design

2.1 Phase 1: A national picture

The first phase of project work aimed to provide an overview of FIP working practices and key issues in relation to families' health needs. Given known variation across the country in the size and stage of development of FIP projects, it was decided that Phase 1 work should be carried out in two stages. To gain a national overview and inform sampling of local projects, telephone interviews were first conducted with all eight FIP regional leads,
whose role was to provide strategic support to FIP projects, linking with central government, and with three national FIP specialists who were responsible for supporting local projects with specific aspects of operational work. Both FIP specialists and regional leads worked across projects and areas, enabling cross-project links and sharing of experience and good practice. These interviewees were thus also well placed to provide a national overview of Family Intervention Projects.

Following preliminary analysis of these data, telephone interviews were carried out with FIP project managers/coordinators in 18 local authorities. These 18 projects were selected to include a range of urban and rural areas, large and small local authorities (eight unitary, three metropolitan, three large county councils, and four inner and outer London boroughs). Projects ranged in size from small projects with two to four key workers, in one case covering a single deprived estate, to large well-established programmes with a team of over 25 staff working across several different types of FIP and covering all or most of a local authority area. Well established projects were well represented, reflecting the aim of identifying models of well-developed practice in relation to health, and ten of the 18 included an Anti-Social Behaviour (ASB) FIP that had been set up in the first wave of FIP development in 2007. Well-developed and well-established practice in relation to health was assessed in terms of the nature and extent of involvement with health services and professionals, including representation by health agencies at strategic or operational level (e.g. involvement in FIP project steering group; health funding of work with FIP; secondment of health professionals to FIP team; examples of successful joint work between FIP and health services).

The purpose of this first round of interviews was twofold:

(a) To provide an overview of key issues for the Family Intervention Programme in relation to work with health, including:
   - FIPs role in assessment and intervention with family health needs;
   - support and training for FIP key workers in relation to health;
   - the role and contribution of health agencies or specialist health workers within FIPs to intervention with families;
   - the role of health agencies and specialist health workers within FIPs in assessing change and outcomes in families; and
   - barriers to and facilitators of cross-agency working with health (e.g. in relation to referral, information sharing).

(b) To provide structural and background information about FIP projects, in order to provide a context for analysis of the health-related data outlined above, and to inform sampling for Phase 2 of the research, in relation to:
   - the organisation and staffing of the FIP (e.g. whether local authority or voluntary or independent sector provider; staffing; budget; how long established; use of DH funding for a specialist health worker);
   - sources of funding for the family intervention service offered (e.g. child poverty, ASB, youth crime);
   - referral pathways into the FIP;
   - frameworks for, and the extent of development of, multi-agency working, particularly with health agencies.
Each interview took approximately one hour, and was carried out at the project coordinator’s convenience. With two exceptions (due to equipment failure), interviews were digitally recorded and a detailed note was made of each interview. Interviews were analysed thematically using the constant comparative method\(^3\), in relation to the study objectives, the areas of interest listed above, and other issues emerging over the course of the research.

### 2.2 Phase 2: Local case studies

#### 2.2.1 Case study area sampling

Following preliminary analysis of Phase 1 interviews, four of the 18 FIPs were asked to take part in the second phase of research\(^4\), involving in-depth case studies of health related work. It was explained that the case studies were selected as examples of well-developed practice in relation to health, and to incorporate variation in relation to the following criteria:

- geographical spread within England;
- urban and mixed urban/rural areas;
- local authority types (e.g. unitary, London borough, county council); and
- variation in types of FIP delivered.

One key selection criterion, given the study’s concern with learning from good practice in relation to health, was that the case study FIPs all had a specialist health worker in situ, employed or seconded using DH funding. The four case studies were sampled to represent variation in the health professional employed, to illuminate the potential contribution of different health professional roles.

Ensuring confidentiality was a key concern for the study, given the distinctive characteristics of many FIP families, especially within their local areas. To minimise the risk of identifiability of families or workers who were interviewed, Table 2.1 provides only a brief summary of case study area characteristics. In addition, quotes and case examples are sometimes unattributed in this report in order to protect confidentiality.

#### 2.2.2 Case study area interviews

Phase 2 of the study involved interviews with the following groups (see also Table 2.2):

- families (parents and children) who had recently completed, or were close to completing, the FIP intervention;

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\(^3\) The constant comparative method is originally derived from grounded theory, originally developed by Glaser (1965). Within the context of the present study, this analytic strategy involves systematic comparisons, to compare each item of data (e.g. each interview) with all others that may be similar or different in order to develop conceptualisations of the possible relations between various pieces of data (see Thorne 2000).

\(^4\) At the time of the initial telephone interview, all project coordinators/managers were asked for permission to be re-contacted by the research team for the second phase of research, and the criteria for selecting the four case studies was explained.
within FIP services, managers, key workers and specialist health workers, including interviews with the key workers for the families who were interviewed; and

- professionals in health agencies that had involvement with the family intervention services.

**Table 2.1 Case study area characteristics**

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A London borough, with a well-established project delivering a variety of FIPs. In this case study, the health specialist employed had a professional education in health visiting.</td>
</tr>
<tr>
<td>B</td>
<td>An urban local authority, with a well-established project delivering a variety of FIPs. In this area, the project had employed two clinical psychologists, drawing on additional sources of local funding.</td>
</tr>
<tr>
<td>C</td>
<td>An urban local authority, with a well-established project delivering a variety of FIPs - but more recently established and with less variety of FIPs than Case Studies 1 and 2. This project had used DH funding to second a health trainer from the PCT.</td>
</tr>
<tr>
<td>D</td>
<td>A county council, where the FIP project encompassed a city and a wide rural area. The city FIP was well-established, and incorporated a variety of projects, but work in the rural area was more recently established. This project had used DH funding to second a community psychiatric nurse.</td>
</tr>
</tbody>
</table>

**Table 2.2 Case study area interviews**

<table>
<thead>
<tr>
<th>Category of interviewee</th>
<th>Area A</th>
<th>Area B</th>
<th>Area C</th>
<th>Area D</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIP project staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project manager/senior supervisor</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Key worker group interview</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health specialist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health agency stakeholders</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Families</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents: initial interview</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Parents: follow-up interview</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Children and young people: initial interview</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Children and young people: follow-up interview</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Family case overview: key worker report</td>
<td>5</td>
<td>3&lt;sup&gt;5&lt;/sup&gt;</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

<sup>5</sup> Interview with one key worker providing information about three families, as other key workers had left.
**Family Intervention Project staff**

Face to face interviews were carried out with a range of FIP staff. In each area, at least one group interview was conducted with FIP key workers, along with an interview with the FIP health specialist, and finally, an interview with the project manager/co-ordinator. This second interview with the manager served to explore in depth issues arising from the initial telephone interview with the manager, along with any other emergent themes from interviews with other FIP staff.

FIP key worker group discussions and interviews with FIP specialist health workers addressed the following areas (adapted as appropriate according to respondents’ roles):

- respondents’ professional qualifications and role in work with the FIP;
- case load of FIP families;
- the needs of FIP families worked with, including (but not only) specific health needs;
- the role of health agencies and specialist health workers and their contribution to intervention with families; barriers to and facilitators of joint working with health;
- the perceived impact of FIPs on participants’ health; and
- advice for other local authorities in the development of health-related work in FIPs.

Interviews and group discussions addressed respondents’ experiences and views of key considerations in relation to these themes, and also sought accounts of health-related work in relation to anonymised families with whom respondents had worked.

**Health stakeholders**

Telephone interviews with professionals in health agencies included a mix of service managers and practitioners, all of whom had involvement with the family intervention services. These were employed by a variety of different services ranging from primary care to specialist provision, and included:

- GP;
- children’s centre development manager;
- community health trainers service manager;
- school nurse;
- joint agency child abuse team worker;
- domestic violence service workers;
- educational psychologist;
- adult/family psychotherapist;
- CAMHS social worker
- CAMHS clinical psychologist;
- specialist lead nurse;
- substance misuse service worker;

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6 Note: It was intended that at least one focus group interview would be carried out with FIP key workers in each case study area. However, both Areas A and B had large FIP teams, and in these areas it was requested by managers that more than one group discussion should take place, to allow all those workers who wished to participate to take part in discussions, and this request was accommodated by the research team.

7 Whilst taking care to protect confidentiality.
• adult mental health service worker.

Interviews with health stakeholders addressed the following areas:
• respondents’ professional qualifications and role in work with the FIP;
• the needs of FIP families that the respondent had worked with (if relevant), including specific physical and mental health needs;
• the role of health agencies and specialist health workers and their contribution to intervention with FIP families;
• barriers to and facilitators of joint working with health;
• the perceived impact of FIPs on families’ health;
• and advice for other local authorities in the development of health-related work in FIPs.

Family case studies
A key aspect of this study was in-depth interviews with parents and young people from 20 families across the four areas. These were carried out at two time-points:
• when the FIP intervention had recently ended, or was close to completion; and
• approximately seven months later.

Initially, it had been intended to combine data from these interviews with a review of family case files, but following consultation with the research advisory group, it was decided that an interview would be carried out with each family’s key worker instead. This decision was taken because (a) the size and complexity of family case files posed difficulties for secure file transfer between FIP services and the research team, and (b) it was judged that an interview with the FIP key worker would provide a useful strategy for triangulating family interviews and offer a professional perspective on presenting health needs and on the extent of change achieved by each family, as well as any specific issues involved.

In each area, families were sampled and approached for initial consent by the case study area FIP managers and key workers. Managers were asked to approach the five families who had most recently completed the FIP intervention, or if that was not possible (because too few families had yet completed), families where the intervention exit was being planned. This sampling procedure aimed to avoid selection bias and identify cases that were typical of families with whom FIPs worked. The ‘index’ child for interview was nominated by the FIP as the child in the family with whom most work had been carried out, to ensure that children who were interviewed had sufficient experience of the FIP to feel able to comment on the service. Managers and key workers were therefore reminded to sample according to the criteria above, rather than selecting ‘interesting’ or unusually ‘successful’ cases, or those which had involved extensive work with health.

Since the research team did not carry out sample selection, the elimination of any selection bias cannot be guaranteed, and confidentiality requirements meant it was not possible to compare case study families to those who were not selected for the case.

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8 Parents were asked for permission for the researchers’ to access FIP information on their case at the initial interview, and all participants agreed.
studies. We did, however, consider how the health needs identified by case study families compared to the national picture identified in our Phase 1 interviews, and to the health needs of FIPs families in the most recently available NatCen data (Dixon et al. 2010). To provide additional contextualisation for the case studies presented in this report, secondary analysis of monitoring data was carried out for two of the four case study area FIPs, using data recorded in the national FIP Information System. This work was carried out for the study by the NatCen research team (see Appendix 1). This analysis showed some differences between case study areas and national monitoring data, but patterns of variation are likely to reflect key area characteristics (such as local populations) and were broadly in line with the national picture.

Parent and child interviews
Parents and children were interviewed face to face in the family home, with consent sought by telephone when arranging the visit, and then again at the beginning of each interview. Among the parents/carers interviewed, most (16/20) were mothers, but the sample also included three fathers and one grandmother. All but three of the families were of White British ethnicity; two were South Asian and one family was of Black Caribbean origin. The children and young people interviewed ranged in age from four to 17 years (mean 11.6 years); seven were girls. Parents and children were interviewed using parallel topic guides (described below), but – reflecting the wide variation in their ages – interviews with children and young people were adapted as appropriate for their level of understanding.

Initial interviews were arranged soon after contact details were provided by the FIP, and families were contacted again seven months later. Families were contacted for the follow-up interviews by phone, and if unreachable by phone (e.g. if a mobile number was no longer working), then contact details were checked with the FIP team. Perhaps unsurprisingly, given the instability in many families’ lives, there was some sample attrition between the initial and follow-up interviews, and one third of those originally interviewed (7 out of 20 families) did not take part in the second round of interviews. Attrition varied across FIP case study areas: four out of five families in Areas A and D took part in follow-up interviews, but only three of the five families in Area C, and two of the five in Area B participated in the second round of interviews.

Of the seven families who did not take part in the follow-up interviews, six were unreachable within the study timeframe. For five of those families, telephone numbers were no longer available, or no response was secured when researchers telephoned, or called round and left notes, or wrote, to the family’s last known address. In all cases (and in line with families’ original consent for researchers to access case information from the FIP), support from the FIP team was sought to contact families, but this proved unsuccessful.

In two cases (Area A and C), families’ addresses and phone numbers were still valid, but attempts to make contact were unsuccessful. For both of these families, difficulty in making contact was judged by the research team to indicate indirect refusal. Both were families of secondary school-aged children, one family of White British origin and one of South Asian origin. In one case, the FIP key worker reported that children in the family were the subject of care proceedings (and were subsequently removed from the family home). It seems likely that this situation (and the timing of our follow-up contact in this context) accounted for the difficulties making contact. In another case, initial telephone contact was made with the parent, but (s)he was unwilling to speak to the researcher at
the time of the call, and was subsequently unreachable despite several attempts. In both these cases, it was decided by the research team that the parents were indicating that they did not wish to take part in the follow-up, and attempts to make contact were terminated.

The challenge of achieving follow-up interviews with families was made more difficult by changes in FIP services at the time of the research. Area D FIP closed completely after local authority funding was withdrawn, and the other three FIP projects all experienced reductions in funding, with concomitant restructuring and loss of some staff. These changes had implications for FIP projects’ capacity to maintain links (and up-to-date contact details) when families were no longer involved with the service.

Key worker interviews
Interviews with family key workers were also affected by restructuring and funding changes to FIP services. Wherever possible, the family key worker him or herself was interviewed, but in some cases this was not possible, because the worker had left the project (e.g. because of redundancy or restructuring). When the family key worker was not available, another member of staff was interviewed about the family, if possible – but this relied on the availability of another worker who had sufficient knowledge of the family to discuss the case files. Hence Table 2.2 shows the number of families about whom FIP workers were interviewed, and not the number of key workers interviewed. In some cases, workers were interviewed about more than one family, and in Area B⁹, availability of staff with appropriate knowledge meant that key worker interviews were only conducted in relation to three families.

Initial interviews with families obtained information on family size, structure and key demographic characteristics such as employment and housing, but were otherwise open-ended, following a topic guide. The aim was to ensure that the interviews were sufficiently flexible to allow family members to discuss areas that they considered to be significant, whilst ensuring a focus on issues including the following:

- perceived physical and mental health, support needs and symptomatology of the individual respondent and other members of the immediate family;
- the health practices of the respondent and other family members, for example in relation to factors such as drug and alcohol use;
- experiences and evaluation of the role of FIPs in identifying and responding to families’ health needs;
- personal priorities in relation to physical and mental health, and desired change in relation to the respondent’s and other family members’ health needs;

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⁹ Follow-up work in Area B was additionally disrupted by other events affecting the FIP service, including a period of inspection.
• awareness of, and agreement with, intervention plans in relation to health; views of interagency working in relation to health;

• perceptions of the relative priority attached to health-related intervention alongside other aspects of work with families;

• barriers and facilitators in relation to health for the respondent and other family members.

The interviews explored, in particular, perceptions of change or improvement in relation to physical and mental health for the respondent and other family members since starting the FIP intervention. This included reported changes in levels of need; levels of service use; physical and mental health symptoms or health behaviours.

**Follow-up interviews** with family members were again open-ended, following a topic guide. Summary information about the family collected at the time of the initial interview was reviewed, to identify any areas of change (e.g. in employment status, family structure, or living arrangements). The remainder of the interview addressed the same topic areas covered in the initial interview, focusing in particular on any specific issues identified previously by respondents, and seeking evidence of maintenance, improvement or deterioration in relation to health outcomes for both the respondent and other family members. As with the initial interviews, the aim was to ensure that the interview structure was sufficiently flexible to allow family members to discuss areas that they consider to be significant, whilst ensuring a focus on issues directly relevant to the study objectives.

**Family key workers**
Family key worker interviews were carried out at the end of the follow-up period, and were conducted face-to-face where possible, at the worker’s convenience. In cases where the family key worker had left the FIP by the time of interview, a senior colleague (e.g. senior practitioner or supervisor) was interviewed instead. Interviews were conducted with reference to the family’s case file, and workers were asked to talk through the case, beginning with referral and presenting issues, and covering the process of work (including barriers and facilitators, and with particular attention to work involving health needs and/or health agencies) until the time of interview (including case closure if relevant, and any contact following case closure).

**Ethical considerations**
This research study did not require National Research Ethics Service approval, because it comprised a service evaluation within the terms of the NRES definition, but it was nevertheless submitted to and approved by an Institute of Education Faculty Research Ethics Committee (Approval FCH218). The project addressed a potentially sensitive topic (health and well-being) in the experience of a potentially vulnerable and disadvantaged group, and so particular care was taken to address key ethical issues in relation to each group of interviewees:

**Professional stakeholders**
Care was taken to ensure that workers who were nominated to participate by a senior colleague did not feel pressured to agree to participate, and understood that they could refuse to participate, or to answer any questions, or withdraw from the research at any point. All interviews were conducted at the convenience of respondents in so far as
possible, and ground rules were agreed for group interviews. Care was taken to ensure confidentiality of information shared by interviewees, particularly when discussing cases. Concerns about identifiability have been addressed through anonymisation in reporting, and discussion of case files was carried out with the prior permission of the parents who were interviewed.

**Family members**

All interviews were conducted with the freely-given, fully-informed consent of participants, and were undertaken by experienced researchers accustomed to addressing sensitive topics, and to research with children and families. Potential participants who met the selection criteria were given an information sheet about the study by their FIP coordinator or key worker, and asked whether a researcher could make contact to tell them about the research and seek their consent to participate. Families were only included if both a parent/carer and a young person gave consent; young people’s consent was not assumed just because parents agreed to take part. Participants were asked if they could be re-contacted approximately seven months later, and consent to participate was sought again at the time of the follow-up interviews. Each family member who participated in an interview was given a £20 gift voucher as a thank you for their time in contributing to the research (at both initial and follow-up interviews). Whilst there is some debate about the ethics of compensating participants in this way, this was judged to be justified for the present study, not least because of the time commitment involved in the in-depth interviewing. However, care was taken to ensure that the vouchers were not used to pressure family members to participate.

Interviewees were made aware that they could refuse to answer any questions or terminate the interview at any point. If an interviewee showed any signs of distress or discomfort (e.g., a child seeming restless), the researcher asked if they wished to continue, to take a break, or to stop altogether. All family members completed all interviews. Particular care was taken to ensure that participants understood that the research team was wholly independent of the FIP and the case study local authority, and that all information provided would be treated in confidence.

A research protocol on confidentiality was established to specify that confidentiality would be maintained, unless the researcher was concerned that someone might be at risk of being hurt. This was explained to potential participants before they made a decision about whether to take part in the research. Care was also taken to reassure family members of the confidentiality of the research, noting that comments would not be fed back directly to the FIP teams with whom they had worked, but anonymised within reporting from the study.

This attention to ethical considerations helped to ensure a high participation rate, since there is frequently a low response and recruitment rate in research with disadvantaged groups. No family members declined to take part in initial interviews, and, although there was some attrition between initial and follow-up interviews, this was not related to negative feedback about the research process. On the contrary, several parents commented to researchers or to their local FIP project (reported in feedback during key worker interviews) that they had enjoyed participating in the study.

**Analysis**

All interviews were digitally recorded. Those with family members (parents and children) were transcribed, and a detailed note was made of each interview with professionals.
The interview data were analysed thematically using the constant comparative method (see p24), with a designated member of the team leading analysis for one category of interviewees (e.g. health stakeholders) and other team members contributing through discussion and review in analysis meetings. Analysis focused on the specific research questions, along with themes and issues emerging over the course of the research. In addition, if a theme emerged from analysis of one category of interviewee (e.g., relational work with families highlighted by FIP key workers), analysis of other participant groups was revisited in relation to that theme to (a) triangulate, and provide a check on themes emerging (e.g., checking family members’ perspectives on relational work alongside workers’ accounts) and (b) identify higher-order cross-cutting themes in the data.

In keeping with the analytic frame described above, presentation of the findings incorporates analyses of both phases of work; data from the 20 family case studies and accounts of family health from professional stakeholder interviews are presented together. Chapter Three focuses on the characteristics and health needs of families using FIP services, before we move on to consider work with families’ health in relation to work with health services (Chapter Four) and FIP intervention in relation to families’ health (Chapter Five). Chapter Six considers evidence of the extent to which FIP intervention is associated with change in families’ health, and use of health services, and the extent to which change is maintained over time. Finally, Chapter Seven ends the report with a synthesis of key findings and implications for policy development.

Throughout, where interviews or case accounts are unattributed to specified sources, or where gender is disguised by using ‘(s)he’, this has been done in order to protect participants’ anonymity.
3. Family characteristics and health needs

3.1 Family characteristics

3.1.1 Case study families

Family structure
The 20 case study families varied considerably in family structure, including some small and nuclear families, but also lone parents and large families with four or more children. Thirteen of the 20 families were in lone parent households: 11 were lone mother households, of whom 10 were single or separated/divorced, and one was a widow. The sample also included one lone father and a separated/divorced grandmother who was a kinship carer for her grandchildren. Three of the families interviewed were step-families.

Family size varied from one to nine children (including up to six resident children), and eleven families had at least four children. Non-resident children included adult siblings, but also children who were in public care, and biological and step-children living with ex-partners or other relatives (such as grandparents). Non-resident children (including adult siblings and other extended family members) were often closely involved in family life, visiting regularly and/or occasionally resident. In addition, some of the parents interviewed suggested that the behaviour of non-resident parents could cause or exacerbate children’s problems, as the following examples illustrate:

*Every time I let them go ... every time I let them go there, there’s complications. ... Drinking, stuff like that and that’s why ... like last ... last time they were supposed to go there, [13 year old son] ended up in hospital ... because they ... they were supposed to go and see her and then she let them out and then they ended up drinking.*

(C4, initial parent interview)

*But now [child] doesn’t misbehave for me at all, it’s just [with] his dad he misbehaves more. He had a conversation with [my friend] a couple of weeks ago about why he misbehaves for his dad, and he was like ‘Well, ‘cause my dad lies to me about my mum and says that I hate my mum. I know I’m going to see my mum and he says I’m not’ – this that and the other. And I was just going ‘What?’*

(C2, follow up parent interview)

Family structures were also often marked by instability, and for seven of the 20 families arrangements changed significantly over the period of the study. These changes included:
- children becoming looked after, or returning from care (three families);
- a child in one family being placed in a residential school (because of special educational needs);
- changes in parental relationships (one family, where a previously non-resident father moved into the family home);
- an (adult) child returning from prison (one family); and
- a young person moving into independent accommodation (one family).
**Housing, education and employment**

At the time of initial interview, 17 of the 20 families were in local authority or housing association accommodation. One family owned their former council house, and two other families (both from Area B) were in privately rented accommodation.

All but two of the young people interviewed were engaged with education of some kind at the time of the initial interview, but educational arrangements varied, and included one young person in a residential boarding school, and others who were attending educational settings part-time. For example, two young people (both aged 15) were in part-time college education at the time of the initial interview. This account of educational engagement needs to be considered in light of the fact that initial interviews were conducted shortly after, or close to the end of, the FIP intervention, and – as discussed later in this report – educational engagement was often a key focus of FIP activity. For example, of the two young people attending college part-time, both had previously experienced problems at school; one had been persistently non-attending and one had been permanently excluded. In both cases, college admission (and support for their attendance) had been organised with the support of the family FIP worker.

The majority of the twenty parent/carers interviewed were economically inactive, and in receipt of benefits: 17 were neither in paid employment nor in education at the time of the initial interview, just two were in part-time employment and one was studying full-time. However, it should be noted that half the parent/carer sample reported significant physical or mental health problems (see below), and this may be a factor in relation to employment status for these families.

### 3.1.2 Professionals’ perspectives

The complexity of family structures among case study families is consistent with the national profile of FIP families (Dixon et al. 2010), and with managers’ and FIP key workers’ accounts of families involved with their services. For example, a project manager described one of the families engaged with their FIP project:

> We have one family ...we’ve been working with them for, I think about six months now, there are six children in the family so you can imagine, their age range is from I think about two up to 19. Some of them live, they live in and out of the home. They’re there sometimes, sometimes they’re not. Working with, the family were in chaos, [the children] were failing in education. One member of the family had sexual health needs – a 12 year old who was desperate to have a baby. And the family home, their home was at risk because of the noise and because of the conditions within the home. They were on the brink of child protection proceedings.

(PM8)

Project managers consistently described work with complex families. Specifically, their comments highlighted the inter-relationship between family problems and complexity and instability and family structures. This included inter-generational disadvantage, for example in work with families with ‘entrenched criminal and anti-social behaviour across generations’ (PM3). Involvement with crime was also linked to family instability, with family members (adults or young people) moving in and out of custody.
Another manager spoke of work with young families:

... where you know, there have been maybe multiple births in a very, very short space of time. [These are families] where there are likely to be attachment issues. So we may be working with families where you know, there has been previously a child born in to the family that’s actually been removed in to care. And then mum becomes pregnant again.  

(PM4)

Not all families involved with FIPs are large in size, but family size, and the instability and complexity of family structures, were often implicated in the multiplicity of problems that families were experiencing. One regional lead gave the example of a family with five children, of whom four had anti-social behaviour orders. She commented:

No one had been in the property for 20 years, and it took 20 visits to get in... There was five inches of impacted waste [on the floor] – that’s why they didn’t want people in.

(RL1)

All the FIP project managers interviewed gave examples which highlighted the inter-relationship between complex family problems and complex family structures. For example, PM2 described the following case:

Another family, the mother was taken into care at two... She had been abused on every level. She came into care and was then abused. She left care and returned home in [her] early teens and ended up on the streets as a drug addict. She was in danger and she had a child at 15 who was put up for adoption. She subsequently had a partner and had five children with him, three have got ADHD, the husband [also] has ADHD.  

(PM2)

As noted earlier, many families involved with FIPs were lone parent families, and particularly for this group, managers and other professional interviewees highlighted concerns about isolation. One (PM17) noted that ‘so many of our lone mothers are suffering from low level mental health issues which are having a real impact on their parenting’, and another gave an account of work with an isolated single parent with one child, who was schizophrenic and ‘hadn’t been out of the house for years and years, you know, and [was] very, very isolated’ (PM10).

Unsurprisingly, given these patterns of complex family structure and inter-related difficulty, FIP managers, specialists and regional leads consistently emphasised the importance of whole-family approaches, and commented on the importance of ensuring that FIP workers had relevant skills and experience for working with complex families. The complexity and variety of family structures means that, as one FIP worker (group interview participant, Area A) remarked, ‘there is no “one size fits all”’ in work with FIP families. These issues are discussed further in Chapter Five, in relation to the FIP approach to working with families to address their health.
3.2 Basic health needs

Interviewees in all stakeholder groups (FIP managers and practitioners, workers in health agencies, and parents and young people in FIP families) regularly described physical and mental health needs among families engaged with the intensive support services. Family members’ health needs were varied, but common themes emerged across data sources, and are summarised below. As well as more serious health problems (discussed below), a consistent picture emerged of key basic health needs, which were often unrecognised and/or unmet, or poorly managed. Lack of engagement with primary and specialist health care services was a strong theme to emerge across different data sources, and is discussed in depth in Chapter Four. In the context of the present chapter’s focus on family health, the implications of this lack of engagement were consistently described.

Key workers and project managers commented that certain health-related practices, such as harmful levels of alcohol consumption, poor diets, drug use, often appeared normalised within the local community. There was also evidence that unmet basic health needs posed a barrier to engagement with other services, including other aspects of the FIP intervention. One project manager highlighted the need to organise dental care for a parent with severe tooth decay, who then gained the confidence to participate in a group parenting programme.

3.2.1 Immunisation

Across national and case study interviews, key workers and project managers commonly cited low uptake of immunisation as a concern in their work with FIP families. One key worker (group interview, Area D) commented that this failure to use services was sometimes related to families’ prior experiences. She observed, ‘I have a mother that won’t allow her children to be inoculated because she has a fear of child death’, a fear which, she said, stemmed from the mother’s experiences of child bereavement.

3.2.2 Dentistry

Poor dental care and lack of use of dentistry services were consistently highlighted by project managers and FIP workers as a common cause for concern. Several respondents also noted that poor dental health had wider implications, in terms of self-esteem and confidence, and thus for engagement in other services (such as group parenting programmes) and even in helping parents to find employment. One FIP project manager (PM11) commented that ‘[w]e must have seven or eight [parents] with a whole new set of teeth’ as a result of FIP support in accessing dentistry. In one case study family (D4), a mother explained why she did not use dental services:

‘Don’t do dentists – I don’t have teeth. ... See I don’t need to go because I lost my teeth at 19. I had a violent partner. So I have never bothered with dentists.’

(D4, initial parent interview)

Dental care was not only an issue for parents, however, but was highlighted as a significant concern for children in FIP families. The mother quoted above also explained that she did not take her children to the dentist routinely, but would use emergency dental services for the children if necessary. In a different local authority, a FIP key worker (group interview, Area B) commented that it was ‘common for parents to have never been to a dentist themselves, so their children won’t have gone either’. One FIP
Regional Lead (RL1) spoke of ‘some tales of horror about the state of teeth’, and gave an example of a case where a FIP worker had provided toothpaste for a family, but then found the children trying to wash their hands with the toothpaste because they did not know what to do. This example may be extreme, but interviewees across the study described cases where (as RL1 said), ‘basic, basic things [were] not being done’ in relation to family health.

#### 3.2.3 Optometry

The professionals interviewed also noted concern about children with uncorrected or poorly managed visual impairments, again linked to low uptake of services and families’ problems with managing their health needs. A FIP project manager observed:

> sometimes with some of our families because they're so chaotic they just, they’re families that are just not getting the children’s eyes tested. And unless [the children] get their eyes tested and get their glasses they're not going to be able to actually settle in class, and see what’s being taught and so on.

(PM1)

A FIP key worker in another area (group interview, Area D) gave the following example:

W:  
I’ve got one little girl who’s on probably her seventh pair [of glasses], and she’s lost them last week again. I think they think they are worth nothing, that no one has to pay towards them. So they don’t respect them and take ownership of them. It’s quite interesting.

I:  
What do you do?

W:  
Go back to Specsavers and do a bit of groveling – because the child needs her glasses. But they’re going on a rope [round her neck] and I want another pair kept in school now, so she has a pair there if she loses the home pair.

#### 3.2.4 Diet and nutrition

Workers and managers consistently highlighted problems of poor diet, with concomitant under-nutrition and/or obesity among family members. As with dental and eyesight problems, poor dietary health was often seen as linked to other family problems, as illustrated by the following example from a FIP project manager:

> Diet is a biggy [a big health issue] – two teenage girls in one family are extremely obese, mum was in care herself ... how can she know how to cook a healthy meal she has not had a consistent adult role model. ... She thought she couldn’t afford to offer a healthy diet – we worked on menu planning. She went to Iceland and she showed us the bill and it was all chocolate and it turned out she was bribing her children with it. They were getting obese and bullied – it’s a vicious circle. It needs to be recognised and broken.

(PM18)

Similarly, in one case study family – a large family where several family members (adult and child) were overweight or obese – the key worker linked family dietary practices to the mother’s childhood experience of significant abuse and neglect:
She lived with an extremely abusive mum and dad and she was very, very, very physically abused ... and they weren’t fed either so she would steal so that she could survive, there wasn’t any food. So in terms of her relationship with food I wouldn’t say that that was particularly a balanced view in some regards.  
(Family D4, key worker interview)

In other cases, poor diet was seen to be associated with families’ chaotic lifestyles, and more specifically, with lack of parental understanding of children’s needs:

I took her food shopping so that she could better understand what she was feeding her children wasn’t appropriate, but with [this mother], because she felt she couldn’t manage the parenting on her own, because she was so reliant on her ex, domestic violent partner, she felt that she couldn’t do it. She didn’t know how to cook so for her it was easier to send the children out to play with a couple of chocolate bars than actually sit them down and do structured things together.  
(Family D3, key worker interview)

Poor dietary health was also linked to problems in the home environment – discussed further in the next section – and several respondents gave examples of families with no functioning cooking facilities, or of homes where poor hygiene posed a risk in terms of food safety so that children had frequent gastric illnesses.

Many FIP respondents related the prevalence of overweight and obesity to stress and low level mental health problems including depression and isolation, and commented on the need to develop activities and routines for children and families. As one key worker observed (group interview, Area B), this meant encouraging families to ‘[get] out and [be] doing things rather than sitting at home with the curtains closed watching TV all day every day’.

Being overweight or inactive were not concerns for all FIP families, and some respondents noted that under-nutrition was also a problem. One FIP manager commented that children who used their service often ‘go hungry’ during the summer when they did not receive free school meals. (S)he observed:

We don’t have a problem with obesity – some of the young people are lacking in nutrition. ... exercise is less of an issue as the kids are out on the streets possibly walking miles. Lots of the mums are thin, drawn and old looking.  
(PM2)

Family members themselves also commented that stress and problems within the family could affect aspects of family health like eating, or sleep. For example:

... before the FIP [was] involved, my family situation was so bad. So because of that, I didn’t have my meal properly, I didn’t sleep well, I didn’t do things properly. So therefore it affected my health.  
(Parent A5, initial interview)

3.2.5 Environmental health

Problems that could broadly be categorised as ‘environmental health’ issues were commonly cited as matters of concern among key workers and managers across FIP
projects. Poor hygiene in the home was consistently raised as an issue by FIP interviewees, and included problems such as rat infestations and accumulated rubbish. Relatedly, FIP key workers highlighted health and safety issues related to home organisation – including a case where the worker had found an open bucket of petrol in a small house with young children (Area B).

Environmental problems were also linked to poor housing conditions for some families. In Area B, a key worker gave an example of work with a family living in privately rented accommodation, where the home was very damp, partly as a result of flooding in the cellar. (S)he noted:

So the house itself was in a really poor state and I know that having spoken to my colleague, [she] was trying to get the landlord to make the improvements necessary. In our opinion it was substandard accommodation. But to get the landlord to do anything was an uphill battle.

(Key worker, Area B)

At the same time, this respondent noted that the family’s other difficulties (including disorganisation, depression, and drug and alcohol use) had exacerbated the challenge of addressing housing problems. The mother in this family also reported damage to the house incurred during episodes of violence in the home.

As well as poor hygiene in the home, poor personal hygiene was highlighted as a critical issue for some families. It was noted that this in turn could lead to more serious health problems. In one case family, a secondary school-aged child was reported to have a chronic head lice infestation which had caused severe dermatitis on their scalp. As noted above, frequent gastric illnesses linked to poor food hygiene were also mentioned by FIP workers and managers, and could be associated with wider problems such as disrupted education. This was illustrated by a case example given in one FIP key worker group interview (Area C, researcher notes):

This is a family with mum and dad, three secondary school-aged children, a primary school-aged child, and a toddler. They are living in a very small house – there is a severe lack of social housing in this area. So there is a lot of overcrowding and conflict in this home, and along with lack of cleanliness and poor diet, family members are often getting ill and illnesses pass easily between family members. That means children are missing lots of school and playing up at school – leading to them getting excluded and being at home more which leads to more overcrowding and conflict.

(FIP worker group interview, Area C)

### 3.2.6 Smoking

High rates of cigarette smoking were reported among parents and young people. The manager of Area C, for example, reported that 78% of families in her FIP smoked, and her decision to second a health trainer to the FIP (using the Department of Health’s £19,000 for health-related work) was informed by her concern to address the prevalence of smoking and poor diet among FIP families on low incomes. Similarly, the manager of Area A commented on the prevalence of smoking among FIP families, including smoking during pregnancy and in front of the children. She linked this practice to chronic health problems for children including asthma, and a lack of parental attention to chronic low
level coughs. In a similar vein, another FIP manager described her project’s activities in relation to smoking cessation, but also what (s)he termed ‘harm reduction’:

… which is very much about, actually if you’re going to have a cig do it outside, if you’re going to have a cig try and do it out of you know, view of the kid. Because if they see you smoking they’re more likely to want to start smoking themselves, that kind of thing.

(PM12)

This approach also raises a question about how best to support achievable levels of change in health behaviours and practices, a question to which we will return.

Unsurprisingly, heavy smoking was related to more significant health problems for some case study family members, including asthma and chronic obstructive pulmonary disease (COPD). Examples were also given of parents and children starting smoking at young ages, again reflecting intergenerational patterns of health behaviour. One key worker (Area D, group interview) commented, ‘If any of us have got 12 year olds in our families, they’re smoking.’ In one case study family, the mother had reportedly started smoking at the age of seven: both parents in this family were described as heavy smokers with chronic pulmonary problems (early stage emphysema, COPD, asthma) and several children in the family had asthma.

3.3 Social and emotional health

Social and emotional health problems were also consistently reported across stakeholders in the sample. Again, there was evidence of inter-relationships between different factors, such as a co-occurrence of depressive symptoms and heavy alcohol or recreational drug use (for parents and young people). Some young people spoke specifically of feeling stressed or short-tempered, and feelings of stress could be accompanied by physical symptoms, such as headaches or sleep problems. For example:

I get so stressed and just so stressed. I’m just a stressy person really, like if something’s not right I just don’t like it.

(Young person, C3 initial interview)

In relation to parental social and emotional health, professional stakeholders raised concerns about a lack of formal diagnosis of mental health problems such as depression and anxiety. Another common theme, across stakeholder interviews, was a high prevalence of relationship problems, including: domestic violence; child protection and safeguarding concerns for children, and adverse family histories; and poor sexual health for both parents and young people.

3.3.1 Domestic violence

Professional stakeholders consistently highlighted domestic violence as one of the most prevalent health risks facing families involved with FIPs. Examples included partner violence, but also violence between children and young people and parents. For example, in one case study family the key worker reported domestic abuse from an adult son towards other family members. In this case, the violence had in fact triggered the FIP
referral, after another child in the family sought accommodation in a refuge, following a physical attack by their sibling.

Partner violence was commonly reported in parent/carer’s relationship histories, and two case study mothers had ex-partners who were imprisoned at the time of initial interview, either wholly or partly as a result of domestic violence. However, the study also revealed examples of ongoing relationships which involved partner violence: in at least two other case study families, key workers reported previous incidents of domestic violence between the mother and her currently resident partner. Domestic violence was often said to be linked to – or exacerbated by – other problems such as debt and substance misuse. Reflecting the prevalence of domestic violence in FIP families, many FIP project managers discussed work with local domestic violence services, and of using funds specifically to develop training – described by one FIP manager (PM10) as ‘awareness raising’ – for FIP workers in relation to domestic violence.

3.3.2 Parents’ adverse childhood experiences

As is evident from examples given in relation to other aspects of health throughout this report, both parents and workers spoke about parents’ adverse childhood experiences, often including periods in care, and related these experiences to current difficulties. Among the case study families, reported childhood maltreatment included abduction, physical and sexual abuse, parental psychiatric problems and suicide, and major episodes of domestic violence (including an attempted murder of one parent by another)¹⁰.

3.3.3 Child protection and safeguarding

Given the remit of Family Intervention Projects, and the extent and complexity of problems described by parents, young people and professional stakeholders, it is not surprising that many FIP families had social services involvement at the time of referral to the FIP service, most usually as a result of child protection and safeguarding concerns. These concerns related to many of the issues documented in this report, including emotional and material neglect and risk in the physical home environment; risk to children and young people associated with domestic violence; physical and sexual abuse (actual or suspected/alleged); and significant risk-taking behaviour on the part of one or more young people in the family. In some cases, the local social services team had initiated the referral to the FIP project, but for other families, formal social services input followed FIP involvement.

3.3.4 Sexual health

It is perhaps not surprising, given the earlier observations about large family sizes, that use of contraception was highlighted as a key sexual health issue for many FIP families. This was illustrated by the following quotes from key worker group interviews:

¹⁰ Detailed examples are not given here, to avoid risk of identifiability from distinctive experiences.
‘Many FIP families are not using birth control, for some it is because they have little understanding of it, for others it is because they don’t know how to access it. Key workers often have to go with them to clinics otherwise they probably wouldn’t go. More often than not parents do want to access birth control once the key worker has talked to them about it.’

(FIP Worker Group Interview, Area A)

‘[There is a] lack of knowledge in the families about contraception and sexual health, including amongst the parents – not understanding how to use it, or not being able to manage it.’

(FIP Worker Group Interview, Area B)

The key worker for one case study family also commented on the importance of work with one of the young men in the family in relation to sexual health and contraception, noting that it was suspected that at least five of his ex-partners have had terminations following a pregnancy.

Project managers and key workers spoke about the need for FIP intervention to address sexual health, within a broad framework that encompassed supporting young people and adults in developing awareness of sexual health, and ‘healthy appropriate relationships’ (PM12). Awareness of sexual health issues was an evident issue for some FIP family members; participants in a key worker group interview (Area B) noted that it was not unusual for family members to disclose sexually transmitted diseases that had gone untreated for long periods of time. Similarly, one case study young person had been referred for treatment, with support from the FIP worker, in relation to a long-standing and previously unaddressed gynaecological problem.

The above-quoted project manager’s (PM12) comments about healthy and appropriate relationships corresponds to earlier observations about the prevalence of domestic violence, and the extent of adverse childhood experiences among parents using FIP services. These findings relate to another facet of concern about parents’ and young people’s sexual health: the impact of parental experiences of sexual abuse in childhood. Whilst data are not available on the prevalence of sexual abuse amongst family members participating in FIP interventions, this was consistently raised as a concern by professional stakeholders, and was an issue for some families within the case study sample. In one family, the teenage daughter had been sexually abused earlier in her childhood, and – while she had attended a therapeutic service as a result of this experience – at the time of the referral she was described by the key worker as engaged in sexually risky behaviour. This worker suggested that the young person’s behaviour was in part a reaction to her mother’s unsympathetic response to her earlier abuse – a response that the worker attributed to the mother’s difficulty in addressing the trauma of her own earlier abusive experiences. The key worker suggested that the mother needed:

to address her own childhood abuse and her abuse as an adult through domestic violence and to help her make the connections of that experience and how she minimised what had happened to her own child.

(Unattributed family key worker interview)
3.4 Child development

Interviews with all stakeholders (professional and family) indicated that FIP projects were identifying developmental concerns, or working with children and young people with known developmental problems, including emotional/behavioural difficulties (e.g. Attention Deficit Hyperactivity Disorder (ADHD), speech and language problems, foetal alcohol syndrome, and specific learning difficulties, including dyslexia.

There was some discussion among professional respondents about the extent to which some of these developmental problems related to diagnosed disorders, or were a reflection of the wider difficulties in parenting and children’s lives. For example, key workers in one group interview questioned diagnoses of ADHD:

*Children are being diagnosed with ADHD when it is actually an issue of poor parenting: every parent we work with says that their child has ADHD. A psychiatrist has said that sometimes they prescribe Ritalin because if they don’t it makes life worse for the children because the parent(s) will continually scapegoat the child, whereas if they get a diagnosis then the parents are happy with that and will view the child differently and treat them better. It is very common for parents to label their children with behaviour disorders when a large part of the problem is poor parenting practices, lack of stimulation, poor diet.*

(Area C, researcher notes on key worker discussion)

Concerns about links between child developmental problems and adverse parenting experiences were echoed by professionals across the sample. For example:

*[We see a] mixture, of diagnosed and self-diagnosed ADHD. Self-diagnosed is the hardest, [because] they’ve used it for years as an excuse for their poor relationship and the behaviour of their kids. ...Quite a lot of self-diagnosis goes on in these families – they turn up with files of their medical history. I’m thinking of one in particular, she is in the assessment stage at the moment – it’s quite disturbing about what she thinks is wrong with her and her kids. She turned up with the files of the problems she reckons they have had.*

(PM2)

In a similar vein, a key worker (Area D), discussing a family case study, observed:

*[Young person] is definitely the scapegoat. He’s got ADHD but if you go back into the chronology of the family, [his mother has] had mental health difficulties since day dot and [young person’s] been impacted by that since he was born. .... But right from an early age [young person] would cry in his cot and rather than [mother] going in to see to him to settle him [she] would leave the house until he stopped crying. So that screams out to me massive attachment issues for both of them and [young person’s] sixteen now. He’s got a lot of the same anxieties as his Mum but he displays his behaviour rather than [internalising].*

(Area D, family key worker interview)

The contested nature of diagnoses of ADHD, and the disorder’s association with parenting difficulties, are of course well-established within the academic literature (e.g. Todd et al. 2008). Nonetheless, FIP intervention was also often said to have been associated with identification of previously undiagnosed developmental problems –
including significant emotional/behavioural difficulties (such as ADHD), speech and language problems, and learning difficulties, including dyslexia. For example, in one case study family (C4), the key worker initiated a formal assessment of one young person whose father suspected he had undiagnosed learning difficulties; the worker reported that assessment revealed that the young person was profoundly dyslexic, but that this had not been identified previously by the school. At the time of the initial interviews with the family, this assessment had not yet taken place, but the parent voiced clear concerns about the son’s dyslexia, and suggested that his behaviour (which eventually led to his exclusion from school) could be traced back to the school’s failure to identify his learning needs:

Nothing really gets done much, like to do with like [young person’s] school and things and him being dyslexic and finding out whether he’s been ... whether he was dyslexic or not, because most of his troubles, I ... I imagine is, when I spoke to the school, is that he can’t get on with the work that he’s working at school, for whatever reasons. It’s not ‘cause he don’t want to do it, he can’t do it, so he just sits there misbehaving and now he’s fallen so far behind, he’s ... he’s not gonna catch up ... Well, this is the thing ... to find out whether he’s been tested and if not, can he be tested and I said to them “I asked you to test him ages ago and nothing’s been done about it”. So he’s gone off at all of his school and not being tested and fallen behind because of the school.

(Initial parent interview, C4)

The key worker described the above family as ‘notorious’ in the local area, with problems including family members’ involvement in crime and a history of drug and alcohol use. The young person’s dyslexia was evidently not the only potential barrier to education that he faced. Nonetheless, his experience indicates the possibility that specific learning difficulties may be missed if they are misattributed to social problems. In this family, by the time of the follow-up interview, two younger children were receiving speech and language therapy, as a result of developmental concerns raised by the parents and pursued by the FIP worker through the multi-agency Team Around the Family.

### 3.5 Chronic and complex health problems

#### 3.5.1 Physical and mental health

Chronic and significant family health problems were consistently reported by project managers and key workers in all areas, and were a key feature of the lives of many case study families. Chronic health problems for children and young people were often attributed by FIP workers to factors in the home environment. As discussed above, child health problems included: asthma linked to parent/carer smoking; dental problems or chronic lice infestations linked to inadequate personal care; overweight and obesity linked to poor diet and/or inactivity; and emotional and behavioural problems related to adverse care-giving experiences including prior sexual abuse for some children and young people.

In addition, family members and key workers within the case studies reported an apparently high incidence of specific health problems within this small sample of children and young people. These included:
• bulimic eating patterns;
• persistent and severe migraines;
• sleep disturbances (including an eight-year-old with significant behaviour problems who reported being prescribed sleeping tablets);
• hearing problems;
• self-harm;
• physical injury (including accidental or sporting injuries and injuries resulting from domestic violence);
• epilepsy;
• health problems linked to prematurity; and
• significant (e.g. hospitalising) episodes of alcohol and/or substance misuse.

Parents and carers in case study families were asked at initial interview about their current health, and about any changes in their health and well-being. Half (10/20) described current significant and/or chronic health problems as follows:

• three respondents reported respiratory problems (e.g., asthma, chronic pulmonary obstructive disease);
• five reported mental health problems (e.g., depression, anxiety, agoraphobia, panic attacks);
• four parents/carers described conditions causing chronic pain and affecting mobility (e.g., arthritis, sciatica and back/shoulder problems, ligament problems); in two cases, these problems stemmed from a previous major injury;
• one parent had problems with liver function, as a result of chronic alcohol addiction (key worker report); and
• one parent reported a gastric ulcer.

In addition to these current problems, parents and family key workers also reported a prior history of significant health problems for many families, including:

• significant physical injuries (e.g., related to domestic violence or to accidental injury, in one case from a fall, and in another from a road traffic accident);
• alcohol and/or substance addiction;
• cardio-vascular problems, including heart attack, strokes, and circulatory problems;
• septicaemia;
• cancer; and
• previous significant mental health problems including suicide attempts (three parents) and self-harming behaviour.

FIP professionals – regional leads and FIP specialists, project managers, and FIP key workers – also consistently reported a high prevalence of chronic parental health problems. These included:

• significant and/or disabling physical health problems, such as liver problems, blood borne viruses, sleep apnoea; diabetes; back and joint problems;
• chronic pain conditions;
• chronic emotional and mental health problems, ranging from undiagnosed or GP managed anxiety or depression to significant and hospitalising psychiatric problems; one project manager (PM2) reported that 80% of families involved with her service had some kind of mental health problems, albeit ranging in severity.
3.5.2 Alcohol and substance use

Professional respondents consistently commented on the prevalence of alcohol and substance use among parents and young people, and on the interaction of these influences on mental health. As one health specialist (Senior Mental Health Practitioner, Area D) observed, ‘alcohol is so much part of the culture that heavy use of alcohol becomes normalised and families don’t see it as a priority issue’. At the same time, she went on to say, ‘A lot of their mental health problems [FIP families] are generally in response to having a very miserable life so I think if you are able to tackle some of those things that contribute to that then you’ll see an improvement in the mental health’.

Parents and young people also expressed concern about alcohol and substance use – both in relation to their own practices, and in relation to other family members. One young woman, who said she had been smoking cannabis since she was 10 or 11 years of age, gave the following account of the effects she perceived from her drug use:

Now, suddenly now Year 11 I’ve clocked. It’s messed up my head. It has like, because I used to be bare [really] clever. I could go in my school and I could put my head down. Now I have to read and ... I go back and read it again to make sure I’ve read it properly, where before I could just read it in my head and go through. Now my lips have to move, because I can’t, my head won’t read it for me.... My concentration span’s gone. (...) if you smoke and then like someone pissed you off, I will not smoke but I’ll put the zoot [cannabis cigarette] away and then I’ll be chilling and then someone will piss me off in a text and it’ll be a silly little text, but if I weren’t [smoking] it wouldn’t affect me how it would. But it would get me like angry and emotional, then everything would come back in my head and then I wouldn’t want to go out. I will smash up my room and it’s just like it would get you in a more emotional way, whereas if I didn’t [smoke] I would have read the text and text back laugh out loud. I would find it funny.

(Young person follow up interview, unattributed)

A fifteen year old in another area described his experience of having to attend hospital due to episodes linked to drug and alcohol use:

I: Have you ever been in hospital?

YP: If I’m getting drunk too much. ... And overdosing on ketamine.

I: Okay. What happens there then? Tell me about ... was it just one time? Or have you been in hospital more than once for that?

YP: Twice. ...For drinking ... and then once ...

I: And then once for the ketamine.

YP: Yeah.

I: Okay so what happened, tell me about the drinking, what happened?
YP: Do you know Frosty Jack’s\textsuperscript{11}? The big three litre bottle? I think I drank about half of that. And then got into a fight with some man, and then ... And then ended up in the park, and then my mates phoned the ambulance.

(Young person follow up interview, unattributed)

Some parents and FIP key workers also commented on problems associated with parents’ reliance on prescription tranquillisers, as was illustrated by the experience of one case study family, where both mother and key worker partly attributed problems with social services to the mother’s use of prescribed tranquillisers:

I’ve put the phone down on [the social worker] a couple of times, so she’s been a bit hostile with me after that, and I’m just like well don’t say this and don’t say that, just leave it. There’s no need for you to bring that up, that’s none of your business. ... Just about my mental health and my medication - ‘You shouldn’t be on medication.’ Well you don’t know me so it’s not for you to judge is it? My mental health worker thinks I should be on it, so I’m on it – simple. That’s why she tried to come to my mental health meetings and I was just like ‘No. I’m staying on my medication, I’ve taken myself off my Diazepam, which is what you wanted, so you can’t complain.’ But yet she still ... she picks every little thing and she’s down my throat constantly.

(Parent, follow-up interview, unattributed)

After [serious domestic violence] she went on some quite strong medication from the doctor and she was very, very shaken up as you would expect, I suppose being physically hurt. ... [Mother] unfortunately remained on this high level of medication despite several attempts ... to try and have that reduced to help her find it more easy to manage her day to day life. Unfortunately she was under such a strong influence from the medication she was on it was very hard for her to manage typical life at the same time. And as a result ... [child] went and lived with his dad. Previously they had shared care arrangements. ... It was meant to be a temporary arrangement. Then ... because of [mother’s] presentation on this high level of medication they felt that it wasn’t appropriate for her to have [child] back. They obviously didn’t think that she was able to manage caring for him on this high level of medication. So [I] continually tried to help her reduce, help her get support to reduce her medication. That’s only happened recently unfortunately, so in this time she’s only had reduced contact with her son which is very sad.

(Family key worker interview, unattributed)

3.5.3 Death and bereavement

Perhaps unsurprisingly, given the extent of families’ health problems, several FIP project managers gave examples of cases where a family member had died during, or after, the intervention period. For example:

\begin{ex}
\end{ex}

\begin{footnote}
\textsuperscript{11} White cider, 7.5% ABV. Source: http://www.drinkaware.co.uk/facts/alcohol-facts-and-information/cider
\end{footnote}
There have been two deaths of parents [since our FIP was established]. One had done really well, she was quite a big drinker but she had really turned around but then she got an infection in her liver and died. Also a father [who was] entrenched in IV drug use.

(PM11)

In addition, parents’ experience of bereavements – for example among extended family members - was cited by some professional interviewees as an influence on other aspects of their health behaviour. As noted earlier, one mother was said to be reluctant to vaccinate her child because of fear linked to experience of child death; in another case study family, the key worker described the parents ‘going into panic mode’ when a young person was experiencing severe migraines, because the father ‘had experienced lots of bereavements, including a sister who died following a brain tumour’. One young person (Area A) also spoke of the worry (s)he felt about the impact of a series of bereavements on their mother:

It’s like she was ... for a very long time and after my father passed away, she was, like, didn’t really know what to do. And then after that her brother passed away and her mum passed away and then she had really bad problems.

(Young person initial interview, Area A)

A case study parent described the impact that bereavement and significant illness had on her and her children, as detailed in the following extended quote:

P: Years ago [my health was] not too good really. I went through cancer, lost babies, [I was an] emotional wreck really. Depression kicked in, but the last two years I’m gradually building myself back up and my confidence as well. It does take a lot though. I’m still up and down with my stress levels now, trying [to] find my footing, but I’m doing quite well at the moment.

I: You said you had cancer. ... [Did you have] your children at that time?

P: Yeah, I had all three, yeah. ... It was hard really to be honest. I didn’t think I’d survive, because my mum died, passed away with the same disorder. So, I thought, well, all I can go and do is party and I did party in front of the kids too and then I clicked in that I shouldn’t be doing things like that, moved away from the area and tried to sort myself out from there really.

I: Yeah, and you talked about depression. Has that been, is that ongoing or is that something that’s ...?

P: No, that’s been going on since [I was] 15, 16 because I had abuse from my father when I was a kid. So it’s just been uproar really, and but now I haven’t got all that and I’ve got to think about the future now.

(Parent initial interview, unattributed)
3.6 Summing up: complex and inter-related health problems

The analysis presented in this chapter indicates that health – in its broadest sense – is a fundamental issue of concern for families involved with Family Intervention Projects. Moreover, health problems are evidently not straightforward. As one project manager (PM11) observed, ‘Some days it’s all about nits, other days there is a risk of suicide’. Case analysis and professional stakeholder accounts demonstrated that parent and child health problems were often complex, with inter-related physical and mental health issues. These were often exacerbated by poor housing and family environments, and because underlying health conditions were not being managed as a result of difficulties with access to services.

For example, two case study parents, in different areas, were living with chronic pain which at the time of referral was poorly managed through limited use of health services. Both had previously attempted suicide. One of these parents, at the start of the FIP intervention, was managing her pain with a combination of anti-depressants, codeine-based painkillers, and amphetamines. Critically, for many families, health problems appear to be a key influence on other difficulties in family life. As one FIP project manager observed:

> from the families that come through there’s so many undiagnosed health issues, that unless you get that right, you know, children are not going to gain good outcomes.

(PM16)

The following chapters analyse how FIP services work with family health, before going on to analyse evidence of improvements associated with health-related work.
4. Working with health

The recognition and identification of family health needs, and support for families in accessing and engaging with health services, were very commonly described as key priorities for the intervention. However, work on health issues was often seen as challenging, for a variety of reasons related to structural factors within health agencies, as well as to families’ understandings and engagement with health. Reflecting these challenges, a consistent picture emerged of family intervention services’ work with family health – from analysis across all stakeholder groups, including family members and health workers in related agencies. There were two key strands to this approach: work to address family difficulties in accessing and engaging with health services; and direct work with families in relation to underpinning health issues, as part of the FIP intervention with the family. In this chapter, we address the identification and emergence of family members health needs, and family members’ use of health services. In considering work with health and with services, the analysis presented here also addresses the limits of FIP workers’ expertise in working with health, and relatedly, projects’ use of Department of Health funding for specialist health input.

4.1 Identification and emergence of family health needs

4.1.1 Health literacy and understandings

FIP workers consistently reported that most families appeared only to have a basic understanding of health-related issues and the factors which contribute to health and illness. This not only included individual health issues (such as managing basic health needs as noted above) but also extended to broader aspects of health, such as managing interpersonal and familial relationships.

Interviews indicated that some aspects of health were more visible – or more likely to be recognised as problematic for families – than others. For example, diagnosed illnesses and health conditions were recognised as health concerns and discussed by case study respondents. However, FIP workers frequently commented that health-related practices, such as harmful levels of alcohol consumption, poor diets, smoking and substance use, were often seen as normal within the local community or in relation to parents’ own childhood experiences. Key workers in Area B described families’ lack of knowledge around cooking and healthy eating as part of a cycle of poor parenting which passes down the generations. Similarly, senior practitioners in Area D made the following observations.

R1: Issues such as diet/exercise won’t be something that is on their radar. There are [health] issues that frequently require prompting by the FIP worker – particularly sexual health.

R2: Another issue is that certain lifestyle choices and behaviours are intergenerational and also very common in the community in which the family lives so the family often won’t see these things as a problem – for example, smoking, what they eat.

(FIP worker group interview, researcher notes, Area D)
There was a common perception among FIP workers and managers that some aspects of health appeared to be unknown to families – not ‘on their radar’ – until they became apparent through discussions with key workers. One element of this appeared to relate to the normalisation of ill-health within family histories, or a lack of awareness of the potential impact of past abuse on present understandings. A key worker in Area D described a family where, (s)he said, the mother’s experience of partner violence and childhood sexual abuse had affected her response to her own children’s maltreatment:

She’s normalising the abuse of her own children because of her own experiences. The experiences are brushed under the carpet.

(Area D, family key worker interview)

At the same time, parents and young people spoke of connections between their circumstances and/or past experiences and their health status or health behaviour. For example:

Well I was out of school for about nine months. Like the whole time I went to sleep during the day.

(Young person, D4 initial interview)

I’ve started [a healthy diet] at the minute, because I was eating because like of what happened like with my mum and my dad, I’ve been kind of comfort eating a little bit. ...Like once I got so mad at all that and sad and I ate like a load of cheese and onion rings. I had about six packets of them. And I started being sick, but I just eat myself, I just eat until I start being sick.

(Young person, A3 initial interview)

Examples such as this show how health status, and perceived health, is situated within the wider context of families’ lives.

4.1.2 Assessing health needs: ‘a minefield’?

Given the complexity of families’ lives and their health needs, as documented in Chapter Three, the assessment of health would appear to be a critical area of practice for Family Intervention Projects. One health stakeholder observed, ‘it’s a minefield’:

if you’re thinking about the families that FIP is working with, it’s not straightforward and the health could be about the family, it could be about the child, it could be one or other having an impact on the other, and it’s about having the understanding what is causing what and ensuring that services are connected up. And not only services for the children but the adult services as well.

(Area A, senior manager with responsibility for Children’s Centres)

All 19 of the FIP project managers interviewed reported that workers addressed health within the initial family assessment, and described some training for workers in relation to health assessment. In areas that had recruited health specialist workers using the Department of Health £19,000 grant, these professionals often contributed to training of key workers. For example, the FIP project manager in one area (PM15) described their rationale for using Department of Health funding to establish training by CAMHS that aimed to support FIP workers’ assessment of families:
I’ve kind of guided that [training] as the most appropriate place is around that assessment period, because obviously for me... the assessment is the pivotal bit in the FIP, and [it] is about absolutely getting that right in terms of ... being clear about what the needs really are and what therefore interventions should be put in place, and looking at kind of plan with the family around, okay these are your issues this is what we need to input. And obviously as I said with these families it’s very clear to me, you know probably in every situation the mental and emotional health for the parents and for the children and young people will be a key issue.

(PM15)

Assessment was carried out over a series of visits with the family in the weeks following referral. This process allowed the gradual emergence of health issues as trust developed (see Chapter Five), but professional stakeholders also commented that this staged approach enabled a fuller understanding of health needs, because families were seen repeatedly over a period of weeks, and at different times of day. For example, a health stakeholder, from a domestic violence service (Area D), said: ‘they’re not looking at one aspect, they’re looking at the whole ... you know, what’s happening in this family. And the families are involved in that process’.

Another experienced mental health practitioner – a psychologist seconded to the FIP team in Area B – highlighted the value of the FIP approach in illuminating the wider context of mental health:

I’m trying to imagine some of the families if they had come to the clinic and seen me in the clinic. I probably would have had a completely different impression of what was really going on. To see the family as they really are, I’ve been so shocked that that is how the family is actually functioning and you can see this boy screaming horrendous things and windows being smashed and you can see it how it really is. If that had been in a clinic setting then you would have missed a lot of that or even the standard that they are living in, their houses are, when FIP have first got involved, are really, really unpleasant to live in, so seeing that as well.

(Area B, psychologist)

The difficulty of assessing mental health needs when clients have other inter-related problems was discussed by many interviewees. For example, a senior mental health practitioner, seconded to the FIP in Area D using Department of Health funding, observed:

There are many [health] screening tools available, but these are not particularly useful for FIP because they just show that FIP families score highly in terms of mental health issues. But this doesn’t necessarily mean that their needs can be best met by specialist mental health services.

(Area D, mental health practitioner)

A health stakeholder from a substance misuse team in the same local authority area made a similar observation:

If somebody’s using [alcohol or substances] in that house, you can’t assess their mental health until that’s been tackled, because that can be affecting that. I mean the reality is, we get so many people that come through the service that are
drinking and have mental health problems, so they say, or their GP says, and they stop drinking or they cut their drinking down and miraculously, their life is so much better.

(Area D, substance misuse practitioner)

A FIP worker in Area C provided a further example of the difficulty (especially for non-health specialists) of assessing health needs in families with complex problems, in an account of work with one case study parent:

More recently, we can’t place our finger more recently on what her problem is, whether it is [drinking]. ... she’s had alcohol testing which come back negative and we know she uses a lot of prescription painkillers and we can’t quite work out, ‘cause often she presents as slurred, incoherent, sometimes quite jokey when we are having quite serious conversations. And one of our concerns is that she makes a joke, she’s incoherent, she presents as being intoxicated but I don’t think she’s drunk. We can’t work out if it’s a mixture of some sort of mental health problems, misusing prescription drugs, misusing illegal drugs, or alcohol, or a mixture of the lot really. It’s difficult for us to assess exactly what it is.

(Area C, FIP family key worker)

4.2 Access to and engagement with health services

4.2.1 Families’ capacity to address health needs

Corresponding to the apparent normalisation of poor health, family members often appeared to have little agency with regard to addressing their health and wellbeing. This related to factors including lack of understanding of what needed to be done, mistrust of professionals, and past attempts to seek help being experienced as thwarted or unsatisfactory. At the same time, families who ‘normalised’ poor health appeared to have low expectations in relation to their health, and this apparently impacted on their sense of agency in the management of health problems. These inter-related issues were summed up by one FIP manager:

I think with mental health there’s an unwillingness to agree that there is a problem. Not all the time but quite often. Also especially if you’re talking about depression, it’s just a sheer inability to take action. You know they know there’s a problem but they’re actually too exhausted or just don’t have that impetus to do anything about it. With physical health problems it can be that they actually don’t prioritise it, other things are more important.

(PM6)

The previous chapter included an example of a case study mother (D4) who was diagnosed with chronic obstructive pulmonary disease (COPD) after the key worker had supported her to seek medical advice. This mother, who had been in care as a child as a result of severe neglect and physical abuse, had started smoking at the age of seven. Asked in the initial interview about the impact of COPD on her life, she said:
Just my breathing and the coughing and ... well it’s terminal anyway. So ... it ain’t going to stop. Even if I give up smoking it’s not going to go away. It might get a little bit easier but it ain’t going to go away.

(D4, initial parent interview)

The FIP key worker’s account of supporting the mother in addressing her smoking illustrates the ways in which inter-related factors in families’ lives can pose a barrier to change:

I thought that one of the smoking nurses she saw was really, really good... They were very welcoming and very non-judgemental and there was one doctor had given [the mother] Zyban12 [but she] forgot to take her tablets so I’d send her a text in the morning “don’t forget your tablet” and I wrote a sign on her bedroom wall saying “tablet” and I said stick this somewhere. But because everything was so chaotic she just found it impossible. So then she’d feel guilty and not go back to the doctor.

(D4, family key worker interview)

As these examples illustrate, for a variety of reasons, some parents felt little power to change their health practices or address health needs. For some, including the parent quoted above, difficulty in managing health was exacerbated by a wider distrust of health professionals.

For families living with multiple problems, professional stakeholders noted that it appeared difficult for them to prioritise health needs over other incidents and concerns in their lives. Crises – for example in relationships, with housing, with debt and with law enforcement – often took priority over addressing health needs or attending health appointments. Several FIP managers commented that families sometimes did not engage with services, or respond to attempts to engage them such as appointment letters, because they were overwhelmed by their difficulties and the chaos in their lives. For example:

When families lead a very, very chaotic life, children aren’t necessarily getting in to school, [and] health appointments might not be right up there in terms of [where] someone’s priorities are.

(PM4)

Parents were often described as being reluctant to disclose or seek help for health problems because of fear that engagement with health issues could give rise to child protection proceedings. However, professional stakeholders also cited case examples where parents’ failure to engage with health problems had contributed to the decision to move towards child protection proceedings and placement of children in public care. For example:

This is one of the main things in the child protection plan is just be available, show that you can answer phone calls and deal with this stuff. I mean, with

12 A prescription anti-smoking medication.
health, one of the main neglect issues is [12 year-old’s] had awful psoriasis on her head and the head lice, and that has been largely untreated. There was one point where [parent] missed 16 dermatology appointments with the hospital and it was just not fair really because this is a girl whose scalp is falling off at points, really chronic head lice and psoriasis. [Parent] will say she is treating it but I don’t believe she is, I believe actually if she was sitting down with her daughter every night and combing her hair and washing it with the right products and attending those appointments it wouldn’t be anywhere near as bad as it is, and as a result of that [young person] always wear her hood up, I think, because it is so bad.

(Family key worker interview, unattributed)

We’ve got a mum who was referred through social care. Children had been on the child protection plan for a significant amount of time, the key worker meeting mum, and ... mum ringing the police quite regularly saying that she felt that people were outside of her house in the middle of the night. ... And having those initial discussions around the assessment, the key worker was very concerned that there was an underlying mental health issue. And as time went on, sadly the children were removed and through that process mum had to undertake a psychological assessment through the legal framework because nobody could get mum to engage in that with just her GP, and there was sort of queries around whether it was needed or not you know, but actually when she was assessed she did have a significant mental health problem that she was unmedicated for.

(PM16)

4.2.2 Using primary health care services

There were consistent accounts (from all stakeholders) of families failing to use, or misusing, primary health care services especially General Practitioners. Some managers reported low levels of GP registration, but even when families were registered, difficulties in using health services were commonly reported by workers and family members.

Several project managers and key workers described how families tended to use hospital Accident and Emergency services instead of primary care provision, as the following examples indicate:

And [the mother] sort of had a bit of, a sort of breakdown the other day and was really concerned about a lump in her breast and, it was ... [the key worker’s] Friday night shift, it came out then. And they were in casualty till half past ten that night because she was complaining of pains in her chest but what it boiled down to was that she was really concerned about a lump that she’d found there.

(PM16)

And you know... we’ve got records to prove that, you know, when a child has a health problem, the family take them straight to casualty. They don’t even stop and think about you know, well is this a case that’s serious enough to go there, you know it might just be a tummy ache or something like that. They just take them straight to casualty, it’s like a culture that’s developing, and a less of an understanding of how to cope with, you know children.

(PM5)
She would use A&E and she would take her kids there but she had a total aversion to any kind of doctor.  

(Family D4, key worker interview)

This key worker’s description of the mother in Family D4 was borne out by the parent herself, who gave the following account of her feelings about using healthcare services:

P:  If I’m ill it gets to a point where I have to go to hospital or something before I’ll go.  

(laughs)

I:  You mean you just don’t like going to doctors.

P:  Going to doctors, don’t do doctors.

I:  So you wait until you’re really sick and then …

P:  Yeah.

I:  Right.  Has that happened much?

P:  It’s happened a few times.  If I’ve had water infection or kidney infection or whatever – it’s got to a point where I can’t actually walk. And I had a cough for like two years, and [FIP key worker] made me go doctor’s, and then it was lung x-rays, and they found out I’ve got COPD … thanks to her.  See I wouldn’t have known otherwise.

(D4, initial parent interview)

Later in the same interview, this mother described an earlier experience when she felt that a GP had not paid attention to her perceptions of the problem:

I called them out once ‘cause he … he cut his leg and he was hallucinating on the settee.  So I called the doctor out.  They said ‘Oh what’s the matter with him?’  I said ‘Well something’s wrong with his legs’.  They have a look at his legs and [he] moved and he coughed - ‘Oh he’s got a chest infection’.  I said ‘It’s nothing to do with his chest’.  I said ‘there’s something wrong with his legs.’  And [the GP] was having none of it – ‘Oh he coughed so he’s got a chest infection.’  I thought ‘No, sod you.’  So I took him up the hospital, got someone to help me get him up the hospital.  He had septicaemia … and this doctor’s telling me he’s got a chest infection.  Know what I mean?  It’s a waste of space.

(D4, initial parent interview)

Other parents also spoke of difficulties with primary health care practitioners, and particularly GPs:

Sometimes I think well, maybe they’re [GP] not listening to me fully, they’re only listening to what they want to hear.

(D3, parent follow up interview)

I found with the … with the depression and when I first started having panic attacks, they put me on these panic attack pills and they didn’t work and I kept on
going back for ages saying they’re not working. And they just kept on telling me to take them and ... but I saw a different doctor one day and she put me on some different tablets, which started to work, but then I read the small print and it said ‘Do not take these if you have breathing problems or asthma’. [respondent has asthma and early stage emphysema] So, of course, when I started to take them, I started to think I can’t breathe even more, so I started to panic even more and it’s ... so I’ve stopped taking them for the last week and I’m gonna go back to the doctors and try and get that sorted... You need somebody who knows you, prescribe you the same thing again and can see you again and again, rather than different ones, ‘cause they’re all gonna have different opinions.

(C5, initial parent interview)

Although some of the professionals who were interviewed implied that the use by many FIP families of A&E rather than local surgeries was inappropriate, others were more understanding of the reasons for this. One senior practitioner (Area A) noted that workers in their service sometimes advised families to attend A&E because of difficulties accessing support through the GP. (S)he explained:

There have been incidences where the key workers have encouraged FIP families to take an adult or child to A & E and were justified in that. This is usually because the key worker felt that the family haven’t been getting appropriate support from the GP and the GP has been dismissive. For example, [we had] a case of an adult mother who had been a substance misuser and who had been getting a swelling in her leg. The GP dismissed this, telling her just to put her feet up and take anti-inflammatories. She ended up being hospitalised and diagnosed with DVT, resulting from an infection from where she used to inject. [She] was in hospital for several weeks.

(FIP worker, Area A)

Whilst it is not possible in this study to gauge how commonplace such experiences might be, this worker gave three examples of significant delayed or missed diagnoses among FIP clients (adults and children), including a missed diagnosis of epilepsy for one child. (S)he attributed difficulties with GP services to two factors. First, GPs may have negative pre-conceptions about families, or see them as a drain on resources (a perception shared by some family members). Second, she suggested that the lack of time available in GP consultations could mean that ‘things get missed’. This observation – about the time needed to identify family health concerns – was a recurrent theme in the study, and is considered in more depth in the next chapter.

Another interviewee (key worker, group interview) in the inner London FIP (Area A) noted that language and communication difficulties made it difficult for some families to benefit from primary care services, even when they did attend. (S)he gave an example of a mother with five children, all of whom were under five years of age, and reported that the mother was not bathing her children because she had understood that the health visitor had told her she only needed to use wet-wipes. The worker commented that (s)he felt the situation has arisen because the health visitor had not fully appreciated the needs that this parent had in relation to basic parenting practices.

Parents were also often described as being reluctant to use primary care services, for a variety of reasons. For some, there were practical barriers, including transport difficulties. One worker commented that parents who have to attend a large number of essential
appointments (e.g. relating to debt, housing, probation) might find routine health appointments too much to deal with or ‘inconvenient’. This factor was also related to family size and complexity, for large families with multiple service involvement. Echoing these observations about practical barriers to accessing primary care services, one parent (B4, initial interview) stated that she was prone to running out of a prescription medication because of difficulties accessing her GP surgery:

I always take it, I just run out. ... It’s like last week I did. I was trying for over a week to get in touch with the doctor’s ‘cause I knew I was running out. But every time I phoned the doctors were either, the wrong receptionist was on, the doctors were shut ‘cause they’re keeping stupid hours at the moment, or it was too late in the day – ‘cause you can only order in between 11 and 12, and 2 and 3.

(B4, initial parent interview)

The young person interviewed in this family – who described herself as a young carer in relation to her mother’s health needs – also described concerns about this issue:

So we hope that every time she rings the doctors they’re open and they can give them her. And since she’s been on them she’s been all right, because you can’t tell that she’s depressed because she gets up and she does everything and all that lot. It’s when she doesn’t take them, because she hasn’t got them. ... When it’s like the other week she didn’t have them because the doctors were messing about and it was getting a bit tough because she was crying most of the time and she needed cuddles and then the kids were wondering why she was crying and asking questions and you can’t go oh it’s because she’s depressed and that. So we had to go oh she’s not very well. She’s a bit poorly...

(B4, initial young person interview)

Barriers to families’ use of primary care services cited by FIP professionals included fear of stigma – especially for parents with mental health problems – and fear of the consequences of disclosing problems. One key worker (group interview, Area B) gave the example of a mother who had been having seizures, but had not told anyone, nor sought any medical help. When she disclosed the situation to her FIP key worker, she was supported to access her GP, and was subsequently diagnosed with epilepsy.

Unsurprisingly, the lack of uptake of primary care services could lead to the exacerbation of difficulties, and have wider implications for other family members. These wider implications were illustrated by a case example from one project manager:

Currently one of the workers is working with a female who’s bed ridden and her bed is now in the middle of the sitting room ... She’s got an alcohol issue but it’s [her] opinion that she can’t walk. There’s no medical diagnosis as to why she can’t walk, and we’ve been trying to get her to go and see her GP, but she’s very, very reluctant. ... because she’s scared that she was going to end up in hospital. ... There’s some concerns as to whether it’s more of a mental health issue. .... And it’s a key issue, because what we need is this mum to be either up on her feet or at least have her up in her own bedroom so that the children have their own living space, and the family can get [back] to some kind of normality. And getting to the bottom of her health issues is the main issue at this moment in time.

(PM14)
4.2.3 Using specialist health services

Many families involved in FIP have, or have had, involvement with specialist health services, corresponding to the adult and child health needs detailed in Chapter Three. However, just as interviewees described families’ difficulties in accessing local primary care services, problems with access to specialist healthcare services were also widely reported. One parent, who ascribed a previous suicide attempt to pain associated with her chronic back problem, explained that she had been taking strong prescription painkillers for two years:

Two years, because there’s only one actual back pain clinic here [in the city] that does it all. ...and when we had the snow this year as well lots of people broke bones and everything ... so I was put to the back of the list again.

(follow up parent interview, unattributed)

This mother said her FIP worker had helped her negotiate the clinic’s appointments system:

[FIP worker] got in touch with my doctor about it as well because the appointments, they kept cancelling all the time. [FIP worker] took me to one herself one day and we got there and the bloke had had a heart attack and there was only one bloke doing it. I know, and it was ridiculous.

(follow up parent interview, unattributed)

Professional stakeholders (regional leads, project managers and key workers) also described difficulties related to factors such as the complexity of families’ lives and experiences, their reluctance to engage with services, or their difficulty in dealing with professionals when they did. For example, they noted that families often missed specialist appointments and so ‘lost’ referrals:

If adults miss two to three mental health appointments, they are struck off and have to go back through referral which is unhelpful.

(Regional FIP specialist 1)

Mental health is very difficult to get sorted. [FIP workers have had] to re-broker appointments with hospitals because two strikes and you are out. No one ever followed up why they were missing – [it may be about] literacy, [but it is] assumed they were being defiant. Health service delivery is very much [organised] for the service provider not the service user.

(Regional lead, RL4; researcher notes)

for some families the way those services are currently delivered doesn’t you know doesn’t actually meet their needs. Because ... the usual sort of traditional way of delivering services [is] that the client has to go to the service... actually the services need to go to the client.

(PM10)

The key worker for one case study family (unattributed), in which the mother had significant mental health problems, gave the example of this parent’s psychiatric support being downgraded (from psychiatrist to Community Psychiatric Nurse) because of her failure to keep appointments:
[The CPN] was only involved towards the end, ‘cause initially she was ...referred to a psychiatrist so I used to go to those appointments with her sometimes. Sometimes her mum went and sometimes I went. But then she, over the time where things were very bad after the [domestic violence] incident ... she didn’t attend a few appointments so that meant that then they referred it to [the CPN] and I think the case was maybe put on hold with the psychiatrist. ...which is terrible. Because you normally miss appointments when you most need them. When you’re feeling the most wobbly.

(Family key worker, unattributed)

A further potential barrier, described by respondents including FIP manager PM15, was that access to health services was ‘a bit of a maze for people who are not actively involved in that world’ and that there were inadequate links between adults’ and children’s services. (S)he explained:

I think it’s a mix of thresholds and a mix of pathways that can lead to confusion. ... one of the things that we’ve discovered at our last Think Family Board was ... the perceptions around the lack of working between adults and children’s services, and I think it was a clear consensus there was a big kind of chasm between the two services. That has been [caused] in part by the break-up of what used to be adult and children’s social care, but also [by] the different legislations, the different directions we’ve kind of travelled in.

(PM15)

The size and complexity of family structures, along with a high level of specific family problems, meant that multiple professional involvement was a common feature of FIP families and this could pose an additional barrier for families trying to co-ordinate and manage specialist appointments. One striking example, given by a project manager, was of a family with 23 professionals involved at the time of the initial referral. Another interviewee – a mental health social worker (Area A) – gave a similar example of complex agency involvement for a FIP family with whom (s)he worked:

FIP weren’t already involved [at the time of initial referral to CAMHS]. This family, three of the children in this family were referred to CAMHS individually. One was referred ‘cause his mum thought he had ADHD. No, that wasn’t the reason for the referral. The reason for the referral was that some of the children had been sexually abused and another child in the family was referred because of behavioural problems and sleep walking. So yes, three of them were referred and there was another child who wasn’t referred. And then since then there have been another two children born in the family, who haven't been referred but I’m aware of. ...There are now five birth children [at home] and one child who is in a care arrangement. There’s six. And mum’s pregnant again so there will be another one very soon.

(Area A, mental health service social worker)

**Mental health services**

Many professional respondents also commented that specialist health services were not organised with the kind of flexibility that is needed by families with complex and chaotic lives, such as those involved with FIP services. This was seen as particularly problematic in terms of families’ access to adult and child mental health services. The issue was
summed up by an educational psychologist who worked with FIP families in Area B; she also commented on the value of FIP workers providing important practical support in helping families get to appointments:

*It’s like CAMHS, you know, I’m not criticising CAMHS, but there’s a logistical arrangement of actually getting to a clinic. Whereas the FIP, if needed, they will take you there. So you don’t have to worry about it’s going to cost me ten pounds in a taxi and I’ve got to catch three buses and the appointment’s at this time, so I can’t do that because I’ve got to go and fetch the children, you know. So I think there’s that whole logistical arrangement around it as well which they very, very aptly bypass and make it accessible .... what they offer, it makes it far more accessible, it’s far more attainable and it’s safe.*

(Area B, psychologist)

Even when families were keen to access specialist services, long waiting lists and referral criteria were said to pose a barrier to meeting health needs, particularly for mental health services. A GP in Area D, discussing a family where the mother’s mental health problems meant she would not leave the house, said that he had been unable to secure timely access to the mental health services she needed.

*We’re on our own with mental health, waiting lists for counselling in this city are six months plus, if they’re not closed.*

(Area D, General Practitioner)

These comments were consistent with the experiences of other professional interviewees, from health agencies and FIP projects. Discussing the accessibility of adult mental health services, a community mental health nurse, seconded to the FIP in Area D, described difficulties in initiating joint working with her own agency (researcher notes):

*I asked if I could go to [the agency] team meeting with [the FIP project manager] to talk about FIP and how they can improve joint working, and some staff didn’t bother turning up or turned up late. I found it very frustrating as it was evidence of how closed they are as a service. I assured them that having closer links with FIP wouldn’t result in a large number of new cases for them, it would be one or two over the course of a year and just giving advice and information to the FIP staff so they can make better referrals. But because the thresholds are so high, particularly for mental health services, it makes these services defensive.*

(Area D, community mental health nurse)

A CAMHS worker (Area A) also referred to high thresholds for adult mental health services, in discussing a complex FIP family with input from a variety of specialist children’s services:

*Mum doesn’t fall within the remit of mental health services even though probably everything I’ve said would suggest that maybe she would but she doesn’t. ...It’s about thresholds, it’s about severity, it’s also, probably because some of her difficulties are more to do with learning difficulties. She’s never been assessed as having learning difficulties so she probably wouldn’t meet their thresholds.*

(Area A, CAMHS practitioner)
For some families, difficulties in access to specialist services were hard to understand. In one follow-up interview conducted while the FIP intervention was still ongoing, a parent described their concerns:

The main things that we do need right, is for their education to be getting sorted out, yeah, and for their family counselling to be getting on top of. [The FIP key worker] has been more like into ... I don’t know if he’s more interested or anything like that, but just seems to ... like the boxing [course for teenage son], that took off when he got that all sorted out really quickly. Now all this counselling and stuff, [we] like would really benefit from that ... and that’s taken so long for anyone to get round to be like getting like anyone in place to do. It’s stupid. ... Well, what [FIP worker] is trying to do is, he’s ... trying to like ... make up his own kind of counselling with some other people and they just like start the whole programme off like that. Rather than get someone who’s doing counselling and ... try and do that. But the organisation of that has taken so long that nothing’s happening.

(Parent follow up interview, unattributed)

By contrast to this interpretation of the delays in access to counselling, the FIP worker himself was, when interviewed, evidently both aware and very supportive of the parent’s desire for family counselling – highlighting the parent’s concern about the effect on their family of their earlier experiences (which included childhood adversity, and involvement in crime and substance addiction as an adult). The worker had referred the parent for a therapeutic intervention, but said they had not been able to access this service because it was being piloted – he thought as a Randomised Controlled Trial – and the family had not been selected for the trial. The keyworker expressed concerns at how frustrating and discouraging this had been for the parent, falsely raising expectations ‘because they went through a very long assessment, and then didn’t get a place’. He went on to observe that none of the FIP families he had referred for the intervention were allocated to the trial. Whilst acknowledging that this could be coincidental, he described the assessment and allocation process as ‘awful’. As a consequence, he said, he was working with local counselling services to try and establish family counselling for FIP families.

4.2.4 Social services involvement

As noted in Chapter Three, many families in the study had involvement with social services. However, some parents also spoke of difficulty in accessing social services support. For example:

P: I mean at one point I took [young person aged 15] down there [to the social services office] and um ... they locked me in the building because I said I couldn’t cope with her anymore and I’m leaving her here with you for her own safety ... because she was going out doing all these stupid things ... [They] locked me in the building, wouldn’t let me go unless I took her. And I was right on the edge then, I couldn’t cope with her, no one could, she was doing what she wanted ... the safest place you’d think would be to go to social services ... no.

I: So what sorts of things was she doing?
P: Oh she was running away, staying out. She was smoking, taking drugs, she was doing everything. Getting in trouble for burglaries and goodness knows what else.

(Parent C3, follow-up interview)

In another case:

I was really struggling with his behaviour. So um ... I tried, social services were going to help me, and they’re like ‘We can’t’ so I thought ‘Right, I’m not having this.’ So ... I actually took [child aged 8] to school one day and said to the school I wasn’t picking him up, because I thought ... obviously I wouldn’t have done it, but I said to the school ‘Right I’m not coming back’ and they said ‘What do you mean?’ I said ‘I can’t cope with him no more, you have him. See you later’ and walked off. And obviously the head teacher was like ‘Well you can’t do this’, and I’m like ‘Bye’. And um, went. And obviously within 15 minutes of me doing it social services were at my door – which is what I wanted. And she sat down ‘What are you doing?’ I said ‘I want help, I can’t cope’. ... But ‘cause I’d done that then [child] actually then got [a support service] ...

(Parent D3, initial interview)

In some cases, young people themselves had initiated social services involvement. In one case, a young person self-referred to a refuge following a physical attack at home; in another, a young person contacted social services, and was subsequently accommodated in residential care, because of their parent’s alcoholism. In the extended extract below, (s)he described the decision to seek help:

I’ve watched my mum’s drinking since I was about five or six. But I didn’t know what it was. It’s growing up it’s more - it’s like as you grow up the wider your eyes get. Because you see more, isn’t it? From young I just thought it was like a normal drink. And then I was seeing like bottles get smashed and [my parent] get slapped, arguing like mum and her boyfriend like he’d hit her because she’s drinking and I’d think well, that’s what men do, don’t it? And then I thought I got older and I was like wait, why do men do that? Why are men allowed to, and why is that bottle always in the same place? And why do you keep buying another one? ... And it was all coming to me, like it all started registering the older I got and I just realised, and then I told my mum it’s the drink or me. Because it was affecting, the drink was affecting my mum badly and the weed [I was smoking] was affecting me. And when I mean we’d fight, like full on fight, up and down this passage, everything and it was only I went on internet, went on socialservices.com and I looked it up. I got the number for the homeless. They put me through to [social service office]. Then they said we’ll give you a FIP worker. They give me [FIP key worker]. ...They moved me to [residential home] and from then I told [FIP key worker] everything. I cried my heart out to her and told her look, we need help.

(Young person initial interview, unattributed)

Families’ experiences of social services were mixed. Criticisms were consistent with other literature on parents’ and children’s experiences of social work (Statham et al 2006, Dumbrill 2006, Altman 2008, Oliver 2010). Some parents and young people were unhappy with discontinuities in support associated with turnover in social work staff. For example, Parent D3, describing the day she refused to collect her son from school, said that when a social worker did visit, ‘the problem was when I done that it was a different
social worker again. So obviously we’ve had too many to count social workers.’ Young person C1, in her follow-up interview, was also critical of the turnover of social workers in her life:

I’ve had like seven social workers. Like they always had to go on maternity leave or things like that. And I didn’t mind so much ... but ... some social workers I got along with and some I didn’t. Like [X], I really got along with him. And then like [Y], she was really annoying. She was like ... every time I got in her car it always smelled and she always used to like ... I don’t know if she was really just a very annoying person.

(C1, young person follow up interview)

Others were resistant to social services involvement, because they perceived that social workers lacked understanding of families’ concerns. One parent (C2, follow-up interview), who had started working with her third social worker four months previously, explained:

she’s even said that ... She’s said ‘Look I don’t really know you all that well.’ So ... She just doesn’t do anything to help. She wants me to have all of these assessments and I don’t need them. So I’ve just sort of said no.

In a similar vein, Parent B4 (initial interview) observed:

I think with social services anything they offered me, I didn’t want it because I didn’t like social services. And if they were going to be as intrusive as they were, anything they were going to offer me was going to be just as bad. So no, anything they offered me I turned it down. I said no.

(B4, initial parent interview)

The young person interviewed in this family (follow-up interview) had similarly critical views:

I just don’t like social workers really. ...I just didn’t like my social worker, I thought she was an idiot, and I told her.

(B4, young person follow up interview)

Views of social work involvement were not universally negative, however, and several parents and young people spoke very positively about their social workers. For example:

He’s brilliant, really nice geezer. Probably the only social worker I’ve actually ever got on with, do you know what I mean?

(Parent C1, follow-up interview)

Parent D3 (initial interview) was quoted above criticising the difficulties (s)he had experienced in accessing social services support, but was very positive about the social worker (s)he was eventually allocated:

who is brilliant. Because I sat down, like I am with you, had a chat with him, told him what I want, told him what I’m going to do, asked for his help, and he has done everything he’s promised to do.

(D3, initial parent interview)
Another parent acknowledged that limits on social workers, in terms of their time and caseloads, meant that they could not provide the level of support that FIPs offer to families:

\[\text{Social worker help is not enough for the families. The social worker been involved with my family as well, before, and they involved with so many other families. [It cannot] work out like that the social worker they work from different way [to FIP]. They are very restricted.}\]

(A5, initial parent interview)

This parent also argued, however, that a social work perspective was less sensitive than the FIP approach to their Muslim family's cultural expectations:

\[\text{they say [to my daughter] okay, you stay with us we'll find a place for you. You can go to a school. You can go to your boyfriend. That's no problem. Your parent is not agreeing that you can go continue with your boyfriend. You are doing right, okay. You're still with us. You can have your food and go to work. You don’t have to bother with your parent. That's the difference between FIP, FIP is not doing this way. ... they are not arguing with me for the equal right. They was trying to get my daughter back home. ... FIP are working with the family.}\]

(A5, initial parent interview)

Despite the criticisms of social services detailed above, there were striking commonalities between the qualities of support that family members perceived as being helpful among social workers and positive accounts of support from FIP workers, a theme we will return to in the next chapter in discussing approaches to intensive family intervention.

\[\text{4.3 The limits of FIP workers’ expertise}\]

Given the evident complexity of assessing and managing health needs in FIP families, it is hardly surprising that professional interviewees (from FIP services and from health agencies) consistently highlighted the importance for FIP workers of knowing the limits of their expertise in assessment and work with health. FIP key workers have diverse professional backgrounds, and project managers and regional leads described this diversity as valuable in ensuring that the FIP team as a whole combined expertise relevant to the range of problems which families faced. FIP key workers interviewed for the present study included workers with professional backgrounds in youth work; youth offending services; social work; residential care; teaching; early years services; housing; and the police force.

A FIP key worker in Area B explained why access to specialist health expertise was seen as critically important:

\[\text{You can never take away what the professional health person is there to do, there is a very fine line, I wouldn’t want to have that complete responsibility, I wouldn’t be comfortable with it. There are people who we can access to get that.}\]

(Area B, FIP worker interview)
It was argued by some managers that FIP workers need to have sufficient health expertise to know when referral is appropriate, and of what kind. At the same time, a consistent theme, emerging across stakeholder interviews, was that FIP workers must be aware of the limits of their expertise:

FIP workers shouldn’t be expected to be specialists in everything.
(Substance misuse practitioner, Area D)

Until you start unravelling [the family’s needs], it’s very hard anyway, as I said, it’s not just one thing, it’s usually much more complex. But ... you can’t be specialised in everything, can you?
(School Nurse, Area C)

Access to health expertise was seen as especially important when working with families who have significant mental health problems. One project manager, explaining their rationale for using DH funding to secure expertise in adult mental health, gave the following example:

the children’s side of it with CAMHS nurses and everything like that it’s been absolutely fine. Adults [adult services] it’s been a bit sort of flaky ... especially around the mental health side where key workers have been working with the family where one minute, dad is sectionable and then ... he’s done a runner, and by the time they’ve caught up with him, they’ve then said no he’s okay for a community package, which left the [FIP] key worker thinking, gosh, you know...he was sectionable a moment ago. ... it’s different if there was say a child protection [plan] around the children, but there isn’t always that. It’s only a third of our families are on a child protection plan. So the key worker [is] taking lead responsibility with that family and ... when you’re told somebody is sectionable and then they’re not it leaves quite an anxious sort of feeling in regards to that key worker managing that, and supporting the family.
(PM16)

Health stakeholders interviewed were also consistently satisfied that FIP staff in the case study areas were aware of the limits of their expertise, and were working within those parameters. For example:

Everything was entirely appropriate in what they did, I was very happy with how they worked within their abilities. There’s a lot of common sense within the [FIP] team, it’s very good.
(GP, Area D)

If you’re asking me about family centre workers, I would be definitely saying that some of them, you know, take on things that they don’t have knowledge for but I haven’t had that experience with FIP, I have with family centre workers, giving advice on, you know, housing law, the domestic abuse, that it’s been totally inaccurate and unhelpful, but no, I haven’t had that with FIP workers.
(Domestic Violence Advisor, Area D)
4.4 Use of Department of Health grant

Health specialists recruited with the Department of Health £19,000 grant appeared to have a much-valued role in supporting FIP workers in managing the limits of their expertise whilst working with families who have significant health needs. This related to support for assessment and identification of needs, as discussed above, as well as helping workers to overcome barriers to accessing health services. For example:

*the specialist mental health assessments are such a challenge that we invested at a kind of consultant level ...a consultant psychiatrist that enables us to get that assessment of the family’s needs. Because often we find that mental health covers kind of across the generations of that family.*

(PM7)

The health specialists recruited using Department of Health funding in the case study areas came from a variety of professional backgrounds (including health training, midwifery, psychiatric nursing and clinical psychology); but all were said to have a key role in signposting and alleviating barriers to health service access. In some cases they were also involved more directly in assessment or case work with families.

In addition to practical benefits for FIP teams, such as supporting the assessment process, the Department of Health grant was also seen as having potential strategic benefits in improving joint working between FIP services and key health agencies, such as CAMHS or adult mental health, facilitating multiagency working and access to information. This objective was described by PM15:

*Where we positioned the CAMHS [involvement using DH funding] was really more about the joint assessment process for those families. With the view that you know, if we could get CAMHS involved in the assessment project and engaging with the families in the assessment, it was more likely they would take those families on a longer term basis. ... So we’d get more value for our buck if you like. And also you know a mechanism for actually, introducing CAMHS workers to those families in much more flexible outreach kind of method. And then hopefully build the relationship up enough for the CAMHS worker to kind of induce the family in to more longer term support.*

(PM15)

Case study interviews (across stakeholder perspectives) highlighted the potential for specialist health workers to address barriers to access to health services for FIP families, for example by identifying the right person to speak to or by advising on thresholds for access to services. In two of the case study areas (A, D), the health worker had created a resource pack with health signposting information for FIP workers. In Area D, the health worker had been ‘creating a library’ of useful resources and information packs/leaflets for key workers to use with families.

FIP project manager interviews were carried out in spring and early summer of 2010, and so it was not possible, within the timescale of our research, to comment on the impact or effectiveness of the Department of Health’s investment in FIPs. As several project managers observed, it was ‘early days’ (PM15). At the time of interviews, not all of the 19 FIP projects sampled had yet succeeded in recruiting or seconding a health specialist with Department of Health funding. Difficulties were usually ascribed to organisational
factors within local health authorities, including service re-structuring and bureaucratic hurdles. For example:

\[
\text{it’s impossible ... they can’t sort out the logistics of being able to pay [the health professional]. It’s mad not being able to do this with the 19K but it’s a step too far for them. ... It’s to do with pensions and sick leave – there are always barriers put in the way. It’s a very frustrating thing from health – they are the only agency that puts barriers up before every conversation.}
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(\text{PM 3})

Structural barriers were especially acute for FIPs located in large county local authorities. In one such area, the FIP project manager commented, ‘it’s very hard to get an awful lot of other health money because of the way the funding is configured in [this area]’. In another county council, a single FIP manager was responsible for both a county-wide FIP and another FIP in the county’s main city. At city level, (s)he reported that strategic buy-in from health was well-established, with a senior health manager on the FIP steering group, but it was more difficult to secure health engagement at county level. In the study as a whole, examples of matched or supplementary funding from health were exclusively found in smaller urban or metropolitan local authorities, where PCT structures were more likely to be co-terminous (or close to co-terminous) with the local authority boundary. Not all city FIPs had succeeded in securing matched funding, however. Project manager PM7, for example, laughed when asked if any additional funding had been linked to the DH investment, saying: ‘most recently [I’m just] trying to keep all the funding [we’ve got]’.

Several managers also commented on the short-term nature of the Department of Health funding, which was fixed until March 2011, and questioned the extent to which the necessary expertise for FIP families’ needs could be secured within a budget of just £19,000, although as explained, some had managed to secure matched funding from health services and others had supplemented the DH investment with funds from other budgets (e.g. Youth Crime Action Plan). The project managers’ desire for longer-term investment of more substantial funding for health-related work did not however negate the perceived usefulness of the existing investment. All of the FIP project managers and key workers interviewed in the study valued the availability of funds specifically linked to health, not least because it helped to signal to the PCT that addressing health issues was an important component of the programme.

\section*{4.5 The role of FIPs in supporting access to health services}

Reflecting the apparent difficulties of families in making use of primary and specialist health services, FIP workers took an active role in this area, through helping parents and young people to identify and prioritise their health needs (as noted above), and advocating and providing practical and emotional support for engagement with health and related services. Examples included texting reminders about appointments, and accompanying family members to primary and specialist healthcare appointments. The family case studies provided examples of key workers supporting a parent in her decision to have surgery to address a chronic health problem; supporting a young person in accessing social care support following diagnosis of a learning disability; and organising alternative childcare so that a parent could enter a residential alcohol treatment programme. Again, the worker-family relationship was seen as important in this regard, as will be discussed in the next section.
FIP staff also worked directly with health agencies. This included liaising with health professionals to request and facilitate specialist referrals, and liaising with health professionals to gather information about management of chronic health conditions (e.g. managing a young person’s diabetes).

Facilitating access to other universal and specialist services was consistently highlighted as a key aspect of the FIP approach. This could involve work with services as well as with families, for example liaising with a GP or specialist health worker on behalf of the family. One FIP project manager commented that:

‘The whole purpose of FIPs really is to get a family engaging to the point where they can actually engage with the universal services’

(PM4)

And another observed:

‘It’s not about throwing money at it, I think it’s about making sure they [families] engage with our health services, and that they respond to those needs’

(PM7)

### 4.5.1 Coordinating and joining up services

Service coordination was a key component of the FIP approach, described by one worker as ‘almost like a Lead Professional role’. The collective expertise of workers from different professional backgrounds within FIP teams was viewed as a valuable resource in this regard, and the health specialist input established with Department of Health funding was seen as particularly valuable in relation to health services which could be difficult to access for staff outside the PCT.

This co-ordinating role appears to be particularly important for families with multiple problems who are often chaotic and have multiple professionals involved in their lives. On a case management level, FIP workers were said to bring complementary insights, and could also supplement the less frequent contact that specialist workers had with families. This was helpful for specialist health workers in two key regards. First, it meant that FIP workers could reinforce the messages given by specialist workers, as the following examples – across health agencies and in all four study areas – illustrate:

So the conversations that we’ve had in the clinic, the FIP worker has carried on with the mum.

(CAMHS social worker, Area A)

Because I needed, for my work to be successful with the daughter I needed dad to be doing things. But he wasn’t, which [FIP key worker] was able to work on.

(Specialist Lead Nurse, Area B)

We’ve discussed basics, you know ... when immunisations are needed to be caught up with the children, appointments at hospitals and dental appointments.... Because we can advise as School Nurses, but we can’t take parents and children to those appointments and FIP have been involved, making sure that they actually go.

(School nurse, Area C)
So we did that three-way working, so the FIP worker could reinforce them and build on what we were doing there.

(Domestic violence advisor, Area D)

Second, FIP workers’ detailed knowledge of families’ everyday lives and circumstances was seen as valuable by professionals in other services who saw families less frequently. This was particularly valuable where there were potential child protection concerns. The CAMHS social worker interviewed in Area A gave the following example to illustrate this point:

The two youngest children, their father is now living with the family. And the FIP worker was quite involved really, because on paper he sounds quite alarming. And so from a CAMHS perspective not having met him because he didn’t attend here, it was quite useful to have the FIP worker going in to the family and actually giving some positive feedback to his role. Not all positive, but the things that were concerning were looked at ... the FIP worker was actually going in to the home more regularly, and so could give feedback about what he was like with the children. This is a complex family with lots of social problems ... 

(CAMHS social worker, Area A)

In the same area, the FIP project manager discussed joint work between FIP and Family Nurse Partnership (FNP), commenting that her FIP team ‘are careful not to duplicate the work of FNP, [but] FNP pick up a more “motivated” group than FIP does and they pick up pregnancy much earlier than FIP [which can] pick up those who are more difficult to engage and who are in later stages of pregnancy.’ She gave a case example where both FIP and FNP were working with a family, with a 13 year old girl who was pregnant. At the time of FIP referral, FNP had already made contact with the young woman. FIP became involved because of the high level of violence and criminality in the family home; the manager commented that the young woman was regularly being beaten up by a sibling. It was decided that FIP and FNP would work jointly, so FNP would focus on the mother and child, and FIP would focus on the wider family and the adult in prison. The FIP manager said:

FNP support for the young girl has been very effective but it hasn’t taken her out of the context and it is the context that poses a risk for the baby. FNP are coming to the end of the two year intervention with her, the young girl is too old to get a foster placement but is not quite ready for independent living. Social services are not concerned about her ability to care for the baby, so aren’t intervening. FIP are trying to get more involved by getting her on the FIP intervention [in her own right] to support her in independent living as FNP are pulling away...the dangers in the home still remain and the young girl is beginning to slip into criminality (and got arrested for shoplifting). FIP can then try and work more intensively and more forcefully with the rest of the family once the baby is safely out of that dangerous home environment. The conflicting needs of mother and baby and the rest of the family require separate work.

(FIP Project Manager, Area A)
4.5.2 Work with primary care services

As discussed above, lack of engagement with primary care services (particularly GPs) was a key issue for FIP families, and was often a key priority for Family Intervention Projects. For the most part, this related to individual case work, as the following examples show:

One surgery has been de-registering difficult families and they have had to go to the other one on the estate. One father had chronic alcohol issues, the GP refused to see him until he got help. Dad wanted a named GP, so he didn’t bother going, but we made contact with the GP surgery and explained about FIPs and the FIPs worker went to the initial appointment and they were able to sort this out. Dad is now back at that surgery and needs that support, it’s great to be able to make those links.

(PM18)

But certainly recently we’ve had some good exchanges with GPs about families we’ve been concerned about in terms of substance misuse and using solvents and we’ve had a really good information exchange initiated by us, or them, but very valuable.

(PM15)

It was very useful, extremely. The family have moved on tremendously. I could really see how it was working when I’ve sat down with the family and looked at the rules they’ve agreed. The mother is now able to leave the house, and comes into the practice herself. But I don’t think she’s needed to come for 3 or 4 months.

(GP, Area D)

Those areas which had succeeded in developing strong joint working relationships with primary care providers had adopted a range of strategies to facilitate this. In case study Area A, joint working had developed through the secondment of a specialist in integrated work in children’s centres, using the Department of Health grant. This worker’s line manager (within health) hoped that the post would provide an education for FIP workers in PCT structures and systems:

an education of where and how because if you don’t understand how health works you might not necessarily find it that easy to access the relevant services. You might need to know [that] the family might have a named health visitor but the named health visitor might be linked to a GP practice. And [that] the GP practice might not be the practice where the family live. It’s the detective work around them. If you work in health you would have an understanding but if you’re out of that you might not necessarily think of it in that way.

(Area A, strategic manager for children’s centre development)

In another area, the FIP project manager described a pro-active approach to the development of links with GPs:

we’ve written to every single GP practice in [the city] and introduced the project and asked if we could please come along to one of their staff meetings to explain more. We got a little bit of response... from two or three practices. So we went
along and explained what we were doing, asked how we could make it easy for them to use us. And we just keep doing that, keep going back. We keep making sure that they remember, our team. And also I think the main thing is that those first referrals that came through we made sure that we were really on it and we kept reporting back to them that we were engaging [with families]. So I think they felt that we were doing a good job and then that generates some more referrals.

(PM10)

This manager subsequently reported that the FIP team had now established links with more practices in the city, although still just ten per cent.

Where links had been established between FIPs and primary care – whether at a strategic level, or in relation to work with specific families – experiences were consistently positive. The examples given here indicate the potential benefits of addressing the barriers to joint work between primary care and intensive family support services. The challenges noted earlier in this report, however, along with the paucity of examples of strong strategic links between intensive family intervention and primary care services, suggest that this is a critical area for development.
5. FIP approaches to direct work with families

The literature review at the start of this report highlighted key aspects of the approach of intensive family intervention services, drawing on international evidence from studies of intervention with families who have multiple problems, as well as on the guidance provided in England for managers of such projects (CWDC 2011). This chapter draws on our interviews with parents and young people, and on accounts by FIP and health agency professionals of families with whom FIP services had worked. It examines the approaches to intensive family intervention that were most relevant to work with families’ health needs. As noted earlier, FIP key workers approached work with family health in two main ways:

a) addressing access to health services through:
   - identifying unmet needs;
   - addressing families reluctance or difficulty in engaging with health services;
   - signposting and facilitating onward referral and access to health services;

b) encouraging behavioural change and the ability of family members to manage chronic health difficulties, through direct work with families.

Within that over-arching framework for practice, the variety and complexity of families’ health needs necessitates a broad understanding of health. Analysis suggested that the holistic and flexible approach of the FIP model seemed well suited to this. Key features of FIP work with families, which underpinned work on health issues, included ‘hand-holding’; relationship building; persistence and assertiveness; a ‘whole family’ holistic approach; intensive hands-on work including practical support; careful timing and staging of the work; and a gradual exit process. These are examined in turn below.

5.1 ‘Hand-holding’

The term ‘hand-holding’ was widely used by FIP professionals (regional leads, managers and key workers) to describe the approach to intervention. As it was described, the term can be seen to equate to the French concept of ‘accompagnement’ (accompaniment) in parenting and family support. This means ‘going with’ or ‘going alongside’ families, both practically and emotionally, through a process of change (e.g. Boddy et al., 2009). For example:

_We can point the families in the right direction, do that hand-holding and make them go, and support them through the process as well because it can be quite scary._

(PM16)

_Yeah, it’s a hand-holding exercise and you know, sometimes, playing the parent to the parents I think._

(PM14)

[FIP work is about] helping families to recognise their problems and hand-holding them into support.

(Key worker group interview, Area A)
This kind of practical and emotional accompaniment was repeatedly described by workers as critical in ensuring FIP family members’ engagement with health services, such as addressing their failure to attend appointments. As one young person observed:

But like if my mum needed a lift [to counselling], [FIP worker] would come and pick her up and take her ... which was a good side, because sometimes mum didn’t have the money to get there.

(Young person B4, initial interview)

Family members – parents and young children – also described an approach to support that was distinctive from their experience of other workers (often social workers), in being more respectful and relational in style. In this sense, ‘accompaniment’ was seen by family members as enabling of changes that they themselves wanted to make. For example, one parent, who had a significant problem with cocaine and alcohol use at the start of the FIP intervention, described the support of her FIP worker in accessing a residential rehabilitation service. This parent was apparently at the point of feeling ready to make change – saying ‘I’d just had enough ... I knew I’d make that decision eventually’. But, (s)he explained:

I don’t think I would have gone in. So, that was on my mind, but I was kind of probably putting it off as well. ‘Cause I didn’t feel alone with FIP, otherwise I’d have had to do everything myself and organise everything. But they helped me to put things in place before I went in you know. And even when I came out – so I didn’t have no worry or no concerns. They carried me basically, I think they carried me.

(Initial parent interview, unattributed)

One FIP key worker, however, reflected on the limits of the ‘hand-holding’ approach in relation to a particular case where the parent had engaged initially but become more resistant to FIP involvement over time.

Well, the social services have asked me to be more pro-active in assertively supporting her to do this [make and attend health appointments] but I’ve been cautious with that because I think it’s not our job to create a dependence. I feel that she needs to show she can do these basic things if the kids can stay [i.e. not be taken into care]. It’s no point me doing, I have at times sat down with her and phoned the nurse and passed the phone over to her but more recently I’ve not done that because I feel that if I do that and then withdraw and she doesn’t do it herself what has that, that hasn’t helped those kids at all, actually she needs to show that she’s capable of doing those basic parenting jobs and if she can’t then those kids can’t stay.

(Family key worker interview, unattributed)

This worker explained that (s)he might provide more pro-active support in cases where (s)he judged that parents clearly needed that, ‘but in this case where it’s a case that I just don’t feel mum gives a damn, I think actually the best thing we can do is evidence that and show that, you know, so that those kids can be removed, you know.’

By contrast to the worker’s perspective, the mother in this case commented that she was reluctant to disclose the full extent of her health problems to the FIP worker, because of concern that (s)he would reveal the extent of her mental health difficulties to social services:
P: I don’t think [FIP worker] actually realises how bad that I do panic.

I Right, okay, I mean have you talked about it with [FIP worker] or ...

R Not to the extent that I’m telling you how much I panic, no.

I Right, what ... why is that, why do you not tell [FIP worker]?

R Because I’m worried that if I tell [FIP worker] that I’m panicking so much and my health’s so bad, then social workers will see that I’m not coping and then ... yeah.

I So it’s kind of fear of the information getting back to Social Services and the effect of that. ...

R Yeah, they share so much, [FIP worker] says to me what ... a lot of what I say is confidential and yeah, (s)he doesn’t tell social workers that much, but because they’re all in the same sort of thing, I ... I do worry about it.

(Initial parent interview, unattributed)

Whilst it would be unwise to seek to pinpoint a single ‘truth’ in the accounts of this complex case, the lack of mutual trust, and contrast between parent and worker’s perspectives, is striking in the context of an intervention predicated on relational work, and illuminates the process by which barriers to engagement may develop for some FIP families.

5.2 Relationship building: trust and respect

Professional stakeholders and family members highlighted relationship formation as central to the work, with the development of trust and respect seen as essential for families that have had extensive, and often unsuccessful, previous professional involvement. As one key worker observed:

It’s very, very non-blame which is the only way to do it in my opinion.

(FIP key worker, group interview, Area D)

In a context where underlying health issues were often either normalised or hidden because of fear of stigma or child protection proceedings, FIP managers and key workers frequently described cases where health problems only became apparent, or were disclosed by parents or children, after a trusting relationship had been established with family members. It was noted that physical health needs were rarely highlighted in initial referrals, but were often identified once work with the family was established. One manager (PM16) commented that: ‘the health stuff creeps out later on’, and explained:

So yeah things do come out. I think if you can open up those conversations in the early days around health [then health concerns] do tend to [come out] later on.

(PM16)
In Area B, a key worker observed:

You have a dialogue all the time with these families. And...it would have either come out in the in-depth assessment or in the length of time that we were involved. And during that time, that’s just when you, I describe the first three months of working with a family as swimming in glue. Yeah, you’re just wading through everything, and sometimes you have gut feelings. And then normally after three to six months the family will either disclose something that’s significant or they will go in to some form of crisis which gives you another insight into what is going on within the family. They can only put up the wall for so long. And then natural daily life will just, they can’t sustain it, something will happen and the true picture of the family comes through.

Professional stakeholders also noted the need to attend to subjective constructions of health among family members, as part of the development of a trusting relationship. For example:

I think if the family perceive it as a health need, it needs to go in the assessment. ‘Cause if they believe, just the fact that they believe [it makes it] a need. I’m not saying it is a health need but it is a need. Because if you want to bring about change, someone who is saying well I really can’t do anything because I’ve got this chronic asthma. And somebody else is saying no they don’t have chronic asthma, then there is a need in there somewhere isn’t there?

(PM8)

Parents and young people also spoke about disclosure of health concerns in the context of developing trust in the relationship with the FIP key worker. One parent with chronic physical and mental health problems said:

She really understands the pain people are going through, she really understands that.

(Parent A4, initial interview)

Two young people living with parents with drug or alcohol problems spoke about the importance of trust and empathy in the worker-family relationship:

She [key worker] was with me for about six months before I actually spoke to her about everything. But with her going to my meetings with my mum and all that lot, with social services, she knew what was actually going on and she could like relay it back to me in the same way.

(Young person, B4 initial interview)

And then I see [FIP worker] down there and I said to her look like we need, I need help. Get me, my mum needs help and I don’t know who else to talk to. You look like a trustworthy person like. And then she explained to me what she could do. I told her everything and since that day she’s stuck by my side.

(Young person, A2 initial interview)

Another young person described the FIP worker’s initiation of a relationship with her mother:
At first like my mum didn’t let her in for a couple of times because she thought that she’d just be all like... and then she like sneakily like went down to the school and was like ... ‘hello, I’m [FIP worker]’ and they just got on since then. Like my mum was like she’s really nice do you know I met her and she’s just so - she’s lovely. She’s lovely. I couldn’t have asked for like a better person.

(Young person, C3 initial interview)

A common theme from family interviews (parents and children) was the contrast between the FIP worker and other professionals who had been involved with the family. Parents and young people evidently valued the continuity of involvement over a long period of intervention. It was rare for FIP workers to change (and when it did happen, was more usually said to be for case related reasons, or at a family member’s request), and this stood in contrast to families’ experiences with other professionals such as social workers who more often changed, as discussed earlier. But parents and young people also noted differences in the nature of the relationship and style of communication. For example:

Yeah, [FIP worker] is just so much down to earth like. She just really is. I just - I actually love her. Mum gets on really well with her and it’s good like she don’t really she don’t get on with social workers, like she don’t really but with [FIP worker] it’s just different. Like she’s just so, she’s just funny, she’s just so down to earth like.

(Young person C3, initial interview)

It’s like I say you know my mum and [FIP worker] they’re close, like they’re really close and it’s like they’re close mates and that. ...Even when she’s got a lunch break she comes to see my mum.

(Young person A4, initial interview)

I’ve always liked [FIP worker] in the way she dealt with things, because in my eyes she was doing it the right way. ... Whereas you’ve got them stuck up people who come in because they’ve got a higher job and think they’re better than you and will tell you that you’re in the wrong. And she spoke to my mum and did it perfect.

(Young person B4, initial interview)

Two key points stand out from these extracts. First of all, the young people describe relationships which are distinct from their experience of other professionals in being more personal. They talk of ‘like’ and even ‘love’ – of having a more genuine connection. Similar comments emerged from interviews with many parents/carers. The grandparent who was a kinship carer for children in one case study family (Area A), described the key worker as follows:

when [the children] see [FIP worker] they just want to be with her, it’s like it’s their mum ... you know she’s not just like the worker, she’s like a best friend coming into the family - that’s how I can say that.

(Family carer initial interview, Area A)

Similarly, a parent in Area D described her relationship with her key worker as akin to friendship:
it felt like I had a friend that if I needed her, whatever time of the day, I could text her and she ... well, obviously if it was in the middle of the night, she weren’t gonna text me back till the next morning, but she was there. If I needed a chat she’d fit me in somewhere. She would come and see me, if I needed to go to shopping, she would take me shopping and to me, that was more like a friend rather than a FIP worker. And with Social Services as well, I didn’t get on with half the social workers I had, which made me then like ‘For fuck’s sake, well she ...’ – I just wouldn’t bother. But with her, I got on with her from the start, which then made the relationship a whole lot easier and then I could trust her more.

The second striking feature of the comments above relates to the effect of family health problems on young people involved with FIP projects. All three of the young people quoted above have parents with significant physical and/or mental health problems, and this was evidently worrying for the young people themselves, who expressed concern in their interviews about their mothers’ health and well-being. In that context, the comments above show they clearly valued the fact that the FIP workers were liked by their mothers. Similarly, the grandparent quoted above expressed concern about the effects of family breakdown, and appreciated the strong bond the worker had formed with the children she looked after.

Very few families were critical of the FIP intervention, and only one parent was adamant that the work had actually been unhelpful. When parents were less satisfied with their experience of the FIP intervention, their concerns focused on a lack of trust and mutual respect, as the following quotes from two parents\(^\text{13}\) indicate:

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\text{I’m a very open and honest person, but [FIP worker] was coming in and she was getting aerated and I didn’t like that. I thought she could’ve been more well-spoken to me. I’m a human being, so I had a word with the [FIP] manager and she got me [a different key worker]. ... And then from there it got better.}
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(Parent, initial interview)

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\text{No it was just more a case of ... every time [the FIP worker] come up it was all negative, there was no positive, you know ‘Well you’re doing this right, you’re doing that right’ it’s all ‘Well you’re doing this wrong, this wrong and this wrong ... you need to do this, you need to do this’ ... it’s all ... you know it wasn’t any structure to it or any meaning ... so every time you was coming and you knew he was coming it was more a case of ‘Oh can’t say ...’ ... So you knew it was like ... you felt pretty shitty after [the worker had] been here, know what I mean? ... It was always what everybody else said, that was what was true.}
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(Parent, follow up interview)

In this last case, the young person interviewed in the family was fairly positive about practical support the family had from FIP in relation to schooling and housing issues, but the parent had clearly found work with FIP to be a difficult and unhelpful experience. Nonetheless, this family had experienced positive change in a number of key areas which

\[^{13}\text{Quotes unattributed to protect confidentiality.}\]
had previously been problematic – including anti-social behaviour, schooling and housing – raising questions about how engagement with FIP links to outcomes. We will turn to this issue, and return to this case, in the next chapter.

5.3 Persistence and assertiveness

Parents’ and young people’s accounts of friendship and affectionate relationships with FIP workers sit in apparent contrast to the assertive language of the Respect Agenda (Respect Task Force, 2006), within which FIPs were originally rolled out across England. However, both workers and family members were clear that persistence and an assertive approach were also major features of the work.

Family engagement in the intervention was secured by making repeated visits and being flexible with time. As one FIP manager said:

*Even though it is an assertive model of intervention, there is a mixture of sanctions and support. These people’s backs are against the wall, they have lost their way and are desperate for some help but don’t know where to get it and think people are going to take their kids into care, which is possible. If an official envelope arrives they don’t open it. We have to be inventive in how we engage with families. We try to be introduced by the referrer if possible and we use texting and emails. They often don’t have money on their phone but can receive texts and that is sometimes the first point of contact. You have to persist until you get the breakthrough.*

(PM2)

Similarly, researcher notes of a key worker group interview record key workers as saying:

*Even in cases where the family doesn’t want to engage with FIP we won’t give up on them and will keep calling and dropping by to encourage the clients to work with them and to earn their trust. [We] are creative in trying to engage clients, e.g. seeking young clients out in the park or at friends’ houses, visiting in the evenings and weekends.*

(FIP worker group interview, Area A)

Other key workers described their persistence in relation to work with case study families:

*I had five cases when I was working with [this parent], and [the family] was getting three visits, four visits a day and that’s not an exaggeration. I would be like a bad smell in that house.*

(FIP worker group interview, Area B)

*I’m very persistent, and you have to be persistent in certain cases. Because you know I’m not going at my pace, I can’t go at my pace, I have to go to their pace, I have to go to their level in order to reach an understanding. And I think once you grasp that understanding I think it will flow. They’re willing to adapt to you. So, you know it’s the persistency that I had, made her be persistent [in dealing with her problems].*

(FIP worker group interview, Area A)
At the same time, both family members and professionals commented that the trust in relationships described above depended in part on workers’ being open and clear about potential sanctions and consequences. This was described by one manager as ‘not a threat, a reality check’, and by a parent (A2, initial interview), simply, as ‘no bullshit’. This same parent also talked about the way in which persistence combined with continuity of support had enabled her daughter to develop trust in the worker:

she was reluctant to trust in people. But like [FIP] wouldn’t give up, they’d always be there you know. They’d make an appointment for her, she wouldn’t be there, but they’d still help her. I think she’s seeing that, you know, and the continuation of a support – that’s the only way I could think that we’ve lasted – because she would have given [up] by now, you know, she would have. Because of being let down – she got let down quite a lot in school and things like that with her teachers. And so she didn’t have no trust for anyone.

(Parent A2, initial interview)

The FIP key worker role is distinct from that of other professionals – notably social workers – in being free of statutory responsibilities. Thus, the sanctions which may be applied to families who do not cooperate or engage are not applied by the FIP itself, but by other agencies such as housing or children’s social care. Sanctions are therefore at one step removed from the relationship between the FIP worker and the family. That separation seemed to facilitate the balance of persistence and honesty with families, allowing workers to explain the potential sanction, whilst offering to help prevent it, and without being the person who levies the sanction. Thus, this separation of statutory responsibility from intensive support appeared to be helpful in facilitating engagement for families with whom services have struggled to engage.

Persistence was also seen as valuable – by workers and families – in enabling families to access agencies including health services, for example, in advocating for family needs and securing appointments. In Area D, the FIP project manager argued that her service’s success in engaging health agencies was ‘about the persistence and assertiveness of key workers. They are expected to – and will do – things that other professionals will not, or don’t have time to. That’s what the FIP model dictates.’ She went on to say:

Our key workers are proactive in making those relationships with the key professionals. The consequence is that they [professionals in other agencies] understand the service and the work, and have an interest to turn up at meetings. That’s something that we can do because we’ve got the luxury of time for that face to face and chasing up.

(FIP Project Manager, Area D)

In Area A, discussing a case study family, a key worker gave the following account of her role in supporting the parent’s engagement with health services:

I had to keep chasing it every minute of the way ... And I could easily see how families lose the threads easily, I found it quite hard to get through to the specialist, quite hard to pin him down to a meeting and actually discuss [family member’s] care with an interpreter so that she could understand, that was quite hard. But we did manage to do it, and she did have [the medical procedure] in June last year. In fact I’ve had problems liaising with mental health as well, largely, until recently. I’ll tell you about that too. ‘Cause what happens with them is that
the people change and things get lost. They had massive problems with the mental health. Every time we went to a psychotherapy appointment, erm, they said that we haven’t got an appointment and what’s the name and what’s the number. And two times we’ve come away. And I had to put a complaint in. And then I got Dr [X], who’s absolutely wonderful. And she’s made a referral to the community mental health team, she’s also been chasing up the physical health disabilities team, realising the impact [on the family member]. And things started to get off the ground.

(Family key worker, Area A)

5.4 A whole family, holistic approach

Across all stakeholder groups interviewed for the study – parents, young people, and professionals from FIP projects and health agencies – there was a strong emphasis on the importance of looking at family’s needs in the round, and relatedly, of looking at health alongside other issues. Thus, interviewees spoke of addressing the health needs of all family members and of aspects of health – such as diet and home environment – which span the family as a whole, whilst attending to the needs of individual family members, and the interaction between health and other issues, such as poor housing. As one parent explained:

Because it’s help for everybody and everyone in that family is getting help you know. Or anyone in the family that needs help is getting it. ... They worked again with me to sort of build my family, you know what I mean, carried me through. And that’s how we sort of done it. But in that time they was helping me, they were sort of helping [my daughter] in a different way, you know.

(Parent A2, initial interview)

This theme, of whole family working, is fundamental to the approach of intensive family intervention. It emerged strongly from the study, and has been discussed in relation to aspects of health and health-related work in preceding sections, so will not be re-visited in depth here. However, a critical point to emerge consistently from the research was that initial presenting referral issues, which might relate to one or two family members, could be the ‘tip of an iceberg’ of complex family problems. This point was summed up by a key worker in relation to one case study family (Area D):

It’s the most complicated family. On paper it presented as just a bit of ASB (Anti-social Behaviour) and no biggie and we thought we’d be in and out in six months and it’s been the most complicated family I’ve ever worked with in my life.

(Family key worker, Area D)

Not surprisingly, given the need to address key referral issues, workers’ and family members’ accounts indicated that the intervention was sometimes focused on particular family members, with others relatively little involved. This was particularly the impression given by younger children interviewed, who often saw the ‘work’ of FIP as focused on a parent or carer in the family. For some of the young people interviewed, therefore, the FIP worker was someone who would talk to them, or engage them in activities, but they gave little account of ‘work’ per se. For example:
I: What do you talk to [key worker] about? Talk to her about school or your friends?
YP: No she talks about some stuff about me.
I: Like what?
YP: How are you doing. ... I forgot what else.
I: Do you like talking to [key worker]?
YP: Yeah.

(Five year-old child, initial interview)

... she used to come round, help my nan with us, and sometimes she’ll bring us out for like birthdays ... and all that.

(12 year-old, follow-up interview)

In other cases, even when one family member was thought to have triggered the referral, the intervention had evidently encompassed others in the family. A thirteen year-old girl in one case study family said that FIP had become involved because of her brother – ‘He’s just going through one of them stages’ – but in the course of her (initial) interview, she described her own involvement with the FIP worker as very useful, and said:

I’ve calmed down a lot now. ... No, I used to be naughty, like I used to like terrorising people in other words. ...I used to push bins over. Where the old people live and everything. I used to bother-knock and all that. And got in trouble with the police a few times with some stuff. .... And then as soon as [FIP worker] come I just calmed down.

(Young person initial interview, unattributed)

Even when referral issues were clearly focused on particular family members, workers and families also noted that the needs of other family members were taken into account. For example, in one large family, intervention was primarily concerned with one parent and two young people, referred because of crime and anti-social behaviour. Over the course of the intervention, work had also developed with the other parent (in relation to parenting of non-biological and biological children in the family), and in accessing support for other family members (e.g. speech therapy for a younger sibling).

5.5 Intensive hands-on work including practical support

Intensive work with families is central to the FIP approach, with low caseloads enabling time to be spent in the family home. This hands-on approach was highly valued by families, and seen as critically important by workers within FIP projects and in related health agencies. Intensive work was valued in relation to the identification and assessment of family health needs, as was illustrated by the comments of the FIP manager in Area D:

The intensity and depth of key worker visits to the family uncovers issues that other professionals would never become aware of. For example, is there food in the fridge? Does the cooker work? There was a case of a FIP family who always ate takeaway meals and had a very unhealthy diet. The key worker discovered in the course of her visits that the gas was disconnected from the cooker and housing had never repaired it, there was no working fridge and there was no space in the kitchen to prepare food. By addressing these problems the family
were at a place where the key worker could start going shopping with them, teach them about preparing healthy food and change the behaviour.

(FIP Project Manager, Area D)

One key feature of this intensive work was its practical focus and emphasis on creating sustainable and achievable change in habitual practices, for example in relation to family routines and health related practices. Examples across stakeholder groups included work with dental care routines; personal and family hygiene (e.g. laundry, cleaning, and food hygiene); food shopping and cooking; and the management of smoking.

The need to develop physical activity and routines for children and families (whether formal exercise or simply increasing everyday activity) was also highlighted as a priority for intervention by professional stakeholders, linked to concern about patterns of isolation and inactivity. As one key worker observed (group interview, Area B), this meant encouraging families to be ‘[getting] out and doing things rather than sitting at home with the curtains closed watching TV all day every day’.

Both workers and family members described intervention with everyday family practices in terms of ‘small steps’ and ‘drip-feeding’ change. For example:

It’s like, like she like how she was like talking to us and she was really giving us really nice advice like how to do. She brought into details and that telling us like from top to bottom.

(Young person A4, initial interview)

... she [FIP worker] wouldn’t come in, like most people come in, and go right, that washing needs going, this needs doing, that needs doing. She’d go right, the washing can be done in two loads. Put the washer on twice and it’ll be done. All right, do this and then it’d be done and she’d work through it slowly. ... Whereas some people would come in and go right, this needs doing, that needs doing, carry on or we’re taking the kids. Whereas she’d come in and talk to you and sort it out, which I think was better for my mum to be honest.

(Young person B4, initial interview)

at the same time I was trying to get her to smoke outside and not inside the flat as she’s got a child and her friends’ children would often spend time there.

(Key worker interview, family C2)

In considering the value of this ‘small-steps’ approach, it is of note that several of the parents interviewed spoke of feeling confused and overwhelmed by events in their lives at the point of referral to FIP. Small concrete steps may be necessary to achieve manageable change in these circumstances. For example:

before the FIP [was] involved, my family situation was so bad. ... I was losing concentrating [on] things, how to deal with things, how to be active and do something. I was so confused at that time. To organise something it was very difficult for me because of all that situation, pulled my brains on that situation. I cannot organise things because whatever I had to do I get confused very easy.

(Parent A5, initial interview)
5.6 A staged approach

Professional stakeholders, including FIP managers and key workers, commented that work with health ‘is a matter of timing’, because of the need to consider family health alongside other issues. Staging work with different aspects of families’ needs was also seen as critical in dealing with multiple health concerns. For example, a domestic violence practitioner observed:

*It’s a question of deciding which issue they can deal with at that particular time and if there’s drugs and alcohol or there’s other issues, sometimes you have to deal with those before it’s appropriate for me to be involved.*

(Domestic violence worker, Area D)

In some cases, critical basic health needs were apparent at the point of referral, and work with health was a key initial priority. FIP workers also noted that physical and mental health issues often underpinned families’ presenting difficulties, and were thus identified as key priorities for the intervention. Examples included:

- a key worker who described addressing a child’s uncorrected myopia before she could begin work in relation to the child’s behaviour;

- a case study family where the referral related to a young person’s anti-social behaviour and problems in school, where it emerged that the key underlying issue was parental alcohol dependency;

- several case study families where anti-social behaviour problems were directly attributed to a parent’s physical and/or mental health problems, including:
  - a parent with a diagnosed personality disorder, who had grown up in public care; and
  - several parents whose caregiving and household management was evidently affected by heavy use of prescription tranquillisers and painkillers.

In other cases, it was argued that it may not be possible to identify or work with health needs in the initial phases of intervention. Ongoing work with health – for example, in relation to parenting or children and young people’s emotional health – also had to fit around immediate pressing issues or emerging crises in families’ lives. Incidents such as threat of eviction, court appearances or the arrest of a young person meant that work with health had to be postponed until the crisis has been addressed. For example, a key worker gave the following description of work with a young person in a case study family:

*The great difficulty in working with [young person] has been that he responds well, and says all the right things, but then there will be an incident - of violence, of stealing a motorbike - and so it is very difficult to plan work, because you are always having to respond to what has just happened. He can get very nasty, very aggressive, especially when he has been drinking.... [So my work with him] always seems quite reactive because of the incidents that arise. So it is difficult to plan – say that I’ll do four sessions on emotions – because something will happen and you have to stop and deal with that.*

(Area C, family key worker)
In Area D, another case study key worker said:

I delivered an entire parenting programme to this family, literally, it should have taken me twelve weeks but it’s taken me about nine months to deliver it... Tailored it specifically to them. ... So I’ll go in there to do a Triple P session and I have to spend an hour with them listening to what [young person’s] done, he did this, he did, and my main workload with this family has been trying to ... give them some insight and understanding as to why [young person] behaves the way he does. What is ADHD and how their behaviour impacts his behaviour and showing them how his behaviour escalates and what can be done at each escalation level.  

(Area D, family key worker)

As challenging as this case had been, this worker commented that, through a staged process which allowed time to respond to parental concerns, sustainable change was being achieved – albeit slowly. Such experiences may illuminate the finding from Dixon and colleagues’ (2010) analysis of FIP monitoring data, which showed that length of intervention was positively associated with better family outcomes.

A gradual and staged approach to work with health was also seen as important by FIP stakeholders because – as noted above in relation to the development of trust between worker and family members – fundamental underlying health issues did not always emerge during the initial referral and assessment process, but were often disclosed only when a relationship had been established. It was also noted that the timing of health related work may need to accommodate family members’ readiness to address the issues of concern, particularly when problems are entrenched or relate to underlying issues such as parental experience of childhood maltreatment. In Area D, the health specialist (a senior mental health practitioner) described assessment of a mother who had experienced significant trauma that was thought to be having an impact on her current parenting:

But psychologically she wasn’t ready to engage in any sort of support that would help her look at her own trauma. [She had an assessment] about looking at what options there were and her willingness to engage in therapy really, to address her own childhood abuse, and her abuse as an adult through domestic violence and to help her make the connections of that experience and how she minimised what was happening to her own child. And she was highly resistant to that because she had got some very good coping strategies [for herself] so there was a sense of not wanting to rock the boat. They probably weren’t always good strategies for her daughter but they worked for her. ... Perhaps the work of FIP is about the timings of things. Because it would have been ideal if she would have engaged, because she would have had that [FIP] support with that process. But in terms of the therapeutic side of things it was clear that she wasn’t anywhere near ready to do that work. So that might happen to her in a few years’ time. ... From the mental health perspective you have to respect people’s decisions about whether they want to address that. But she would have been ideally placed to have done it because she would have had the support of the programme.

(Mental health practitioner, Area D)
5.7  A gradual exit process

The staging of work was also seen as important in relation to the ending of intensive family intervention. Project manager PM16 gave the following explanation:

And they have a point of contact in the project who then tracks the six month exit. In the first month they ring them weekly just to check out things are okay, the second month its fortnightly and then they, the third month it sort of goes to monthly then, and then you’re actually linked in with that. Generally the housing provider would monitor [for a] period of time thereafter. But within that first three months they do have face to face contacts with their old key worker, just so that they can, you know it’s a real sort of booster really, oh you’re doing really well, or if there’s something niggly coming up then they can try and defuse that and deal with that. I think it’s respectful to the families; you’ve had them for a long time you can’t just say ‘see ya’.

(PM16)

At the time of initial interviews, several parents who were close to the end of their intervention expressed concerns about how they would cope without the FIP worker, raising an important question about dependency on the worker. Concern about dependency has been reported in other studies of similarly long term health and social care interventions, such as Family Nurse Partnership (Barnes et al. 2011) and seems to relate to the closeness of the relationship between worker and client. As discussed above, worker-family relationships in the present study were described by families as both personal and professional, with workers described by some family members as friends (e.g. ‘close mates’; ‘like a best friend coming into the family’; ‘they were like a close family member’) or even as parent figures (‘like a mother’). One worker (Area A) herself described her relationship with a young person as being ‘like a mini-mum’.

So what does this mean for the end of that relationship, as the FIP intervention is completed? Surprisingly, given the comments presented above, there was little evidence that endings were problematic. One mother, at the initial interview said ‘I do think because everything’s coming to an end, I’m thinking “Oh how am I going to cope”’. But she also noted a gradual preparation for the end of the intervention, and commented that ‘I know they’re only a phone call away if I need advice or anything like that’. At the time of follow-up, both she and the worker described very occasional contact; the mother reported that the worker had called recently, but appeared very relaxed about this low level of contact:

Uh, she gave me a ring, ‘cause I’ve not heard from her for a while. And um ... she just gave me a call to see how things were. ‘Cause we keep meaning to meet up ‘cause we’ve not seen each other since ... just to see how I was getting on really, to see how me and [my child] were progressing. But ‘cause she’s moved on you know ... Yeah but it was nice to speak to her. We always say to her we’re going to meet up, we always do, but I’m busy, she’s busy, so ... it will happen I suppose.

(Area A, parent follow up interview)

The worker who described herself as like a ‘mini-mum’ to a young person she had been working with, described her work on closing the case as follows:
So I then had to kind of slip away, and explain to [young person] that now that you’re in a better place now you can’t do what I use to do for you, and walk you through your life. You’ve got to be independent, but if you’re ever in need I’m here to help you know.

(Area A, family key worker interview)

This example illustrates an emphasis on conferring agency – ‘you’re in a better place now... you’ve got to be independent’. At the same time, flexible endings allowed the possibility of re-activating support if necessary. To reduce the likelihood of that necessity, case closure in this example also involved work to ensure the young person’s engagement with other sources of support:

So he was referred to the disabilities team and...we done an application, went to the GP. We explained to the GP, [young person’s] learning difficulties and the situation that he’s in. And they recommended counselling and they also referred him on to CAMHS, [and he went onto their] waiting list. And basically they did say to [young person] that they would do an assessment and then he was provided with disability allowance.

(Area A, family key worker interview)

The staging of endings was also described by another worker in the same team (Area A), who described doing a follow-up visit with families three months after a case is closed, to see ‘whether the situation is still working as expected’. This worker went on to note that families also had the opportunity to call for advice if there was a specific issue that they had difficulty in dealing with. (S)he noted that:

It does not mean we are working with you – but for that particular thing, because we don’t want them... that [one] point could let the whole family down.... [We] still are there, for that specific [thing], [we are] not working with you but suppose you have something that you cannot solve for some specific thing. Suppose ... you get a letter from the housing saying that we’re going to evict you if you haven’t done so and so, just give us call and then we can help you with that specific thing and then close up again.

(Area A, family key worker interview)

Gradual exit was also important from family members’ perspectives, in accordance with the perception that the relationship with the worker was different from that with other professionals that come and go, and in enabling family members to feel secure that support was still accessible after the intervention had formally finished. For example:

She told me what was going to happen ... she was like ‘I won’t just go and [I’ll] never see you again’; she was like ‘I’ll pop in and just see how you are’. I see her, ‘cause her car’s always parked outside. ...So I’m always seeing her and she’s like ‘Hello’, so it’s all good.

(Young person C3, follow-up interview)

P: I speak to her on the phone every now and again. Just like if I need to get stuff off my chest I ring her. But I don’t see her any more.

I: That must be ...
R:  Weird, yeah, very weird yeah, very weird. But I’ve got used to it now, but at the start ... because she was my support worker for like a long time. And ... yeah. ... Yeah, she was absolutely brilliant, I would recommend her for anybody - absolutely brilliant, I love the woman.

I:  But it’s still all right for you to call her when you want to.

R:  Yeah yeah. I speak to her about my social worker and stuff like that, and she’s just like well you’ve got to do this and you’ve got to do that, but don’t do this and don’t do that. And I’m like ‘Okay.’

(Parent C2, follow up interview)

When staged, gradual exit was not possible – as in Area D where the FIP service was closed during the study period because of funding cuts – workers were highly concerned about the potential impact on families of exiting from the intervention without tapering of support. One key worker in this area explained her worries in relation to a case study family with whom (s)he had been working for just under a year:

I’m just so concerned about the level of dependency with this family – and it’s not bad that they’ve had that dependency, because that’s the type of service we are, that’s the service we offer. But because it has been withdrawn like this there’s just no amount of time in the world that can prepare us to close this family. Because their problems are so current and so apparent that you can’t just wave a wand in a couple of weeks and fix anything.

(Area D, family key worker interview)

5.8 FIP approaches to work with family health: summing up

The analyses presented in this and the preceding chapter indicate clearly that work with health was a priority for Family Intervention Projects in the present study. This focus is hardly surprising, given the extent and complexity of family health needs – as detailed in Chapter 3. There was widespread recognition among professionals that it was fundamentally necessary to address health in order to resolve common referral issues that are explicitly central to the core aims of intensive family intervention services, including anti-social behaviour, housing and financial problems, educational concerns for children and young people, and child protection and safeguarding concerns. The research indicates that key characteristics of the FIP approach to intervention (intensive and persistent, but also staged, supportive and relational) facilitated the identification (and disclosure) of health problems, and enabled intervention with health-related practices in everyday family life. Work with health agencies was very widely reported to be challenging by FIP professionals stakeholders, often because of structural barriers, and lack of knowledge of health service systems. However, specialist input from health professionals was universally seen as critically important by health and FIP stakeholders. Two key reasons were highlighted:

- first, given the diverse backgrounds of FIP workers, specialist health expertise is required to support assessment and identification of health needs;
second, FIP expertise is not sufficient to address significant unmet health needs for many family members involved in FIP projects, and so access to specialist services for onward referral and joint working is essential. Where joint working with health had been developed, including through use of Department of Health funding for FIPs, these arrangements were mutually agreed to have been very beneficial.

In considering these findings from the present study, it is important to bear in mind Dixon and colleagues’ (2010) analysis of FIP monitoring data, which indicated that families were less likely to show improvements in health than in other outcome domains. Why might this be? In the next chapter, we consider outcomes in relation to health for FIP projects and families.
6. What counts as success? Health and well-being outcomes for FIP families

6.1 Evidence of positive change

As noted earlier, this research was not intended as a formal evaluation of health outcomes for families participating in FIPs. Within a short-term longitudinal qualitative design, health ‘outcomes’ were explored in terms of perceived health benefits for family members, based on professionals’ case descriptions and families’ own accounts. Sampling intentionally focused on families who were at, or close to, the end of the FIP intervention process, to maximise the chance of identifying good practice in relation to health and so illuminate the potential of intensive family intervention in addressing families’ health needs. The study thus did not include families who had never engaged or had dropped out early on, although selection bias was minimised by asking workers to approach the five families who had most recently completed (or were nearest to completing) their involvement with FIP, rather than to choose themselves which families to approach.

This study provides evidence of sustained health gains for a number of families with significant presenting problems that related to health, confirming the potential of FIPs to improve health outcomes for complex, challenging families. Improvements were reported by all professional stakeholder groups, and by families themselves. Changes related to all aspects of health, as summarised below.

6.1.1 Basic health and well-being

Workers and family members consistently reported improvements in a range of aspects of basic health, including family members’ everyday routines, diet, exercise, hygiene, child safety, and home environment. These changes were often seen as closely tied to the nature of intensive home-based FIP practice, as discussed in the previous chapter. For example, one case study parent, who said the worker had given her ‘a kick up the backside’, gave the following example:

*She was just like you need to eat to stay healthy, like you’re his mum, you need to look after him and if you can’t look after yourself you can’t look after him sort of thing. And then she got me involved with a healthy eating woman who give me healthy eating recipes for me and [primary school-aged child] to do together and we cooked cheesy veggie wedges and I looked at them and I thought mmm, I don’t know about that sort of thing because I don’t like trying new things, but they were actually really nice. [laughs]*

(Parent follow up interview, unattributed)

The above case illustrated how change in dietary health was linked to wider problems for the family. Social services were involved with this family as a result of concerns about this parent’s ability to provide a safe environment for her child. She also had mental health problems, and following a serious domestic assault by a former partner had lost custody of her child. The FIP worker explained her concerns:

*So she took appropriate steps and left that [violent partner] relationship but around this time, approximately a year ago she had a lot of problems with her weight as well.*
She was not eating and lost a tremendous amount of weight and wasn’t really looking after herself and wasn’t, whereas she would when she had [child at home] but she wouldn’t when she didn’t have [child]. And of course before she had [child] most of the time and at this time she didn’t have [child] very often so she wasn’t caring for herself and looking after herself. So I referred to [community health trainer] who started working with [parent] quite intensively which was great and she’s been working with her up until now which is brilliant. And so [trainer]’s done work with [parent] around healthy eating. First of all, it was about starting to encourage her to eat something so it started on, I used to get her chocolate milkshakes and things like that just to get a bit of sustenance in her, and we moved on from there about healthy meals and we helped with some menus and she just did some cooking with [child] which was great.

(Family key worker interview, unattributed)

This example indicates how change was achieved through linked processes of relational work with the parent, practical hands-on support, and referral to a health agency linked with FIP. At the time of the follow-up interview, this parent had regained custody of her child.

Another example from a case study family also indicates how work to establish routines was seen as beneficial in relation to health and well-being. In this case, a primary aged child had not been attending school at the time of referral, but at the time of follow-up was settled into school. The child’s father said:

he missed out on most of the first year, due to his mum and that mollycoddling him too much. As soon as I split up with her, I said to him ‘Right, got to go’ and ever since he’s just loved it ... he gets on with everybody there and he’s catching up really well. So ... I can’t complain.

(Parent follow-up interview, unattributed)

The worker gave a similar account:

He now gets them to school every day and I think he probably does see the benefits of that now and see his son thriving. You know [father tells me], he loves school. He’s really proud and he comes back and tells his dad. I’ve never seen a boy like [child] who loves school as much. He’s six years old, he missed the first year and now he just thrives in that environment so much.

(Family key worker interview, unattributed)

An older sibling was interviewed in this family, and (s)he too had noticed change in the younger child:

he wasn’t very healthy. He was a bit overweight, but he kind of now he’s been exercising a lot more he’s lost a lot of weight.

(Young person follow-up interview, unattributed)

This example stands out from the other case study families because change was achieved despite the fact that the parent was very negative about his FIP worker. The worker described using threat of sanctions to initiate change, and the children were accommodated in care for a period during the intervention. The worker commented:
He did what was necessary to get those kids back [from care] and I respect him for that.

(Family key worker interview, unattributed)

Moreover, it was evident from the father’s interviews that even though he was very critical of FIP, the worker’s input still had some effect:

It was just another thing that [the key worker] moaned about [me] having to do. Do you know what I mean? So ... you know ... do it on my own ... in my own way, on my own terms and ... worked out better anyway, so ..... Yeah but you just have to cope with it the way it is. Do you know what I mean? If you don’t, then what are you going to do? No point sit there worrying about it and end up digging yourself into a hole ... you know so deal with it the way it is and accept it, isn’t it?

(Parent follow-up interview, unattributed)

These two examples are very different in some ways – one parent who said she ‘loved’ her FIP worker, the other negative in his account of FIP. However in terms of wider messages from the research, there are common themes. In both families, concerns about unmet basic needs in relation to health and well-being were linked to wider problems within the family, including – in both cases – maternal mental illness. And, in both cases, support in developing everyday routines like cooking and going to school evidently had wider benefits: for emotional health and wellbeing, and for child safeguarding, in developing demonstrable capacity to parent that contributed to children’s return to the family home.

6.1.2 Education and employment

Dixon and colleagues’ (2010) analysis of FIP monitoring data showed that just under two-thirds of FIP families were living in workless households (where no adult member was in employment, education or training) and 60 per cent of families had at least one child with problems at school (i.e. truancy, exclusion, or bad behaviour at school). Unsurprisingly, in this context, support for children and young people’s engagement with education, training and employment was a key focus for FIP activity with families. Whether this activity is considered to be health-related work depends on the breadth of definition of ‘health’ or ‘well-being’, but there was an evident association between involvement in education and training and emotional well-being for many young people in the present study. Several spoke about the satisfaction they had gained from re-engaging with education. For example, a young woman explained:

Because I was, like, I was naughty at school and that, right, she [FIP key worker] like helped to put the funds towards me going to college and she sorted out my work experience and she’s just sorted out loads of things for me that I wouldn’t have been able to do. ... Like at first I was still not going to school, still not going to college, but then like I just I did like she was giving me lifts to college in the morning and like giving me taxi vouchers and stuff and like just to settle in sort of thing. And she did and so I’m so proud of myself actually for doing it.

(Young person follow up interview, Area C)
She went on to say:

*I think obviously I’ve had to change myself as well. The way I was, I was just getting nowhere. I was rude to people and I was getting arrested and stuff like that, but [the FIP key worker has] made me realise, sort of thing, that there’s just no need for it, like there’s just no need for it whatsoever. Now I’m settled back into school. I’m going like I go Mondays and Tuesdays and now like I’m going up to my work experience and college. It’s just really good.*

Another young person described his sense of achievement in developing a clear career trajectory, based on the support he had received from his FIP worker:

*she was helping me with my school work and that and my education and I was like first, no .... I used to get in trouble with the police and that. And she was like pushing me like get a good education and then I tried my best to get back to a mainstream school. And then I got like myself back to mainstream school and then I told her I wouldn’t mind doing construction and she like told me how to do it and so helped me with construction and she woke me up in the mornings, telling me to go, not to miss it. And you feel like saying I can’t ... but then because I was going to construction I got my NVQ level 1 certificate. And then I’m doing level 2 now and she told me to go to another, do another level and if I do another level I get my CSCS [Construction Skills Certificate Scheme] card and I can start my job.*

(Young person initial interview, Area A)

In Area D, an eight year old with significant behaviour problems had been placed at a residential school for children with emotional and behavioural difficulties. At the time of referral, this child was causing significant concern because of anti-social behaviour problems; at the time of follow-up, his mother reported that, while there were still ‘hiccups’, she could see clear progress with the support of the school:

*the school phoned me and said they actually had an outbreak where he’d had a kick-off the first time, but half an hour later, he actually sat down and talked it through and said what was wrong and what he felt was wrong. ... I think he’s sort of getting to the stage where he’s feeling he can talk slowly about his emotions but half the time, he still struggles ‘cause he doesn’t completely understand why he’s feeling like it.*

(Parent follow up interview, Area D)

For parents/carers in case study families, poor physical and mental health (as discussed in Chapter Three) was an evident barrier to engagement in education or employment. Half the parent/carer sample was reported to have chronic and potentially disabling physical and mental health problems which inevitably limited their potential engagement in education and work. However, in one case, a significant parental alcohol problem was resolved through the FIP intervention, allowing the parent’s re-engagement with work and education. At the time of the initial interview, the parent was seeking voluntary employment and education access courses; by the end of the study the key worker reported that she had secured a university place. Whilst exceptional, this case illustrates the potential of FIP intervention to support families through a process of significant transformative change. In this case, a key factor appeared to be the parent’s readiness to change, a consideration discussed in more depth below.
6.1.3 Diagnosis of previously unidentified needs

As discussed in Chapter Four, FIP workers reported that many families appeared only to have a basic understanding of health-related issues and often normalised being in poor health. Awareness-raising in relation to health issues was seen as an important part of their role. For example:

Often FIP clients won’t see their lifestyles and behaviour as a problem especially if it’s something that they see lots of other people in their community doing, such as drinking and taking drugs. We need to work with them to help them come to a place where they recognise the detrimental impact it is having on them/their family and want to make a change.

(Key worker group interview, Area A)

Diagnoses of previously unidentified or unmet needs was an important outcome of work to improve family members’ health, as detailed in Chapters Three and Four. Examples given by family members and professional stakeholders included diagnosis of child learning difficulties, speech and language impairment, and adult psychiatric disorder. In the context of the present chapter – and in defining health outcomes for FIP families – this raises a critical point. We noted earlier the comment of one FIP manager that ‘the health stuff creeps out later on’. Health problems were often not identified at initial referral: some emerged when family members chose to disclose issues after trust had developed; others were identified through workers’ spending time with families. For example, a senior FIP practitioner gave the example of a parent who had recently been diagnosed with personality disorder, following a previous misdiagnosis which was complicated by her cannabis use:

[She] was being treated with medication for depression, [but] was going into chaos constantly and it took almost a year, eight or nine months, to discover that she actually has a personality disorder and the medication that she had been prescribed was completely inappropriate and was actually making her worse. [The worker] persisted with the appointment with the GP who finally made the referral to the personality disorder clinic ... It was [worker] who picked up that something wasn’t right and made sure they went back to the doctor. The mother was a cannabis user and so initially it was thought that it was the cannabis that was causing the problem and affecting her mood and as she tried to come off of cannabis her mental health deteriorated. The doctor increased her anti-depressants in response but this wasn’t helping her.

(Senior FIP worker, Area A)

This finding – about the emergence and identification of health needs over time – provides another potential explanation of Dixon and colleagues’ (2010) finding that longer interventions were associated with better outcomes. The potential of longer interventions to deal with emergent difficulties may have particular value when those emerging health problems underpin presenting referral issues, such as anti-social behaviour – as was clearly the case in our study.

Dixon and colleagues’ analysis of how far issues identified in the Initial Support Plan have been reduced at the time of exiting the FIP indicated that improvement in health domains was more limited than change in other areas. However, if health problems are not evident at the time of the initial referral and assessment, but emerge over the course
of the intervention, it could appear that the incidence of health problems has increased in association with FIP involvement. This patterning will be discussed in the final chapter, in relation to recommendations for the development of intensive family intervention services. Nonetheless, the identification of previously unmet or unidentified health needs was an important positive outcome from FIP work with families, and is a critical first step in work to address those needs.

6.1.4 Management of health problems

Following on from the identification of health needs, the study provided clear evidence that intensive family intervention could significantly improve parents’ and young people’s management and treatment of chronic physical and mental health problems, by encouraging and enabling engagement with appropriate specialist health services. Positive reported outcomes included decisions to engage in medical treatment (e.g. surgery for a long-standing back problem); resolution of long-standing drug or alcohol dependency; resolution of domestic violence problems; and engagement with therapeutic intervention and counselling related to previous trauma or child maltreatment (parents and children/young people).

Examples of FIP work to support engagement with health services such as those listed above were presented in preceding chapters and will not be discussed in detail here. However, looking across this range of work, it appears that one key outcome to emerge from the present study related to families’ capacity to manage health problems themselves.

Our previous analysis showed a high prevalence of chronic physical or mental health conditions among families in the present study. In these cases, the FIP intervention could not be expected to resolve the underlying health condition, nor could FIP support always prevent recurrence of crisis episodes. This finding again is relevant to understanding Dixon and colleagues’ (2010) data on limited change in health outcomes for FIP families. There was evidence from our study, however, that many family interviewees perceived greater agency in managing health conditions, and in dealing with health services and related agencies such as adult social care, as a result of their involvement in the FIP.

One case study parent said that ‘FIP have given me a lot of the tools to help me through, if that makes sense’, another remarked that as a result of the intervention, she could be ‘in control myself’. One parent described herself as ‘gutted’ when the FIP intervention had ended, but explained:

[you] can’t have them for the rest of your life can you? ... I’m on the level now where I don’t ... I don’t want the support now. I’m cush [very good] now.

(Parent B3, follow up interview)

Similarly, another parent, who had chronic mental health problems, explained:

Yeah, but knowing that I can pick up the phone, it’s made me surer in a way, because it’s knowing that I can do things myself now. And [FIP worker] taught me to do them things myself, and before I had her I wouldn’t even go out the door. And now I’m out the door, I’ve got a new flat and I pick up the phone to people, I pick up the phone to her ... and I just ... I just deal with every day stuff ... which I
wouldn’t have done without her. I wouldn’t have done that without her. She’s absolutely brilliant.

(Parent C2, follow up interview)

Young people also expressed confidence in their capacity to manage their situation in future. For example, one young man said:

Like if it wasn’t for the FIP programme and [FIP worker] and everyone, right now I wouldn’t be, I would’ve been in jail or something. But because he turned my life around like that... Showed me different ways, showed me options, showed me like give me gym cards and things like that, sort of things I can do.

(Young person A5, initial interview)

6.2 The extent and stability of change

NatCen analysis of FIP monitoring data (Dixon et al. 2010) indicated that improvements in health were not achieved by all families, and moreover, could be difficult to maintain. Among a sample of families followed up nine to 14 months after exiting the FIP intervention, there was less likelihood of maintaining reported gains in health than in other aspects of family functioning (Dixon et al., 2010).

The families followed up in the current study varied in their level of engagement with the FIP, and also in the extent to which change was achieved. Analysis of the in-depth family case study data, along with information about other cases described by managers and workers, indicates an interaction between engagement and effectiveness. The analysis identified four categories of potential engagement and outcome:

(a) families who fully engage and achieve significant change;
(b) families who fully engage, but where change is limited by difficulties too entrenched to be fully resolved;
(c) families who cooperate and improve, but do not fully engage; and
(d) families who do not engage with the FIP intervention.

6.2.1 Families who fully engage and achieve significant change

Cases in this category were families for whom major presenting difficulties appeared to be resolved by the end of the intervention; this included 11 of the 20 case study families. Two illustrative cases are summarised below.

The first case example relates to a family described earlier in this report where transformative change had occurred. At the time of referral, the mother had a significant alcohol problem and a teenage daughter was at risk of school exclusion because of her

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14 Throughout the following discussion of these categories, family cases are not attributed to Area or Family ID, to avoid risk of identifiability.
behaviour in school. The daughter was accommodated in residential care for a period during the FIP intervention. Key positive outcomes at the time of follow-up included:

- the mother’s successful completion of a residential rehabilitation programme, and the cessation of drug and alcohol use;
- the daughter’s re-engagement with education and return home from residential care; and
- the mother securing voluntary work and subsequently a place at university.

The second case example relates to a family with a constellation of problems very typical of those referred to Family Intervention Projects (see for example, Dixon et al. 2010). Difficulties identified following referral included parents’ and teenage children’s anti-social behaviour in the local area; parental mental health and substance abuse problems; physical health problems (including a heart attack for one parent); and domestic violence. At the time of the follow-up interview, key positive outcomes for this family included:

- the mother’s cessation of drug use;
- engagement by both parents with the GP in relation to the management of depression and anxiety;
- cessation of domestic violence and reduction of conflict in the home and neighbourhood;
- lifestyle changes in relation to household routines and dietary practices;
- young people’s engagement in training and education; and
- young people’s involvement in relevant health services (e.g. in relation to sexual health).

Both these case examples illustrate the success of intensive family intervention through FIPs, securing significant positive change – including change in relation to health – for parents and young people. This is not to say, however, that these families became problem-free: both parents and young people described ongoing struggles at the time of follow-up interviews. Even for families who described themselves (and were described by workers) as fully engaged, and who had clear positive outcomes from the intervention, change may not have been achieved in all areas.

In the first family case study described here, the key positive changes listed above appeared to be stable at the time of follow-up interview. At the same time, both parent and young person were experiencing stress associated with the young person’s return from residential care, and the young person reported some difficulty in maintaining hoped for changes in relation to their cannabis use. (S)he reported having stopped smoking when interviewed initially, but at the follow-up interview (s)he again said she had just given up. This young person spoke of their concern that long-term cannabis use could lead to schizophrenia, but giving up posed a significant challenge, in the context of a wider peer group where smoking was commonplace:
YP: Like I was with my friend yesterday, he built a zoot about that big, he said ‘Smoke some, ’cause I can’t smoke it myself’. I said ‘I don’t want to’ he’s like ‘Just two, just two. Trust me. Because you ain’t blowed for so long, two will get you lean’. I said ‘If I wanted to feel lean I would smoke’. And then everyone says to me ‘Oh and you can’t chill with people’. I said ‘Look I’ve got enough willpower, if I want to smoke I’ll smoke, if I don’t want to smoke I won’t. And I don’t want to, so I won’t.’ ... [But] like it went through my head, it went through my head - should I, should I. ... like three quarters of my brain’s telling me no. One quarter’s telling me you might as well. But the other three quarters are telling me don’t stoop to that level, don’t.

I: Yeah. I remember the last time I spoke to you, you’d pretty much given up, but you were having the odd puff now and again and stuff.

YP: Mm. But then it went from the odd puff back to every day, every day, every day, every day. That’s what I’m saying, the will power is if I start again – two puffs – that’s it, ‘cause I haven’t got the willpower – once I do it I know I’m going to keep going and keep going. And I thought to myself yesterday when I was sitting in his house, I thought that smells chung ... and I thought ‘Shall I just take two?’ and I thought ‘No, because tomorrow that means you’re going to buy a job’.

In the second family case example, positive changes in relation to parental drug use had been maintained, but there was some evidence that engagement in training and employment was less secure for one young person. His mother explained:

He was doing carpet fitting [an apprenticeship] and it was hurting his knees, so he says. ... So he walked out on it ... well he didn’t walk out – they found him another placement. On Thursday he went for his placement – nobody had turned up – so he come all the way home and then he phones up the placement ... well the place where he finished ... and they said like ‘Oh you’ve let us down’ ... but [he] did go that morning because he rang me from there and I said ‘Wait around half an hour to see if somebody turns up’ – and nobody ever did turn up. But he’s been going up [to the agency that will find him an alternative placement].

To highlight these challenges is not to minimise the significant positive change that both these families – and others – had achieved. Rather it is to note a need for realism in defining ‘successful outcomes’ for families with multiple problems. The research reported here focuses on families who have faced inter-generational disadvantage, who are dealing with chronic problems, and who are situated in communities where disadvantage is widespread. Even when these families can be supported to achieve significant positive change, they are perhaps unlikely ever to be entirely ‘problem-free’, and thus there is some blurring between this category and the next.

6.2.2 Families who engage, but achieve limited or unstable change

Following on from our observations about the need for realism in defining ‘success’, a second category in the present study related to families who were fully engaged and very positive about the FIP intervention, but where positive or stable outcomes were limited by factors which were beyond the immediate scope of the FIP intervention. Six case study
families were in this category, including families with entrenched chronic health difficulties.

By the very nature of their referral criteria, Family Intervention Projects are likely to work with families in which crises can erupt, and this has implications for the sustainability of outcomes. For example, in one case study family, where the mother had significant physical and mental health problems, her poor health had a significant impact on children in the family. Her son, a young man in his teenage years, explained his feelings:

No, you know what I feel like, I really feel worried about, say for example I’m taking my mum out for a walk, a little walk, I come back and the lifts broken, both of them, I’m just saying that. That’s what I’m worried about, say both the lifts are out, how’s she going to be walking up the stairs?

A particular concern for the key worker was the impact of the mother’s ill health on a daughter, who was in the role of carer. At the time of the family follow-up interviews and key worker interview, this daughter had just disclosed to the key worker a recurrence of her own mental health problems. The key worker explained:

Since yesterday [some time after the end of the FIP intervention] I received the information she’s not coping well ... She used to self harm before we came in two years ago, when the family was a bit crazy. When everything got better she stopped. She told me that ... now there are times, she goes any problem, this is her words, any problem that happens ‘I just want to go to the bathroom again’. She’s starting to think about self harming again.

In response to this information, and despite the fact the case had previously closed, the key worker arranged ongoing contact with the family (at a lower level than previously, and by another FIP worker), to address two specific tasks: to support the young person in accessing mental health support, and to negotiate and help to organise a paid carer for the mother (which had previously been offered by adult social care, but which the mother had declined). In this case – as for other families in the study – it was important that FIP could activate further support when a new crisis arose. Given the previous success of the FIP key worker in ensuring access to health services, and the daughter’s evident trust in the worker, in choosing to disclose the recurrence of her problems, this example also indicates the importance of flexible endings – or stopping off points – to an intervention.

The experience of another case study family raises a further question about how, and at what time-point, ‘good’ outcomes are defined. In this case, the presenting referral issues related to anti-social behaviour and child safeguarding concerns, associated with the mother’s experience of serious domestic violence and related mental health problems (including significant anxiety problems and agoraphobia) and prescription tranquilliser use. Over the course of the FIP intervention, positive outcomes included the end of the violent relationship, maternal engagement with mental health services and cessation of anti-social behaviour; the mother also engaged successfully in work around basic health needs for herself and her child, including diet and smoking. When interviewed for the second time, however, the mother reported that several months previously she had experienced violence from a new partner, and this had triggered an escalation of her mental health problems. As a result she had temporarily lost custody of her child. This pattern of events implies that positive outcomes for this family were not maintained, but by the time of the follow-up interview the situation had changed again: the mother had
ended her relationship with the violent partner, withdrawn from prescription tranquillisers, and successfully challenged the loss of custody of her child – all without active input from the Family Intervention Project, although both she and the worker reported that they spoke occasionally by phone. She explained:

*And then I thought, do you know what, I'm not doing this anymore, I'm just going to go and get my son, because in the court order it says I'm allowed him and I've got parental responsibility so you can't do anything ... and [the social worker] didn't like that at all. And I phoned [FIP worker] and I just said 'Look I'm going to go and get [my child]'. So she was like ‘Okay, fair enough, just be careful’. I was like ‘All right’. So that’s what I’ve done, just stuck to the court agreement, done what I’ve got to do, and I've got him back. So ... it’s been up down, up down, up down. Hopefully it'll just stay up now.*

As these case examples illustrate, positive outcomes from work with the family may not be stable if outcomes are influenced by factors – such as chronic physical or mental health problems – which are beyond the immediate scope of the FIP. This highlights the importance of considering what should count as a ‘successful’ outcome for FIP families (and when it should be measured), given that new crises may arise or problems recur.

### 6.2.3 Families who cooperate, but do not fully engage

This category of outcome relates to families who cooperate with the requirements set within the FIP intervention (e.g. participating in parenting courses, attending drug services), but who were said by workers not to have fully engaged. Three case study families appeared in this category. For two, presenting and referral issues had improved or were even resolved by the time of the follow-up interview, but all three families were described by workers as resistant to change – albeit to varying degrees – and some were critical of the intervention. In one case, at the time of follow up, child placement measures were in train.

Two of the three cases in this category had not yet ended their involvement with FIP, and in one case, the worker and family members described developing engagement over the course of the intervention. By the time of follow-up, the parent had grown more appreciative of the worker’s involvement with their family, and acknowledged that ‘*I think [key worker] gets the point across of what I want from things all right*.’ The key worker for this family observed that this parent had still some ambivalence about the support they requested, suggesting that:

*[(s)he] paid lip service to most of it but really didn’t want counselling. ... There is a fear for [them] to change ... so [(s)he] chose not to engage.*

Some aspects of family health had improved significantly for this family, as a consequence of the identification of previously unidentified health and developmental needs and support for access to services. Other concerns, including those related to aspects of young people’s behaviour in the family, were not resolved and remained a focus for ongoing work within the intensive family intervention.

Two cases in this category involved families where the father was the lead family member involved in the work, raising a question of how gender fits into the relational approach to work described in the previous chapter. One of these cases was described
earlier: the father was critical of the FIP worker, but the family had successfully resolved key referral issues, including child safeguarding concerns, children’s engagement with education, anti-social behaviour problems and risk of eviction. The father (as quoted earlier) had commented that, he had to ‘deal with [the FIP requirements] the way it is and accept it, isn’t it?’ Similarly, the worker observed:

He did what he needed to do. I spoke to them, he said ... ‘I’ve done the Triple P group, I’ve done all eight weeks. When I phoned [the Triple P worker] she said, ‘well, he missed two of the eight weeks and when he was there I really felt that he was not being fully open’. ... He puts on this front of this very together guy but he does struggle ... and it is all a bit of a front really.

... He will do what is needed. He will go to the alcohol tests and particularly when it got to the point where his kids were taken into care, something that had never happened really, apart from at the very beginning. He’d always been on that threshold, I don’t think he ever thought that would happen. I think he was a bit shocked when it did. He did what was necessary to get those kids back and I respect him for that. He now gets them to school every day and I think he probably does see the benefits of that now and see his son thriving. ... So, yeah, he has done what’s needed to get through but I’ve really no doubt that he will continue to have links with known offenders, potentially continue to use substances as and when those tests stop and there will be dysfunctional aspects of his lifestyle but it’s at a level nowhere near as bad as it was. Not at a level where he can’t have those kids I don’t think. It is good outcomes with the case really, generally.

As well as the families described above, other cases were described where family members had, for the most part, engaged, but where pockets of resistance remained – in relation to some aspects of work, or by some family members but not others. Limitations in engagement with FIP activities were attributed by workers to parents or children not being ‘ready’ to make changes in entrenched patterns of behaviour, or to their fear of addressing underpinning trauma and difficulties. Across case study areas, several key workers gave examples of family members presenting barriers to change. For example:

I encouraged him to go for work and he said to me, he cannot work [because] he’s not qualified. I told him, okay let’s go to the college. And that way you can become qualified and then you can do it. Erm he ... got the opportunity to be qualified but he didn’t complete it. Because, he has got a knee problem and he has appointments with the hospitals. And secondly he was saying he didn’t get proper communication with the college – what time he will start, what time he will finish, you know things like that. ... But in my opinion it’s human nature, that people, sometimes they do it but they fall down, they don’t continue. ... And as an adult person, it’s not a child. You can take [a child] to the school and tell him go, you can encourage him. I tried to go with [this parent], even with the college, I assisted him. I didn’t tell him to go. I’d pick him up and went with him ... I was waiting for him while he was in an exam. ... I go to the house and pick up and make sure that [he goes] but as an adult, to keep him in class is another matter. [laughing] It’s another matter.

(Family key worker interview, Area A)
[Father] was assigned to Strengthening Families but he had to be taken off the course because of his disruptive behaviour.

(Family key worker interview, Area A)

In another area, a key worker observed:

it certainly does depend on willingness and where they are in their head and whether they are ready for that intervention or not, how far they’ve gone, how much of a crisis point they’ve hit where they’ve suddenly thought actually I need to do something. It’s whether you hit that crucial moment and then you can get in a do the assessment within 6 weeks. Then we’ve got another category of family, haven’t we, where you can put a key worker in and there is a lot of resistance. Where they’re really not in the mindset and sometimes you can work with that and it might take longer but you can get through that and other times you can’t.

(Key worker interview, Area D)

Echoing these perspectives, a parent with a history of childhood abuse, substance misuse, domestic violence and depression described her resistance to engage with counselling for issues that she did not feel ready to address:

[FIP worker] got me in touch with Relate. ...The counselling service. But then I got too emotional. Then I didn’t feel ready for it after that, so I left it. I’d had enough. I always want to concentrate on building bridges in my life, not go back in my past, so I couldn’t hack that at the time.

(Parent follow up interview, unattributed)

By contrast, family members who felt ‘ready’ to make changes appeared much more responsive to FIP support, as illustrated by two parents’ accounts of their feelings at the start of the FIP intervention:

I just couldn’t stop drinking really, couldn’t stop drinking, I was taking cocaine. And it was just that really, I wasn’t erratic or anything – you would never know I was an alcoholic, nobody believed me that I was. I mean I was drinking non-stop for like 10 years every day. But I’d just had enough, just wanted ... just wasted my life away really, you know.

(Parent follow up interview, Area A)

My actual thought was ‘Thank God someone’s coming to help me’. Because it actually took me to get down on my hands and knees and beg a police officer to get me help – because social services were doing nothing.

(Parent initial interview, Area D)

6.2.4 Families who do not engage with the FIP intervention

The primary focus of the present study was on learning from well-developed and successful practice, and in-depth work in the case study areas did not include any families who had not engaged with FIP interventions. There is also, inevitably, limited information about families who do not engage within the NatCen analysis of FIP
monitoring data (e.g. Dixon et al., 2010), and so the challenges of work with this category of families remains an area for further research.

Nonetheless, it is possible to theorise that there may be parallels between the perspectives of these families and those described above as more resistant, or not ‘ready’, for intensive family intervention. The notion of treatment readiness is well-established in the psychotherapeutic literature, and researchers such as McMurran and Ward (2010, p83), writing about psychotherapeutic interventions for criminal behaviour, have argued for a need for ‘practitioners to develop their interventions to promote treatment readiness and engagement’. Arguably, such developments are equally relevant for parenting and family support interventions – and particularly for families with complex problems, where differences in family members’ motivation may act as a barrier to engagement of the family as a whole. One FIP project manager discussed this issue:

So how do you make that initial contact? How do you get them to engage in that service in the first place? ... And the other thing was they’re in certain families where one parent has engaged quite well with the service and the other one’s undermining it all.  

(PM9)

This pattern was evident in one case study in the present study, a large two-parent family. In this case, referral was triggered by concerns about violent and sexually inappropriate behaviour by one teenage child in the family. The main point of contact from the initial referral was the young person’s father, and the key worker explained:

Now at that time ... it was really hard to talk to [the mother] because dad was always there and he always used to say to me, she’s agoraphobic, she can’t come round, and round loads of people she won’t talk. So that’s how he kind of blocked the area between us getting to talk to them. ... At first [father] ... didn’t want us, he didn’t want to ... I think for [father] he didn’t understand that we were here to help, we’re not here to make things worse. But he kind of put gaps in between our level of work, and that kind of really did [limit] the work that FIP could do for [young person]. So I think it got to the stage ....about a month and a half of not being able to be proactive with [young person] and the services.

Through persistence in trying to engage with the mother in the family, the worker managed to get round the father’s reluctance to cooperate with the FIP, by visiting the house when (s)he knew he was not home. (S)he said:

Well [father] wasn’t in, so I went straight to the house, and then I kind of ...I thought let me do it this way, because if [father] knew he’s going to think I’m trying to do a fast one. But I didn’t want to just go by [father] because we had a lot of problems with [him]. He was so controlling and everything that he controlled, spoilt everything. So I wanted to kind of bypass that and get to mum. And [father], you know said he didn’t work but we found out that he did work. ... And every time we had our meetings at a particular time he couldn’t come ... But once I started actually working with mum, she opened up to talk about the problems that she was having.

For this case study family, the worker’s strategy was successful, and engagement was secured. As an example, however, it illuminates potential blocks to engagement with
families – barriers which are hardly surprising given the entrenched mistrust of professionals described by many parents and young people in the study. One FIP project manager commented:

we’re talking about families where patterns of behaviour are entrenched. And intergenerational, and, you know they’ve probably gone on...you know their parents didn’t engage with services, and it’s really about getting people to engage with services. If that service can go to them they’re more likely to engage, and we’ve found that they do.  

(PM8)

In the case described above, work with the family was able to move forwards once trusting relationships had been established with the target young person and his mother. In a similar vein, another FIP project manager commented that her project rarely had problems with families withdrawing from the intervention once initial engagement had been secured:

I have to say we haven’t had many unplanned exits. Once the family actually engages with us over a period of time we actually find they stay with us to be honest. They stay with the project and finish the intervention. Where they’re not going to stay with the project that happens very, very quickly at the beginning in terms of that sort of engagement process, when you’re really trying to get the family, you know get the family to engage with you.... We don’t actually find that people leave the project once they’ve built up a relationship with the key worker. 

(PM10)

### 6.3 Summing up: defining success and stability of outcomes

The findings presented in this chapter indicate the potential of intensive family intervention to contribute to significant improvements in key aspects of family health. Family case studies and workers’ accounts of a range of cases illustrated change in the following areas:

- improving health-related practices, such as diet, home environments, and daily activity;
- supporting engagement with education and training, with concomitant benefits for children’s well-being;
- supporting families in addressing drug and alcohol problems;
- supporting families in managing chronic health problems, through identification of health needs and access to health services.

Nonetheless, the research also demonstrated the need to be realistic about the extent of change that could be achieved in relation to family health. Change in some aspects of health – such as chronic physical or mental health problems – was beyond the scope of intensive family intervention, and the study included examples where change was constrained because of events beyond families’ control (such as a violent ex-partner’s release from prison). For such families, flexible endings to the intervention were particularly important in averting deterioration when problems recurred, and in supporting family members’ agency in accessing other services.
In the context of exit from FIP services, one FIP project manager (Area D) noted a potential structural barrier that could reduce the chances of securing stable change in relation to health. Within the context of an Anti-Social Behaviour (ASB) FIP, (s)he observed that ASB, and not health, was the trigger for referral. Consequently, the FIP service could not ‘retain a family in FIP just because there are outstanding health issues’, once the presenting problem of anti-social behaviour was resolved. (S)he went on:

*By the time FIP comes to closure many of the health needs which the family has will have already been dealt with along the way, but if there are any outstanding [health concerns] then FIP will signpost them on to appropriate support services (universal) and make sure they are well integrated into these.*

(FIP Project Manager, Area D)

Consequently, for many FIP families, successful outcomes in relation to health are not a requirement for the end of intervention – although they may be, if health needs are clearly seen to underpin referral issues. This finding has implications for understanding the variation in ‘successful’ outcomes across different aspects of families’ lives that was apparent in Dixon and colleagues’ (2010) analysis of FIP monitoring data. One might expect less evidence of change in relation to health concerns compared to other domains such as family functioning, given that resolution of health issues is not required before cases can be closed.

Nonetheless, health is clearly central to the difficulties faced by families involved in Family Intervention Projects and as discussed in previous chapters, health was a core focus for the work. In line with Dixon and colleagues’ (2010) quantitative analysis of national FIP data, the results presented here show that, for some families, work with FIP was associated with the resolution or amelioration of long-standing health problems, or the prevention of their recurrence. For other families in our study, perhaps including some of those cases that appear to have achieved less change in relation to health in the national data analysis, positive outcomes were still achieved if a more nuanced definition of ‘success’ is applied, which perhaps more accurately reflects the aims of the FIP programme. These positive outcomes related to the identification of previously neglected health problems, to improvements in the management of chronic or recurrent difficulties, and to a greater sense of agency and capacity to seek appropriate help and support. Within this framework, another FIP project manager summed up the outcomes that (s)he felt her project could realistically achieve:

*we’re looking to get families to a position where they can start taking on some level of responsibility for aspects of their life. And we work through, we work through with them, to a point where they are able to engage with the universal services, themselves. So maybe they don’t need us to go along to health appointments anymore, they can get there, or they can make the telephone calls, they can set them, they can do the negotiation they need with schools. Around, you know maintaining their tenancy. That’s ideally the point that we want to get to, where families will then just [be able to] interact with the community in a way that isn’t just about anti-social behaviour.*

(FIP Project Manager, Area A)
7. Discussion and policy implications

This final chapter summarises the main findings from the research in order to identify key implications for policy in relation to the future development of intensive family intervention services. The study involved over 100 in-depth interviews with a variety of stakeholders, including:

- parents and young people from 20 families who have used FIP support;
- FIP national specialists and regional leads (11 in total); project managers from 18 FIP services across the countries, and individual and group interviews with project managers and key workers in four case study areas; and
- 18 health professionals from a range of agencies, including the four health workers seconded to Family Intervention Projects in the case study areas.

This qualitative work complements the national quantitative monitoring of outcomes for families supported by FIPs, by offering an in-depth analysis of process and progress in relation to work with families, with a particular focus on their health needs. As noted earlier, the study did not comprise a systematic evaluation of health outcomes, and the sample should not be seen as representative of FIPs nationally, nor of intensive family intervention services. The methodological constraints of the research were discussed in detail within Chapter Two, and are not repeated here. However, in considering the implications of the research for policy and service development, it is important to recognise that the study was focused on learning from well-developed services. Thus, for example, the families who were sampled had completed (or were close to completing) the FIP intervention; the four case study areas all had established links with health agencies, and all had appointed a specialist health worker within the FIP project team. The research therefore illuminates the potential of intensive family intervention to improve family health, rather than describing or evaluating what was typical of FIPs at the time of the study. Nonetheless, the study included a relatively large number of interviews (for a qualitative study) representing a range of perspectives – and there was strong consistency in the themes which emerged from different data sources across the study.

7.1 The health needs of families referred to Family Intervention Projects

The extent and complexity of health needs among families involved with Family Intervention Projects was striking. The study adopted a broad definition of ‘health’, including physical, emotional and social health and well-being, encompassing issues such as the ability to manage interpersonal and familial relationships. Within this conceptual frame, it was evident that health was a critical issue for many families involved in Family Intervention Projects. A highly consistent picture emerged of families with unrecognised, unmet, and/or poorly managed health needs. These related to key aspects of basic health, including personal care, environmental and socio-emotional health, and significant and chronic physical and mental health problems, for children and their parents.
A key theme to emerge was of families for whom very **basic health needs** were unmet or poorly managed at the time of referral to Family Intervention Projects. This included poor dietary health – with concomitant under-nutrition and/or obesity among family members – and low levels of personal care. Examples of the latter included severe untreated head lice infestation, and poor dental hygiene leading to significant tooth decay. Smoking was common among parents and young people, and was related to more significant health problems (e.g., asthma and COPD) for some family members. Interviewees (professionals and family members) also frequently reported environmental and related health problems including poor hygiene in the home (e.g., rat infestations; accumulated rubbish) and unsafe home environments (e.g., an open bucket of petrol in a small house). The lack of attention to basic health needs among families involved in FIPs, as reported in the present study, is relevant to concerns about childhood neglect. Some families who are referred to FIPs are the subject of child protection plans, although many are not. As such, these findings indicate that Family Intervention Projects are targeting families with significant levels of neglect that do not reach social services child protection thresholds.

Along with basic parental and child health issues, the study revealed an apparently high prevalence of **major health conditions**. Chronic and significant family health problems were consistently reported by project managers and key workers in all of the study areas, and were a key feature of the lives of many case study families. Chronic health problems for children and young people were often attributed by FIP workers to factors in the home environment. Examples including asthma linked to parent/carer smoking; emotional and behavioural problems related to prior sexual abuse for some children and young people; and physical and emotional health problems related to poor care of children (e.g., inattention to basic care needs; inadequate supervision; parenting difficulties). Ten of the 20 parents in the study described significant and often disabling health conditions, including chronic physical and/or mental illness.

Another striking feature of families in the present study relates to the ‘multiplicity of issues’ described by Devaney and Spratt (2009). Families often faced **complex and inter-related health problems**, and difficulties were exacerbated by poor management of health needs, linked to other problems such as stress, depression, anxiety and substance misuse. Children and young people in the study also reported a variety of conditions that could be attributed to wider stressors in the family environment, including problems such as disordered eating or sleeping patterns, and migraines. For parents, physical and mental health problems were often linked to other factors including history of abuse, domestic violence, bereavement, or relationship issues within the family.

**Poor health or unmet health needs often under-pinned other problems.** Unmet basic health needs could act as a barrier to engagement with other services; project managers gave examples of children with uncorrected visual impairments having problems at school and of a mother gaining the confidence to participate in group parenting programmes after her teeth had been fixed. Chronic health problems, such as disabling back pain which was not being treated by specialist services, were associated for two mothers in the study with depression and previous suicide attempts. At the time of referral, both were making extensive use of pain medication which affected their ability to parent. In both cases, FIP referrals were triggered because a teenaged young person was engaged in high risk or anti-social behaviour, and the two families’ key workers drew a clear link between parental health problems and the young person’s behaviour, so had addressed both in their interventions.
The prevalence of poor health among families referred to FIPs is perhaps not surprising. After all, a wide body of literature shows an elevated incidence of health-related difficulties amongst families with multiple problems (e.g., Flaherty et al. 2006; Romeo et al., 2006). The present study also indicated that a broad conceptualisation of health is necessary to understand the complexity of health and well-being among families with multiple problems. Problems were often intertwined, and the impact of inter-generational patterns of adversity and maltreatment on current health behaviour was highlighted by many interviewees. At the same time, presenting referral issues – such as safeguarding concerns and anti-social behaviour – were often seen to be underpinned by health issues.

**Policy implications (1): Families receiving intensive interventions often have significant unmet health needs**

The extent and complexity of families’ health needs, along with evidence that unmet and poorly managed health needs often underpin or contribute to families’ wider social difficulties, indicates that work on health issues is central to the task of intensive family intervention, and is critical to enabling wider change in families’ lives.

7.2 FIP work with health issues

Although it has been suggested (e.g. Gregg 2010) that FIP services pay insufficient attention to families’ health needs, this was not found to be the case. All 18 projects in the study consistently described two main strands to health-related work: direct work with families to identify and address health needs; and work to address families’ difficulties in accessing and engaging with health services.

7.2.1 Identification of health needs

**Families’ perceptions**

Workers’ and family members’ accounts indicated that health problems were often unidentified or unaddressed. In part, this was seen to stem from a lack of awareness of health needs, but parents, young people and professionals also highlighted difficulties with management of health problems and with accessing and engaging with health services. The study identified a number of reasons for these patterns of health behaviour.

Potentially harmful health practices – such as excessive alcohol consumption, recreational drug use, smoking and poor diet – were often said by FIP and health professionals to be ‘normalised’ within the local community. This observation was reinforced by accounts of drug and alcohol use from parents and young people in the present study, many of whom described problematic drinking and substance use amongst peers, siblings and other family members.

For some families in the study, the normalisation of health problems and harmful health practices also related to intergenerational patterns of adversity. Some parents in the case study families had spent periods in care as children, and they and others in the study had experienced significant abuse or neglect themselves in childhood. Workers in particular drew parallels between these early experiences and parents’ current care-
giving and engagement with health, and a small number of parents also highlighted these issues. Some parents were keen to engage in counselling or therapeutic work to address their childhood experiences; others were more hesitant about raising difficult issues from the past.

Families’ lack of recognition of health needs was also partly attributed by workers to the multiplicity of problems and levels of chaos in families’ lives. At the point that families were referred to FIPs, health was often not perceived to be a priority relative to more pressing concerns such as debt, court appearances, or threat of eviction. Several parents and young people also described themselves as feeling overwhelmed, or desperate for help with their situation, when they were at the point of referral.

**Assessment**
Reflecting the fact that families were often seen to have limited awareness of health issues, the assessment and identification of health needs was consistently reported as a priority for intensive family intervention services. In some cases, health concerns were immediately obvious – and workers and managers described a variety of cases where presenting health issues had to be addressed before other work could proceed. However, many health issues took time to emerge, or required specialist training and knowledge for accurate assessment. A gradual approach to assessment, over a series of visits with the family in the weeks following referral, allowed health issues to be disclosed as trust developed. This staged approach was also said to offer a fuller understanding of health needs, because families were seen repeatedly over a period of weeks, and at different times of day.

One manager summed up the feelings of many when observing that ‘the assessment is the pivotal bit in the FIP’. However, professional stakeholders consistently emphasised the need for workers in intensive family intervention services to work within the limits of their expertise. The experience of health agency stakeholders suggested that this tension was usually managed well, but it was widely argued that specialist health expertise was essential to identify needs and thus appropriate routes for referral.

7.2.2 **Addressing health behaviour and management of health needs**

Christensen (2004) writes about the concept of ‘health socialisation’ within the ‘health-promoting family’, and highlights the importance of the family context for the development of healthy practices and behaviours. The notion of a healthy setting for childhood is similar to the concept of ‘healthy schools’, within the theoretical framework of multi-disciplinary ‘settings approaches’ to health promotion (e.g., Dooris 2009). Whilst ‘settings-approaches’ have often been concerned with institutional contexts such as schools and colleges (e.g., Warwick et al., 2008; Aggleton et al., 2009), the way in which FIP key workers approached work with families’ health reflected a ‘socialisation’ towards more healthy practices within the family ‘setting’. The holistic and flexible approach of the FIP model was well suited to this, including as it did work in relation to daily activities and routines, household environment and safety, personal care (e.g. dentistry), diet and food, smoking, alcohol and substance use, and engagement in education.

The **persistence, duration and intensity** of the approach adopted by FIP key workers were facilitated by low caseloads relative to other services such as children’s social care. As a consequence, FIP key workers spent a lot of time with families, at different times of day, which promoted a more holistic view of families’ health practices, and their needs and
well-being. Both parents and young people highly valued the **continuity of support** and the **relational approach** of key worker support. Many families using FIP had previously been reluctant to engage with health services because of negative experiences with prior professional involvement, and in this context the enthusiasm of parents’ and children’s positive comments about Family Intervention Projects was remarkable. The trust and engagement which developed over time with FIP key workers encouraged the disclosure of poor health and related difficulties. Once health needs were identified, intensive work and practical support with health-related practices could be put in place to support the development of sustained and manageable change in health behaviour. For families with complex and entrenched health needs that may be difficult to articulate in the context of a brief GP consultation, or for those who feared stigma or the consequences of revealing problems, the combination of time and trust offered by FIPs seemed critical.

Another key feature of the FIPs approach was the importance of **flexible endings**, and of a tapered reduction of support. This gradual reduction of support is a feature of other long-term intervention models, such as Family Nurse Partnership (Barnes et al., 2011). However, the greater flexibility of FIP endings contrasts with more standardised approaches in being more provisional, and is particularly important given the unpredictability of the lives of many families involved with FIP.

**Theoretical approaches to intensive family intervention**

Intensive family intervention services such as FIP are not ‘manualised’ interventions, like many parenting programmes such as the ‘Triple P’ intervention, which follow a prescribed model of service delivery. This greater openness inevitably produces more variability in delivery of intervention, and makes it more difficult to calculate the likely Social Return on Investment (SROI)\(^{15}\) from investing in support of this kind (e.g. Allen 2011). A ‘theory of change’ or logic model – which sets out the processes and stages by which an intervention is expected to lead to positive outcomes – could help non-manualised interventions such as FIPs to make the case for investment in the service, for example through the mechanism of Social Impact Bonds\(^{16}\). FIPs have sometimes been criticised for lacking a standardised logic model of change, but in fact our research suggests that there was a high degree of consistency in approaches to FIP intervention, in terms of projects’ working models and key working principles. In addition, the distinctive characteristics of FIP working, described across stakeholder groups in the research reported here, correspond to the principles set out in guidance for managers of intensive family intervention services (CWDC 2011).

Within the FIP approach to intensive family intervention, the **principles** of the approach spanned families and projects within the study. The **content** of the intervention was varied – purposely customised to family needs, to provide a flexible, family needs-led approach that could be seen to enable an attention to health (in the broadest sense), and staging of work with health alongside other concerns. It is doubtful that these benefits could easily be replicated within less flexible intervention models. Flexibility also enabled the persistence that was a key feature of the work, because workers could


\(^{16}\) [http://www.socialfinance.org.uk/work/sibs](http://www.socialfinance.org.uk/work/sibs)
accommodate and work through the crises and unexpected incidents that characterised many families' lives. Similarly tailored approaches are fundamental (and relatively unquestioned) in services such as children’s social care and youth work, and in approaches to parent and family support in other European countries (e.g., Banks 2006; Boddy et al., 2011).

Whilst intensive family intervention services such as FIPs have clear guidance on key working principles (CWDC 2011), these principles are not explicitly articulated in relation to theories of change or intervention with children and families. However, the principles of the FIP approach that emerged so clearly from the current study are wholly consistent with a broad academic literature – so the potential to articulate this theoretical framework is there.

For example, when considering how key workers support families’ socialisation in relation to health needs, one striking theme to emerge was the way in which workers and managers described ‘hand-holding’ as a key element of the FIP approach. Their accounts of ‘hand-holding’ have parallels with models of parent and family support within continental European counties that have been influenced by ‘social pedagogy’ – a theoretical discipline and professional qualification for work with children, young people and families in many European countries (e.g. Petrie et al. 2006; Cameron and Moss 2011).

In France, for example, models of parent and family support commonly refer to the concept of ‘accompaniment’ (accompagnement) (see Boddy et al., 2009b). Join-Lambert and Euillet (2011) write about accompagnement in the context of a partnership approach to work with parents, informed by psychotherapeutic influences on work with children and families in difficulty. This is reflected in the FIP workers’ accounts of ‘hand-holding’, and also in the emphasis on practical support to help families to develop the capacity to manage their complex lives in difficult circumstances. The German social pedagogic concept of a ‘life-world orientation’ (Lebensweltorientierung) is also relevant to work with multiple problems: in common with Bronfenbrenner’s ecological systems approach (e.g., 2005) the principle demands attention to the individual’s current circumstances – their life-world – as well as to their aspirations for the future (Eichsteller and Holthoff, 2011).

These theoretical constructions have parallels with English-language conceptualisations of emancipatory social work (Banks 2006) and informal education (e.g., Jeffs and Smith, 2005). The latter is characterised by particular values and principles which inform practitioners’ ways of working in a range of spaces and places, including people’s homes. The core values that shape informal education are said to be respect for the dignity of people, the promotion of wellbeing, valuing truthfulness, promoting self-governance and autonomy, and promoting fairness and equality (Jeffs and Smith, 2005). Informal education practice is also grounded in a set of principles which bring these values to life through talk and conversation. While activities – such as art, cookery or sport – may take place, just as important are the conversational elements of activities which contribute to dialogue and to learning (Spence, 2001).

Jeffs and Smith (2005) outline a number of ways that talk and conversation contribute to learning. Although a routine part of day-to-day life, they note that conversation is a social, yet complex process, involving co-operation, interpreting and responding to others’ feelings and experiences, and giving one another ‘room’ to talk. It also involves a degree of agreement about a topic or issue under discussion and involves certain commitments
to truth and action – ‘... effective work’ they suggest ‘must always be based upon participants believing in the truthfulness of the educator. Once (...) trust is broken, there is the danger conversation will cease and informal educators will no longer be productive’ (p. 30).

Other features of conversation that contribute to learning are the ability to ‘be with’ a person, rather than seeking to act upon them – again, characteristic of the concept of accompaniment. While proscription and prescription may be necessary on occasions, what those working with challenging families need is the ability to engage with others’ views, even if they are found to be objectionable. Openness to others’ views does not necessarily mean acceptance of them, but does involve the ability to seek clarification on what is being said, a consideration of the history and contextuality of others’ perceptions, and the ability to explore alternatives.

Multi-disciplinary ‘settings approaches’ to health promotion also have useful commonalities with the approach of intensive family intervention. Dooris (2009, p30) has argued that a settings approach is rooted in values such as participation, equity and partnership, and characterised by three interconnected dimensions:

(i) an **ecological model** that ‘represents a move away from a reductionist focus on single issues, risk factors and linear causality towards an holistic vision of health and well-being determined by a complex interaction of environmental, organizational and personal factors within the contexts and places that people live their lives’;

(ii) a **systems perspective**, acknowledging ‘interconnectedness and synergy between different components, and recognizes that settings are both complex systems (unpredictable) and open systems (interacting with the other settings and the wider environment)’;

(iii) a settings approach concerned with **whole-system development and change**: introducing, managing and sustaining change within the setting as a whole system.

Whilst this account draws on organisational theory, there are evident parallels with family systems theory (e.g. Sturge-Apple et al., 2010). The commonalities with the key principles of intensive family intervention highlight the potential relevance of settings approaches to work within the home.

This discussion of theoretical approaches is not merely a matter of academic interest, but has important implications for policy and practice development in relation to intensive family intervention. Intensive family intervention services such as Family Intervention Projects have been open to criticism because they have a less clearly specified theoretical basis for the underpinning principles of their work than do standardised parenting interventions, or services framed within a distinct professional discipline such as social work.

Whilst the theoretical underpinnings for FIPs are not articulated in policy or practice guidance (e.g., CWDC 2011), the key principles underpinning intensive family intervention services – as set out in that guidance and as documented in the present study – clearly correspond to well-established theoretical principles within an internationally recognised academic literature. This includes cross-national evidence on intervention with multiple problem families, and theories of emancipatory social work,
informal education, health promotion, and social pedagogy. All correspond to an overarching theoretical framework of ecological systems theory as proposed by Bronfenbrenner (2005). This concordance with established theoretical frameworks is important because, in the present study, the key principles of intensive family intervention approach appeared to be pivotal in securing families’ trust and engagement in the intervention, and consequently in identifying and addressing unrecognised, unmet and poorly managed health needs.

Policy implications (2): An explicit theoretical base for intensive family intervention

The study indicates the potential value of intensive intervention that is based on consistent principles whilst allowing customisation of the content of the intervention to meet diverse families’ needs. The principles of intensive intervention set out in existing practice guidance appeared to play a key role in work with families’ health needs. However, policy and services in relation to intensive family intervention would benefit from an explicit articulation of the theoretical rationale for the principles which underpin the approach. This would be valuable in order to:

- inform the design of services and training of workers within a service with a diverse professional base; and
- facilitate the articulation of a logic model for intensive family interventions, which would develop the potential to demonstrate future social returns on investment and so provide a rationale for future funding.

7.2.3 Families’ use of health services

Families had varied experience of involvement with health and other services prior to referral to FIP. Given the diversity of the family case studies, it is not possible to gauge how prior service involvement might have impacted on families’ needs at the time of referral, nor is it possible to assess whether prior service use could have prevented the need for intensive intervention. However, the study clearly showed that, at the point of referral, families often had low levels of engagement with both primary and specialist health services, despite their frequently extensive health needs. Consequently, work with health was seen as a priority for intensive family intervention at both a strategic and operational level. FIP managers and key workers, across the country, described similar challenges and priorities for family intervention services in working with health agencies. These priorities centred on:

- access to appropriate specialist expertise for the assessment of health; and
- support for families’ engagement with services that they found difficult to access.

In meeting these priorities, the embedding of health expertise within intensive family intervention services – in strategic boards and in service delivery – is a critical area for development. Consistently positive accounts of Department of Health investment in support for work with health indicated the potential value of this approach, although the impact of this investment was said by some project managers to have been limited by the short timescale for the funding, and/or by difficulties in commissioning, recruitment or secondment, within healthcare trust structures.
**General practitioners and primary care services**

Some parents referred to FIPs were not registered with General Practitioners, and others did not use (or rarely used) GPs and other primary care services. Emergency healthcare facilities were often used instead.

General practitioners could play an important role in supporting families where there are concerns about child neglect, as Wilson and Mullin (2010, p5) have argued:

\textit{we have the benefit of longitudinal relationships with families and therefore acquire enormous knowledge of patterns of family behaviour and of the trajectories of child development. We also know a great deal about the real circumstances of families and generally have their trust.}

However, the findings of our study suggest that - whilst GPs could \textit{potentially} work with FIP project staff in identification and onward referral of health needs, there was little evidence of existing work in this capacity. Referrals to FIP services very rarely came from health professionals, and while \textit{ad hoc} case examples of joint work with GPs were generally very positive, and were said to have increased referrals from GP services, the study revealed very little evidence of strategic links between general practice and intensive family intervention services.

The current study suggests that stronger links between GPs and intensive family intervention services are likely to be of mutual benefit. When FIPs had made links with GPs in relation to cases, this was said to be highly valued by the general practitioners themselves, not least because they often had significant concerns about families, but did not have the capacity to address the complexity of their needs. The one GP interviewed in the study, as a health stakeholder linked to Area D, spoke at length about the reassurance (s)he had gained from working jointly on a case with FIP, where (s)he had significant concerns about a parent but had been unable to access specialist mental health services.

**Policy implications (3): A strategic and operational role for primary care services**

The research indicates a potentially valuable strategic \textit{and} operational role for primary care services – and particularly general practitioners – in joint work with intensive family intervention services, to identify and address the complex health needs of families with multiple problems. \textit{Ad hoc} relationships between GPs and intensive family intervention services are unlikely to be sufficient to address the challenges of meeting family health needs, and to achieve the potential benefits of joint working on a systematic basis.

**Specialist services**

Workers and family members reported particular difficulties for families in engaging with specialist health services such as Adult Mental Health provision. Once these services had been accessed, experiences were generally positive, but accounts of work with specialist health services told a consistent story of difficulty in identifying referral routes, high service thresholds, long waiting lists, and practical barriers for families in accessing the service. Just as studies of services for disabled children and families have highlighted the importance of coordinating professional input for families with multiple service involvement (e.g., Sloper and Beresford 2006), this was clearly a critical issue for many families in the present study. Some families were involved with as many as 23
different agencies at the point of referral, and many described feeling overwhelmed by the complexity of their lives.

In discussing the barriers to engagement with health issues, FIP workers, health stakeholders and family members highlighted the contrast between the features of Family Intervention Projects that have been so successful in securing engagement in the service – flexible, persistent, home-based support – and the organisation of specialist health services, where the client goes to the service, and where missed appointments result in lost referrals. This difference of approach was seen as particularly problematic for families with multiple problems because of the likelihood that they will miss appointments (and so lose referrals), particularly at times of chaos or crisis in the family when they may most need the support.

In German family support services, a useful conceptual distinction is drawn between services with a *Geh-Struktur* (literally, a ‘go-structure’) whereby professionals go to the family, and those with a *Komm-Struktur* (literally, a ‘come-structure’) whereby service users come to the provider to participate in the intervention (Lösel 2006, cited in Garbers 2008). In the present context, it is of interest to note that several Family Intervention Projects had used the £19,000 Department of Health grant to recruit or second adult or child mental health specialists, specifically to embed a ‘go-to-the-family’ approach. These practitioners supported assessment, onward referral, and in one case study area worked directly in the home with families’ mental health needs. Interviews with these specialist workers in Area B illustrated the benefits they saw in this approach, which deepened their understanding of the family context of presenting health issues.

**Policy implications (4): Embedding health expertise in intensive intervention services**

<table>
<thead>
<tr>
<th>Families with multiple problems face particular challenges in accessing specialist health services. There are likely to be distinct benefits in basing specialist health expertise within intensive family intervention services, specifically to support:</th>
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<tbody>
<tr>
<td>• assessment and training for assessment in relation to specific health needs;</td>
</tr>
<tr>
<td>• onward referral and access to specialist health services; and</td>
</tr>
<tr>
<td>• training for and/or direct work with families in relation to key health needs.</td>
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</tbody>
</table>

### 7.3 Health outcomes

Across stakeholder interviews, the study provided consistent evidence that FIP intervention was associated with sustained health gains for families across all the domains of health need identified, including success in addressing complex inter-related health and social problems. Changes related to a number of aspects of health, with examples of: improvements in basic health (e.g., diet, exercise, hygiene, child safety, home environment); diagnosis of previously unidentified or unmet needs (e.g., child learning difficulties, speech and language impairment, adult psychiatric disorder); improved management of, and treatment for, chronic physical and mental health problems (linked to engagement with appropriate health services); resolution of long-standing drug or alcohol dependency; resolution of domestic violence problems; and engagement with therapeutic intervention and counselling related to previous trauma or child maltreatment (parents and children/young people). For some case study families, positive changes in health were marked and had been sustained across the follow-up
period. For others, chronic or entrenched problems were not resolved, but there was evidence that families had gained competency and agency in management of chronic problems.

**Policy implications (5): The potential benefits of intensive intervention for family health**

In-depth case studies in the present study were focused on well-developed practice, and cannot be assumed to be typical of intensive family intervention services across the country. The research does, however, clearly indicate the potential of intensive family intervention to improve health practices and outcomes in families living in extremely challenging circumstances, who have often not previously engaged with health services.

**Stability of outcomes**

Positive outcomes from work with a family may not be stable if outcomes are influenced by factors – such as physical health – which are beyond the immediate scope of the FIP intervention. There may also be a need for services to continue to be offered, or to be re-activated at a later point, highlighting the importance of ‘flexible endings’ to intensive family interventions.

A crucial conceptual point here is that interventions are not necessarily unsuccessful if families (who by definition have multiple, entrenched problems) continue to need support. Concerns are sometimes expressed that users may become dependent on services (e.g. Barnes et al., 2011), but the evidence from the current study was that the relationship between families using FIPs and their key workers tended to be enabling and capacity-building, rather than disempowering by creating dependence. Parents and young people spoke of gaining the ‘tools’ to manage their lives, and to take responsibility for achieving their aspirations.

Conceptualisations of intervention as *curative* (drawing on models of clinical evaluations, e.g. MRC, 2008) are likely to be unrealistic for families with significant entrenched and multi-faceted difficulties. In an earlier cross-European study (Boddy et al., 2008), a Danish manager of a service delivering intensive interventions for families of young people at the ‘edges’ of care, distinguished between three levels of ‘successful’ outcome for families in her service:

- families who subsequently manage on their own;
- those who manage with a lower level of support than was previously necessary; and
- those who manage with the same level of support as before the intervention (but where placement of a child has been prevented).

The definition and measurement of ‘successful’ outcomes from interventions such as FIP needs to recognise that ongoing access to support – even at a low level – may prevent the recurrence or deterioration of family troubles that are costly to society.
Policy implications (6): Defining, monitoring and evaluating health outcomes

Definition, monitoring and evaluation of work with health in intensive family intervention services should take account of the following key points:

a. Stability of outcomes: Positive outcomes from work with the family may not be stable if outcomes are influenced by factors – such as physical health – which are beyond the immediate scope of the intensive family intervention service.

b. Emergence of health issues: Health needs may not be identified at initial referral, but may emerge over the course of the intervention, such that it could appear that the incidence of health problems has increased in association with intensive family intervention.

c. Service use and costs: Use of specialist and universal health services may increase as a consequence of FIP involvement, because of the worker’s role in supporting access and engagement with health issues. This increase in service use may have implications for calculation of cost effectiveness. The research does indicate, however, that addressing families’ underlying health needs can potentially result in longer term savings in relation to risks such as crime, anti-social behaviour, or child placement.

d. Expectations of change: It is not realistic to expect that chronic physical and mental health problems will be wholly resolved as a result of intensive family intervention, and other problems (such as anti-social behaviour) may recur for families where underlying health problems recur or deteriorate.

7.4 Summing up

The introduction to this report described the costs to society of complex, multi-faceted disadvantage, ‘associated both in the short term and into adulthood with a range of adverse outcomes: social, educational, relational, health and crime’ (Buchanan 2007, p191). This in-depth study of health-related work in intensive family intervention services makes it clear that health is central to families’ experience of disadvantage, as both a cause and consequence of wider difficulties. To paraphrase Ribbens McCarthy and colleagues (in press, 2012), the families involved in the present study can be seen to ‘troubling’ to society, in the presenting issues that initiated their referral to intensive family intervention services, and ‘troubled’, in relation to the complex and diverse health needs that they face, and in the influence of community norms and intergenerational patterns of adversity on their understandings of health and health-related practices. Health issues within families ranged from basic unmet needs to significant chronic physical and mental health problems, often compounded by related issues such as alcohol and drug use and domestic violence. Such complexity necessitates a broad conceptualisation of health, encompassing socio-emotional health and well-being.

At the point of intervention, families’ health needs were often unidentified, unmet, or poorly managed. Intensive family intervention clearly made a difference to all these areas, and the study found evidence of sustained positive change across a range of aspects of family health. Embedded expertise from health specialists working within intensive family intervention services was seen as very valuable in the identification and management of families’ health needs. Such expert input is also important to ensure that key workers can safely support change and improvements in health whilst operating within the limits of their expertise.
The distinctive principles that underpin the FIP approach – persistent, flexible, long-term and intensive, practical and relational work – made a clear contribution to identifying need, and establishing and sustaining change in families' health literacy and health behaviour. Whilst these principles were consistently reported across project areas and stakeholders in the study, the content of the intervention was purposely customised to each family’s needs and circumstances, to provide a flexible, staged, needs-led approach that enabled attention to health (in the broadest sense). This approach was highly valued by families, particularly in relation to the continuity of involvement over a long period of intervention and the genuine and respectful nature of the relationship between worker and family. Family trust and engagement with intensive family intervention served a specific function in relation to health, in opening family members up to professional involvement, initiating disclosure of health concerns and enabling wider engagement with other professionals, given the support and encouragement of the trusted FIP worker.

Alongside these positive findings, however, we end by sounding a note of caution. The extent of health needs amongst families referred to intensive intervention services was striking: complex, chronic and diverse needs were reported consistently across stakeholder groups, and across all 18 local authority Family Intervention Projects in the study. The prioritisation of work with 120,000 families within current policy (e.g., Cameron, 2011) significantly widens the scope of intensive family intervention. Nonetheless, the research reported here indicates that – even with a wider target group – it may not be realistic to expect that chronic physical and mental health problems will always be wholly resolved as a result of intensive family intervention. Other problems (such as anti-social behaviour) may recur for families where underlying health problems recur or deteriorate. The value of flexible endings within intensive family intervention provides some indication that models of ongoing support, or flexible access to occasional support, could prevent escalation of difficulties when problems do arise.

The financial and social costs of ‘family troubles’ to society indicate the potential value of intervening with families with multiple problems. The research reported here demonstrates that health must be central to that intervention. Health problems, broadly defined, were clearly both a cause and consequence of wider social problems for families in the present study. Intensive family intervention – based on common, consistent principles, but customised to families’ diverse needs – can make a substantial contribution to improving the identification and management of significant and complex health problems, with concomitant benefits for wider social problems that intersect with health.
References


Appendix 1. Monitoring data for two case study areas

To provide additional contextualisation for the case studies presented in this report, secondary analysis of monitoring data recorded in the national FIP Information System was carried out for the study by the NatCen research team (Cheryl Lloyd and Clarissa White). Key data are summarised below, with two caveats. First of all, the small base sizes of area-level analysis means that the analysis should be treated with caution: there were fewer than 100 families in each area, and this has implications for interpreting percentage frequencies. Small base sizes also risk identifiability for case study areas, and so detail is deliberately limited. Information is presented in broader categories than customarily reported in FIP monitoring data (e.g., in relation to referral agency) and data categories in relation to which the case studies may be distinctive (and hence recognisable) are not included. Similarly, as base sizes for families at exit are very small, these data are not presented here. As an additional safeguard against identifiability, base sizes for area case studies are rounded to the nearest 10.

Table A1.1 Referral agencies and reasons for referral*

<table>
<thead>
<tr>
<th>Referral agency</th>
<th>Area A</th>
<th>Area C</th>
<th>All family interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>11</td>
<td>56</td>
<td>32</td>
</tr>
<tr>
<td>Health</td>
<td>14</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Education</td>
<td>39</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Offending and crime</td>
<td>5</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Social, voluntary/community organisations (inc. social services)</td>
<td>56</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Reasons for referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Issues</td>
<td>8</td>
<td>55</td>
<td>56</td>
</tr>
<tr>
<td>Anti-social behaviour of family members</td>
<td>23</td>
<td>79</td>
<td>62</td>
</tr>
<tr>
<td>School exclusion/ attendance problems</td>
<td>31</td>
<td>45</td>
<td>37</td>
</tr>
<tr>
<td>Parenting and care issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor parenting</td>
<td>35</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>Children at risk of going into care</td>
<td>6</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Child Protection Plan is in place</td>
<td>11</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Family has domestic violence problems</td>
<td>16</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>Substance misuse problems (adult &amp;/or child)</td>
<td>10</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Mental health problems (adult &amp;/or child)</td>
<td>3</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Employment, education, debt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family is without paid employment</td>
<td>18</td>
<td>10</td>
<td>28</td>
</tr>
<tr>
<td>Family has serious issues with debt</td>
<td>0</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

* Base size for Area A was 90, and for Area C 50; for all family interventions the base size was 5168. Percentages add up to more than 100 as the family may have been referred for more than one reason.
Table A1.2  Family characteristics* at the start of the intervention (all families with a Support Plan)

<table>
<thead>
<tr>
<th></th>
<th>Area A</th>
<th>Area C</th>
<th>All family interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family type</strong></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Lone parent/carer</td>
<td>69</td>
<td>54</td>
<td>65</td>
</tr>
<tr>
<td>Two parent/carer</td>
<td>31</td>
<td>46</td>
<td>35</td>
</tr>
<tr>
<td><strong>Number of children (including over 18yrs)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 2 children</td>
<td>52</td>
<td>19</td>
<td>41</td>
</tr>
<tr>
<td>3 or more</td>
<td>48</td>
<td>81</td>
<td>60</td>
</tr>
<tr>
<td><strong>Number of children (under 18yrs)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 2 children</td>
<td>53</td>
<td>30</td>
<td>47</td>
</tr>
<tr>
<td>3 or more</td>
<td>47</td>
<td>70</td>
<td>53</td>
</tr>
<tr>
<td><strong>Ages of children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>37</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>5-11</td>
<td>61</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>12-16</td>
<td>56</td>
<td>81</td>
<td>71</td>
</tr>
<tr>
<td>17 or over</td>
<td>23</td>
<td>38</td>
<td>30</td>
</tr>
<tr>
<td><strong>Ages of parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median maternal age</td>
<td>37</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td>Median paternal age</td>
<td>43</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td><strong>Employment and finances</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workless family</td>
<td>73</td>
<td>88</td>
<td>76</td>
</tr>
<tr>
<td>Debt</td>
<td>24</td>
<td>42</td>
<td>35</td>
</tr>
<tr>
<td><strong>Presenting health issues</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic violence</td>
<td>13</td>
<td>65</td>
<td>29</td>
</tr>
<tr>
<td>Child protection</td>
<td>40</td>
<td>62</td>
<td>28</td>
</tr>
<tr>
<td>Mental health</td>
<td>15</td>
<td>81</td>
<td>34</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>31</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td>Alcohol</td>
<td>12</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>Diet/exercise</td>
<td>4</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>

* Base size for Area A was 80, and for Area C 30; for all family interventions the base size was 3665.
Ethnicity, disability and SEN data are not presented to avoid identifiability of area. Percentages add up to more than 100 as the family may have multiple presenting issues.
Table A1.3  Intensive family intervention* (all families with a Support Plan not in core unit accommodation)

<table>
<thead>
<tr>
<th></th>
<th>Area A</th>
<th>Area C</th>
<th>All family interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical weekly hours of direct contact per family (period from support plan to first formal review*)</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>1-5 hours</td>
<td>25</td>
<td>38</td>
<td>45</td>
</tr>
<tr>
<td>6 or more hours</td>
<td>75</td>
<td>62</td>
<td>55</td>
</tr>
<tr>
<td>Mean (range) weekly hours</td>
<td>7.4 (2-40)</td>
<td>19.4 (1-102)</td>
<td>9 (1-160)</td>
</tr>
</tbody>
</table>

* Base size for Area A was 50, and for Area C 20; for all family interventions the base size was 2677. Data on length of intervention and on contact from final formal review to exit are not presented because of low base size.