Title page

Title: Social Innovation and Social Work: A Case Study of the Early Intervention Support Service

Authors: 1* Karen Winter, 2 Laura Neeson, 3 Daryl Sweet, 4 Aimee Smith, 5 Sharon Millen, 6 Paul Connolly

1 School of Social Sciences, Education and Social Work,
Queen's University Belfast
6, College Park

Belfast,

BT7 1PS
Email: k.winter@qub.ac.uk
ORCID https://orcid.org/0000-0002-1229-7150

2. Centre for Evidence and Social Innovation,
Queen's University Belfast
2-8 Fitzwilliam Street,
Belfast,
BT9 6AX

3. Centre for Evidence and Social Innovation,
Queen's University Belfast
2-8 Fitzwilliam Street,
Belfast,

BT9 6AX

4. Centre for Evidence and Social Innovation,
Queen's University Belfast
2-8 Fitzwilliam Street,
Belfast,
BT9 6AX
Email: Aimee.Smith@qub.ac.uk

5. Centre for Evidence and Social Innovation,
Queen's University Belfast
2-8 Fitzwilliam Street,

Belfast,
BT9 6AX
Email: s.millen@qub.ac.uk

6. Faculty of Social Sciences,
Lancaster University,
County South,
Lancaster,
LA1 4YL
Email: paul.connolly@lancaster.ac.uk

Corresponding author
Karen Winter, School of Social Sciences, Education and Social Work, 6. College Park, Queen's University Belfast, Belfast BT7 1PS, Northern Ireland. Email: k.winter@qub.ac.uk

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Keywords: children and families; early intervention; family support; social care; social innovation.

Abstract

In a national and international context where there is a concern about the effectiveness of social care services for children and families to address chronic, enduring social problems and where there are finite resources available, the concept of social innovation in social work policy and practice to address need in new ways is receiving increased attention. While an attractive term, social innovation in child and family services is not without its challenges in terms of conceptualisation, operationalisation, implementation and evidencing impact. This article reports on the development and evaluation of the Early Intervention Support Service (EISS), a newly designed family support service in Northern Ireland set up as part of a government supported innovation and transformation programme that aims to deliver a voluntary, targeted, flexible and time limited service to families experiencing emergent problems. Using the EISS as a case study, the challenges, benefits in terms of addressing policy imperatives and future direction of social innovation in social work practice are reflected upon.

Keywords: social innovation; early intervention; family support, social care, children and familie

Introduction

In a national and international context where enduring social and economic challenges continue to place families under pressure and where resources to address emergent need are finite, social innovation in services for children and families is increasingly portrayed as both attractive and an imperative (The Young Foundation, 2012; DfE, 2014). Its attractiveness lies in the fact that the term is associated with newness, novelty and is suggestive of responsive, flexible, agile and impactful services (DfE, 2014). Its social construction as an imperative can be understood within the context of 'growing social, environmental and demographic challenges', which Nicholls and Murdock (2012) refer to as 'wicked' problems, so called 'because they are complex, multi-faceted, involve a range of stakeholders and are, by their nature, impossible to solve' (Young Foundation, 2012, p. 5). As the The Young Foundation (2012, p. 5) report, these include the 'failure' of the modern welfare state [and] resource scarcity'. The 'failure', as noted in the UK in a recent House of Commons briefing paper (Cromarty, 2019, p. 4-5), can be understood as the inability of services to respond to increasing demand or, indeed, to prevent increasing demand. The demand is attributable to a range of social structural factors including: poverty; demographic changes (increase in the child population, increased number of unaccompanied asylum seeking children); emergence of new and greater risks to children (gang violence and sexual exploitation); and cuts to early intervention services (DfE, 2014).

Specifically in relation to children's social care which includes support services for families in the UK, the focus on social innovation has arisen in a context where concern about the ongoing failure of the system to respond effectively to children at risk of abuse led to the

government, in 2010, to commission an independent review of child protection led by Professor Munro (Munro, 2010, 2010a, 2011). In the final of three reports (Munro, 2011), Munro highlighted concerns about a system that had become over bureaucratised, focused on compliance, overly prescriptive and was lacking innovation (Munro, 2011, p. 168). In a call to move away from 'a compliance culture to a learning culture' (Munro 2011, p. 7) an emphasis was placed on 'responsible innovation' in services for families and children (Munro, 2011, p.5, 22) and for the removal of 'constraints to local innovation' (Munro, 2011, p. 45).

Despite its appeal, there is confusion about what is meant by the term 'social innovation' and various writers have explored its definition and conceptualisation. Some categorise innovation by type, that is technological, economic, regulative, normative and cultural innovations (Hämäläinen and Heiskala, 2007). Other writers define the term primarily in terms of its impacts. Pol and Ville (2008), for example, suggest a separation between business and social innovation stating that 'An innovation is termed a social innovation if the implied new idea has the potential to improve either the quality or the quantity of life. Examples of innovations that fit nicely with this definition abound: innovations conducive to better education, better environmental quality and longer life expectancy are a few' (Pol and Ville, 2009, p. 881). Other authors further develop conceptualisations (Mulgan *et al*., 2007; Phills *et al.,* 2008; Borzaga and Bodini, 2012). Bringing the various ideas together, The Young Foundation (2012, p. 18) has developed its own definition:

> 'Social innovations are new solutions (products, services, models, markets, processes etc.) that simultaneously meet a social need (more effectively than existing solutions) and lead to new or improved capabilities and relationships and better use of assets

> and resources. In other words, social innovations are both good for society and enhance society's capacity to act'.

It is apparent that social innovation is underpinned by a set of values and attitudes which include a willingness to try out new ways and approaches and to take risks (The Young Foundation, 2012, p. 7). In the UK, social innovation in social care with families and children has been pursued through the launch of The Children's Social Care Innovation Programme (DfE, 2014) with its aims being to: encourage the design, development, implementation and evaluation of new programmes to address chronic and enduring family need; generate new social care research evidence regarding what works; and incentivise further 'innovation, experimentation and replication' to develop more evidence informing best practice (Sebba *et al.,* 2017, p. 8).

Social innovation and social work

Although social work services have responded to the government funded social innovation call (Sebba *et al.,* 2017), some argue that social innovation does not sit comfortably with children's social care for a number of reasons (The Young Foundation, 2012, p. 28). Firstly, social work structures with their associated departmental or team structures, dedicated budgets, lack of horizontal networking/collaboration across teams and centralised, politically driven commitments and programmes can inhibit innovation. Secondly, a risk averse approach characterises the delivery of children's social care (Brown, 2010). Brown (2010, p. 1216) highlights that the 'the blame culture' following the high profile deaths of children known to social services have contributed to a climate in which 'risk appetite' is low and risk taking in service design, delivery can be challenging. It is therefore not surprising that, in this context, space for experimentation, novel and new approaches is limited.

Social innovation, social work, family support and early intervention

Another challenge with regards to social innovation in social care is its link with terms such as 'effectiveness', 'evidence-based interventions' and 'measures' (Munro, 2011; DfE, 2014). Competing discourses exist in social work with regards to the positioning of family support with children and families with some arguing that the aim of family support is to strengthen the ongoing practices and processes of support within families which are: based on love and commitment; enduring, relational, social; and which have practical components that cannot be easily measured (Frost *et al.,* 2015; Featherstone *et al.,* 2014). Others view family support as equating with early intervention and measurable outcomes such as strengthening parenting and improving child outcomes. Frost *et al.* (2015) indicate that the latter approach can be problematic because it has the tendency to: de-value families social and relational practices; create the impression (through use of the word 'intervention') of more authoritarian types of work with families; and lean more towards short term, time limited programmes which measure effectiveness. In the work of Munro (2011) and the most recent House of Commons briefing (Cromarty, 2019), family support appears to be constructed through the lens of early intervention and early help.

There is a body of work that uses the terms interchangeably (Churchill and Fawcett, 2016; Walsh and Doherty, 2016) and that alludes to considerable overlap in the terms and practices associated with early help, early intervention and family support. With regards to family support, it is important to note that successive governments have invested in family support programmes as a means of tackling inequality, poverty and disadvantage and promoting well-

being (Daly *et al.,* 2015; Brady *et al.,* 2017) and that these cover 'an array of interventions which vary greatly in terms of delivery, impact and outcomes' (Walsh and Doherty, 2016, p. 10). Reflecting this, services can be universal (designed for the entire population of families) or targeted at certain groups (single carers, teenage parents, parents who live in areas of multiple deprivation); delivered at home or through health centres, nurseries and schools; focused on specific issues including enhancing and strengthening parenting skills; improving the quality of the child/parent relationship or more broad ranging to encompass the provision of emotional/social support; and delivered either by the State or through NGO's and the voluntary sector (Canavan *et al.,* 2016; CES, 2016; Churchill and Fawcett, 2016; Bate, 2017; Cromarty, 2019; Tolan *et al.,* 2019). Hence the link between family support and early intervention is an important one. Early intervention, as noted earlier, can be described as intervening as soon as possible to tackle or prevent problems for children and families before they become entrenched or difficult to reverse (Israelashvili and Romano, 2016; Early Intervention Foundation, 2018) and it has a role both in terms of strengthening the existing supportive capacity of individuals within families and in terms of offering family support services. The Early Intervention Support Service in Northern Ireland provides an example of where the combined discourses 'social innovation', 'early help/intervention', and 'family support' coalesce. The article turns to its development as a social innovation project and to its evaluation.

Social innovation, early intervention and family support in Northern Ireland

The Early Intervention Support Service was established in Northern Ireland in 2016. Northern Ireland comprises six counties, has a population of 1.8 million, is part of the United Kingdom and shares a border with the rest of Ireland in the South and the West. At the time that the

Early Intervention Support Service was being implemented, there were 460,093 children and young people under the age of 18 living in Northern Ireland (NISRA, 2017). A comparative analysis of multiple deprivation measures in the United Kingdom at the time (Abel *et al*., 2016) found that Northern Ireland was the most deprived area, with 37% of the population living in an area that was within the 20% most deprived areas across the UK. The rates for in-work poverty were highest within Northern Ireland (Murphy, 2015). Furthermore, health outcomes for children in Northern Ireland were described as amongst the worst in Western Europe (RCPCH, 2014), including holding the UK's highest infant mortality rate and highest suicide rate (Wolfe *et al*., 2014).

These statistics reflect a constellation of factors associated with the uniqueness of the Northern Irish context, in particular as a newly emerging post conflict society, which still carries with it the enduring legacy of the impact of 'The Troubles' (a political conflict in which over 3,600 people died and thousands more were injured) including, for example, heightened numbers of people/parents experiencing poor mental/physical health; poverty; and social isolation (Abel *et al.*, 2016). Hence, in Northern Ireland, there are many families 'under strain' and clear evidence that levels of need for family support exceed service availability (CYPSP, 2016; Department of Health, 2017) as reflected in the growing waiting lists for access to the then existing family support services (CYPSP, 2016). Informed by these issues, policy imperatives identified by the Northern Irish government have included: the reduction of the numbers of children and families formally defined as 'in need' by social services because there is evidence that once known to social services, families can become 'labelled' and propelled through the system rather than diverted away from it; reduction in the waiting lists for support services that can only be accessed by families becoming defined as 'in need' by a

social services assessment; and thereby a reduction in the demands on and costs to the formal social services system (Fitzsimons and Teager, 2018).

It is within this context that the Early Intervention Support Service (EISS) has emerged. This is one of the services that sits under a wider governmental Early Intervention Transformation programme (NI Executive, 2014), the aims of which include: promoting social inclusion; reducing levels of vulnerability within the family; and/or minimising risk-taking behaviours (DoH, 2016; Fitzsimons and Teager, 2018). Addressing the policy imperatives, the overriding concern is to provide a family support service to families with emergent problems but where they are not known to social services, have not been assessed by a social worker and are therefore not entitled to services offered under the Trusts' legally binding 'children in need' obligations. In Northern Ireland these families are known as Tier Two families in a model of thresholds of need that has been informed by the work of Hardiker *et al.* (1991) (see Figure 1). Hardiker's work focused on the concept of prevention and its relevance to social work practice with children and families. Adopting the earlier work of Fuller regarding prevention (1989, p.9), Hardiker *et al.* (1991, p. 347), developed a four level model of prevention work (see Figure 1).

Figure 1: Hardiker model of levels of need

Level one refers to the base population whose needs are met through universal provision of services such as health visiting, early years centres, and other universal services and community resources. Level two refers to children and families with additional needs who require additional support to strengthen existing capacity and prevent issues deteriorating. Level three refers to families and children with complex, difficulties who are likely to be

known to social services for safeguarding issues. Level four refers to children who have suffered or are likely to suffer significant harm, who have very complex, chronic and intractable difficulties and includes those removed from home.

There are five Early Intervention Support Services with one in each Health and Social Care Trust area. Each service includes a service manager, 2.5 therapeutic workers, 1 full-time practical support worker and administrative support. Families are referred to the service in multiple ways, for example, through a general practitioner, health visitor, teacher or self-referral or signposted to the service through the family hubs (see Figure 2 for the referral process).

Figure 2 here

Families wait a period of no longer than four weeks before receiving their first visit from a support worker. Usually during the second visit the key worker and family complete an 'Outcomes Star' together. The Outcomes Star is a tool to facilitate goal setting and self-evaluation of progress against chosen goals (http://www.outcomesstar.org.uk). Goal setting involves the worker using either the Solihull Approach, Motivational Interviewing and Solution Focused Brief Intervention Therapy (NCB, 2014). The remainder of the article explores and critically reflects the development of this social innovation programme and the findings from the evaluation.

Social innovation in social work: factors in design and implementation

As noted earlier, while 'innovation' is seen as both attractive and an imperative, the 'good intention' to develop innovative approaches is not enough to motivate their wholesale adoption in social work (Brown, 2007) and nor is the implementation of an innovative

approach alone enough to make a positive impact on identified outcomes. Other factors need to be considered, such as organisational fit and whether there is a clear link between implementation and outcomes. Atkins and Frederico (2017) found there were five key drivers in the implementation process of innovative programmes whose absence precludes other factors from acting as enablers. These include: 1) clear planning and communication; 2) managers committed to the innovation; 3) a reflective culture; 4) perceived fit of the innovation to the organisation; and 5) professionals being open to change. Before outlining the findings and any outcomes emerging from the evaluation of the service, attention is turned towards the implementation process and evidence (or not) of the above identified factors.

In the design phase of the EISS in Northern Ireland, and before the research team became involved, there was evidence of extensive communication. Consultations revealed that while there was generally broad support for another service that could provide family support services, there were a multiplicity of stakeholders already in the field of family support all with services to protect and promote (Winter et al., 2018). This had two effects: a more negative response from those whose own services were under threat by the proposed introduction of a new service; and a decision by the Public Health Authority to put out a tender for the initial 3 year delivery of the service that was divided into lots (by Trust area) thus meaning that different organisations secured contracts to deliver the same service in different areas. Designing the EISS was therefore not without it challenges because the emergence of a new service threatened the delivery of existing programmes.

Consultations also took place with parents in 7 focus groups and 60 parents in total (Parenting NI, 2014). Parental feedback highlighted disparity in terms of availability of and access to family support services depending on geographical location and presenting need. It was noted that families in rural areas, parents of children with special needs (including disability and mental health) were disadvantaged as were parents dealing with acute crises (school transitions, transition into adolescence, bereavement, separation and loss) who reported a lack of timely, focused, non-stigmatised practical and therapeutic help (Parenting NI, 2014, p. 63-71). Parental consultations therefore provided an important lever to justifying the need for a new type of service as it was clear that although many family support services already existed, there was still unaddressed need. This view was supported by most professionals and managers.

Reflecting parental feedback and on the basis of a report commissioned by the Public Health Agency (NCB, 2014) that involved a rapid review of the evidence relating to home based, time limited family support interventions, and as noted above, the following interventions were chosen to form the core components of the programme: motivational interviewing; solution focused brief intervention therapy; and the Solihull approach. While this was an example of good planning, the evidence base underpinning each intervention was far from definitive (NCB, 2014). Indeed, the report of the rapid review (NCB, 2014) recommended that: further work was needed before adopting any of the proposed interventions including the collation of baseline data regarding the extent and variation of need within tier two families; the programme designers needed to be sure that the interventions could address identified need and be mapped onto proposed outcomes; and that an assurance was needed that those delivering the interventions did so with attention to fidelity (NCB, 2014a). These factors point

to the fact that part of the planning process could have been further developed and informed by a logic model, a point further explored in the subsequent discussion section. Nonetheless, the policy imperatives (outlined earlier) were such that the service design was supported and funded. The service became fully operational in January 2016 with proposed targets of responding to the needs of 1,925 families from July 2015 to March 2018. This was equivalent to 140 families per annum per service, on a one-to-one basis. Each family support worker was to be allocated 10 cases to provide support to the family for a period of up to 12 weeks. This provides the context to the set-up of the service and to its subsequent evaluation – outlined next.

The Early Intervention Support Service: the evaluation

Research design

The objectives of the evaluation were to identify and assess: the effectiveness of the service in improving family functioning; parenting stress and self-confidence; and in improving the quality of the child/parent relationship; the reliability and validity of the Outcomes Star as a measure of key outcomes among parents and their children; the fit of the Early Intervention Support Service, and its component elements, to the local geographical and stakeholder context; the experience of parents taking part in the service EISS and what elements were most valued, and regarded as most beneficial, by the service providers and the parents, and; aspects of the service that may need to be modified to enhance the effectiveness. To aid the evaluation, and in the absence of a logic model, the research team devised their own visual representation of the service components (see Figure 3).

Figure 3 here

Notwithstanding the challenges posed in evaluating a service with a diffuse delivery model and a wide set of loosely applied short term interventions, the research team proposed a randomised controlled trial to evaluate the effectiveness of the service and a process evaluation to elicit experiences of the service. However, by the time the evaluation was commissioned, all five Early Intervention Support Services had been established and were operating according to set processes which meant that it was not possible and/or acceptable to use a randomised design. In March 2017, the team decided to therefore use a non-randomised controlled trial design reflecting the service operating guidelines, where each early intervention support service could have an (up to) four-week waiting list to receive the service. It was decided the control group sample would be recruited from this waiting list, and that the service managers would be responsible for selecting the intervention and control group parents. This occurred at staggered time points throughout the duration of the study. Within the timeframe, it was expected to recruit approximately 250 control and intervention families, or 50 per service. As outlined in Table 3, short and well-validated psychometric measures, that mapped on to the core service outcomes and focused on parenting skills and confidence, reducing challenging behaviour and improving positive behaviour, improving well-being and promoting positive family functioning; were selected as outcome measures.

Table 3 here

Ethical approval

Securing ethical approval in Northern Ireland for research applications that involve accessing Trust based professionals, service users and/or their data is a complex and multi-layered process. At a regional level, the Health and Social Care Research and Development Division

has established a Research Gateway to coordinate research applications that involve research taking place across more than two Health and Social Care Trusts in Northern Ireland. Permission to conduct research must be secured from those who service Gateway meetings (Assistant Directors of Social Services) before an application can proceed. The Gateway team meetings occur monthly. Once the proposed research design met with the approval of the regional Gateway team, a full application was made to the Office for Research Ethics Committees Northern Ireland (ORECNI), via the Integrated Research Application System. Minor amendments were recommended and attended to. Once approved by ORECNI, the research application was then further considered at the separate research governance team of each Trust. Trusts have the power to accept, reject or seek further amendments to the research proposal over and above those recommended by the Office for Research Ethics Committees Northern Ireland (ORECNI). This complex multi-layered approach to seeking ethical approval is time consuming and causes time delays. In this study, time delays in securing ethical approval comprised the time available to undertake the time limited study. Furthermore, permission from all five Health and Social Care Trusts in Northern Ireland was sought but, unfortunately, it was not possible to secure permission from one Trust. All participants provided consent to be involved in the study.

Recruitment and data collection

Recruitment to the study took place from March - December 2017, the total number of referrals received by the EISS was 614. Recruitment took place in the first instance by each service. When a family was referred, they were asked to participate in the study and the manager of the Trust based Early Intervention Support Service decided who would be in the control and intervention group. The participant details were then forwarded to the research

team. The details of 216 families were passed to the research team. Contact was initially made with the families via text messaging to allow the parent control over when, and what, to reply. If there was no reply within three days the research team made two more attempts to contact parents, after which they were deemed uncontactable and their details removed from the contact list. Of the initial 216 referred to the research team 107 were excluded because they did not respond to follow up calls. This left 60 parents who were allocated to the intervention group. Two further families dropped out meaning that the total sample for the pre-test intervention group was 58. Fifty one parents were allocated to the pre-test control group (see Table 1 for description of sample).

Table 1 here

Data collection for pre-tests took place at a time and date convenient to the parent. To minimise the time burden on both researchers and parents, an online survey was designed and hosted on a University server. An iPad was used to access the survey before phoning the parent to complete the survey. Each parent was assigned a unique ID number and any data collected was uploaded immediately to the server at the University and deleted from the iPad so no data was retained on it. Across the four participating Early Intervention Support Services, a total of 109 parents completed pre-test measures and, once further attrition was accounted for (11 families from the intervention group and 18 families from the control group) a total of 80 families (47 post-test intervention and 33 post-test control) completed both pre-and post-tests.

Statistical analysis

Based on the exploratory nature of the intervention, the inability to use an RCT design and the lower than expected sample size, the statistical analysis had to be cautiously designed

and interpreted. Scales were computed for the raw data of the 22 outcomes in the evaluation. Regression models were used to compare mean scores for intervention and control groups, with pre-test differences of age, gender, length of time between testing, and Trust area accounted for. The regression models allowed for an estimate of the mean score between control and intervention groups. The coefficient for the constant in the model provided an estimate for the post-test mean score for the control group, and the sum of the coefficients for the constant and the dummy variable for group membership provided an estimate for the post-test mean score for the intervention group. Post-test standard deviations for both groups were estimated directly from the data for each measure at post-test respectively. Effect sizes, and their corresponding 95% confidence intervals, were then calculated using these estimates. Hedges' g was chosen as the effect size measure.

Results

As indicated above, data were collected from 80 parents at pre-and post-test stages. Overall the intervention and wait-list control groups were broadly similar at baseline (see Table 1) and indicated no differences. Most referrals were for children aged 5-11 and nearly three quarters of families had been having difficulties for over a year. Table 2 shows the findings of the main effects of the intervention. Applying regression models to the data, the post-test adjusted means and Hedge's G effect size are presented, indicating whether the differences between the control and intervention group are statistically significant and the size of the difference. Although the results from the main effects analysis (see Table 2) show that there are statistically significant effects for two outcomes: the TOPSE domain measures of Play (Sig.=.039, d=.56) and Empathy (Sig.=.014, d=.67) (which measure perceived ability to play with and entertain a child while having fun, and the perceived ability to understand issues

from a child's perspective), these cannot be taken as indicating improved outcomes because the high number of outcome variables chosen means that there is a higher likelihood of change occurring randomly.

Table 2 here

Adjusted using a Bonferroni correction, this is indeed the case. There were no significant effects found for the other 20 outcomes, therefore there was no quantitative evidence of the effectiveness of the Early Intervention Support Service in relation to the identified outcomes.

Qualitative interviews were undertaken with 55 participants and comprising: 10 professionals with responsibility for managing EISS; 15 professionals with responsibility for delivering the service in family homes; 12 parents who had used the service; and 18 stakeholders. Interviews with these participants were recorded electronically and transcribed with the audio recording being deleted and the participants being assigned pseudonyms so they could not be identified. The anonymised interviews, which focused on both reflections regarding the design and delivery process and perceptions of impact and outcomes, were stored on a secure SharePoint site and analysed in NVivo 11 using a thematic coding framework. Regarding the implementation and the impact of the service, several themes were identified from the interviews. Of relevance to this article were professionals' flexible service delivery rather than strict adherence to an intervention and the perceived positive impacts of the service on parents and children. With regards to the delivery of the service, professionals viewed the relationship with families rather than specific interventions as the most important, impactful element of the service as highlighted in the quote below:

> “So, part of the work is working with the family, meeting once a week with the parent or whatever it might be, and just listening to them, because I’ve heard it a lot of times that parents just haven’t felt listened to; maybe they’ve lacked the support from family, friends, other support agencies that have been there in the past, so we do have that luxury I suppose that we can just go in and make those small steps with the families”.

Parents had positive experiences of the service delivery, valuing the non-judgemental, supportive and flexible approach delivered by support workers in which the quality of relationship was also the most highly valued aspect as outlined in the indicative quotes below:

> “It was nice, you didn’t feel like you were being judged or anything like that… , she was just a genuinely nice girl who was there to help, and I didn’t feel anything other than that, you know, I didn’t feel like she was a professional coming out to try and mark us and catch us out at all, you know, she was there definitely to support us in any way she could, which was great”.

With regards to outcomes, parents and carers also reported perceiving positive change in their children as noted in the quote below by one parent about her son and his changed attitude:

> “I think it has just given him a bit of confidence again […] sometimes I think kids think that parents just want to […] make them go here, make them do this, and now he has realised that all we want is the best for him”.

These perceived improvements on outcomes were captured in the Family Outcomes Star (Sweet et al., 2020). Overall, in terms of findings it is possible to say that parents rated the

service highly and their progress well but that the measures used did not capture any significant effects. On the one hand, it would be wrong to pull out the two sub components of a measure, where there was statistical significance, and focus on those because the larger the number of outcomes, the more chance that any noted effects are random. On the other hand, it would also be wrong to conclude that there is no evidence of any positive impact on outcomes because the analysis indicates slight changes in the right direction. The constraints with the research design, the numbers recruited and the timeframe within which the evaluation had to be conducted and concluded, signal the need for further research on this innovative service response to support families in Northern Ireland. The above has a number of implications for the future development of social innovation programmes in social care with families and children discussed below.

Social innovation in social work: reflections and discussion

The emphasis on social innovation is to be welcomed in that it has potential to improve the lives of families and children in novel and innovative ways hitherto unexplored (Sebba *et al.,* 2017). However, as illustrated in this article careful consideration needs to be given to: the acceptance and fit of the social innovation programme; its underpinning rationale or logic; adherence to the programmes intervention/programme fidelity; and ultimately to the best ways of gathering evidence. As will be apparent from the outline of the service and the subsequent evaluation, the Early Intervention Support Service model is diffuse and was therefore challenging to evaluate. While the EISS was developed with an evaluation in mind the absence of the early input of a research team was a missed opportunity to have a robust evaluation framework incorporated into the design (Ghate, 2016) which could have mitigated against some of the problems that emerged. Furthermore, It is now widely accepted that in

planning aims, objectives and outcomes, it is helpful that these are underpinned by a logic model which helps portray and understand the interrelationships between outcomes, outputs and inputs/activities. The involvement of the research team in the development of a logic model would, it is argued, have been beneficial from the outset of the service design process. These points notwithstanding, the perceptions of positive changes by families plus the growing acceptance of the service by key stakeholders, have strengthened the legitimacy of the service and its success.

These points have implications for the future development of social innovation programmes. On the one hand, a service that is well received and well used by its target group and where its recipients rate it highly, does meet the policy imperatives established at local level. On the other hand the generation of the best evidence (to inform the funding of future policy priorities) is more likely to come from strong, positive and collaborative relationships between academics, commissioners, service providers, practitioners, families and children at local community level and where services are based on the principles of co-design and co-production from inception, through to implementation and evaluation of impact. This type of model carries challenges in that it is likely to take longer in the planning stage to achieve consensus and maybe more costly. However in the longer term this is likely to be outweighed by the generation of best quality evidence to support the investment in further social innovation programmes. The authors hope that this article provides encouragement in that direction.

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Figure legends

Figure 1: Hardiker model of levels of need (adapted from Hardiker et al., 1991)

Figure 2: Flow chart to illustrate the delivery model of EISS

Figure 3: The EISS Model

Table 1: Description of the sample

Characteristics	Intervention		Control		Total	
	n	%	n	%	n	%
Child Gender						
Male	19	40.4	14	42.4	33	41.3
Female	27	57.4	18	54.5	45	56.2
Missing	1	2.1	1	3.0	2	2.5
Total	47	100	33	100	80	100
Trust Area						
Northern	17	36.2	7	21.2	24	30.0
South-Eastern	13	27.7	9	27.3	22	27.5
Southern	13	27.7	8	24.2	21	26.3
Western	4	8.5	9	27.3	13	16.3
Total	47	100	33	100	80	100
Child Age						
2-4	5	10.6	2	6.1	7	8.8
5-11	29	61.7	18	54.5	47	58.8
12-16	12	25.5	13	39.4	25	31.3
Total	46	97.9	33	100	79	98.8
	1	2.1	0	0	1	1.3
	47	100	33	100	80	100
Duration of Difficulty			6			

Under a year	1	26.	2	18.	1	22.
Over a year	2	7	6	8	8	5
Missing	3	70.	1	81.	5	73.
Total	3	2	3	3	9	8
	2	4.3	3	3.1	3	3.8
	4	10		10	8	10
	7	0		0	0	0

Table 2: Main Effects

Outcome	Adjusted Post-Test Mean Scores				Sig	Effect Size (Hedges' g)
	Intervention		Control			
	Mean (SD)	n	Mean (SD)	n		
FFS Score	70.7 (8.7)	47	70.0 (9.2)	33	.724	.09 [-.36, .53]
FFS_Problem_Solving	23.3 (5.6)	47	22.6 (4.7)	33	.599	-.45 [-.90, .00]
FFS_Communication	26.5 (2.0)	47	26.9 (2.4)	33	.598	-.16 [-.60, .29]
FFS_Personal_Goals	20.7 (3.9)	47	20.4 (3.5)	33	.710	.09 [-.35, .54]
SDQ_Emotional	4.8 (3.0)	47	5.9 (2.5)	33	.130	-.37 [-.82, .08]
SDQ_Conduct	3.9 (2.5)	47	4.2 (2.6)	33	.563	-.12 [-.56, .33]
SDQ_Hyperactivity	6.2 (3.2)	47	6.1 (2.7)	33	.885	.03 [-.42, .47]
SDQ_Peer_Problems	3.4 (2.7)	47	3.4 (2.1)	33	.867	.03 [-.41, .48]
SDQ_Prosocial	7.1 (2.5)	47	7.6 (2.4)	33	.409	-.19 [-.63, .26]
SDQ_Difficulties	18.6 (7.9)	47	19.7 (6.8)	33	.501	-.15 [-.60, .29]
TOPSE_Empathy	52.3 (6.6)	47	47.6 (6.9)	33	.014	.67 [-.22, 1.13]
TOPSE_Play	53.2 (6.5)	47	48.8 (10.2)	33	.039	.56 [-.10, 1.01]
TOPSE_Emotions	46.3 (4.5)	47	44.7 (5.2)	33	.258	.33 [-.12, .78]
TOPSE_Control	40.0 (7.9)	47	38.3 (8.1)	33	.550	.16 [-.29, .60]
TOPSE_Discipline	45.2 (11.0)	47	40.8 (12.0)	33	.150	.38 [-.07, .83]
TOPSE_Pressures	47.4 (11.6)	47	44.8 (14.3)	33	.540	.20 [-.24, .65]
TOPSE_Self_Accept	46.7 (6.2)	47	43.4 (5.6)	33	.084	.49 [-.03, .94]
TOPSE_Learning	54.4 (7.1)	47	52.7 (8.3)	33	.474	.21 [-.23, .66]
PSI_Distress	41.3 (8.7)	47	42.3 (10.3)	33	.568	-.11 [-55, .34]
PSI_Dysfunctional	42.6 (6.5)	47	44.5 (7.4)	33	.258	-.27 [-.72, .18]
PSI_Difficult_Child	32.5 (8.6)	47	34.3 (7.1)	33	.408	-.23 [-.67, .22]
PSI_Total_Stress	116.2 (18.4)	47	121.4 (21.1)	33	.241	-.27 [-.71, .18]

Table 3: Measures used in the evaluation of the EISS

Measure	Author	Year	Outcomes
Tool to Measure Parental Self Efficacy (TOPSE)	Kendall and Bloomfield	2005	Measures change in parenting confidence in eight domains, including empathy and understanding, discipline and setting boundaries and play and enjoyment
The Strengths and Difficulties Questionnaire (SDQ)	Goodman	2001	Measure considers positive and negative attributes about a child. 25 questions are grouped into five scales of emotional, conduct, hyperactivity, peer relationships and pro-social behaviours
Parenting Stress Index (PSI) Short Form (36 questions)	Abidin	1995	Measure parent's reactions to Stressful events
Family Functioning Scale	Roncone *et al*	2007	Describes statements that can happen in families and focuses on the areas of problem solving, communication and personal goals.

Figure 1: Hardiker model of levels of need (adapted from Hardiker et al., 1991)

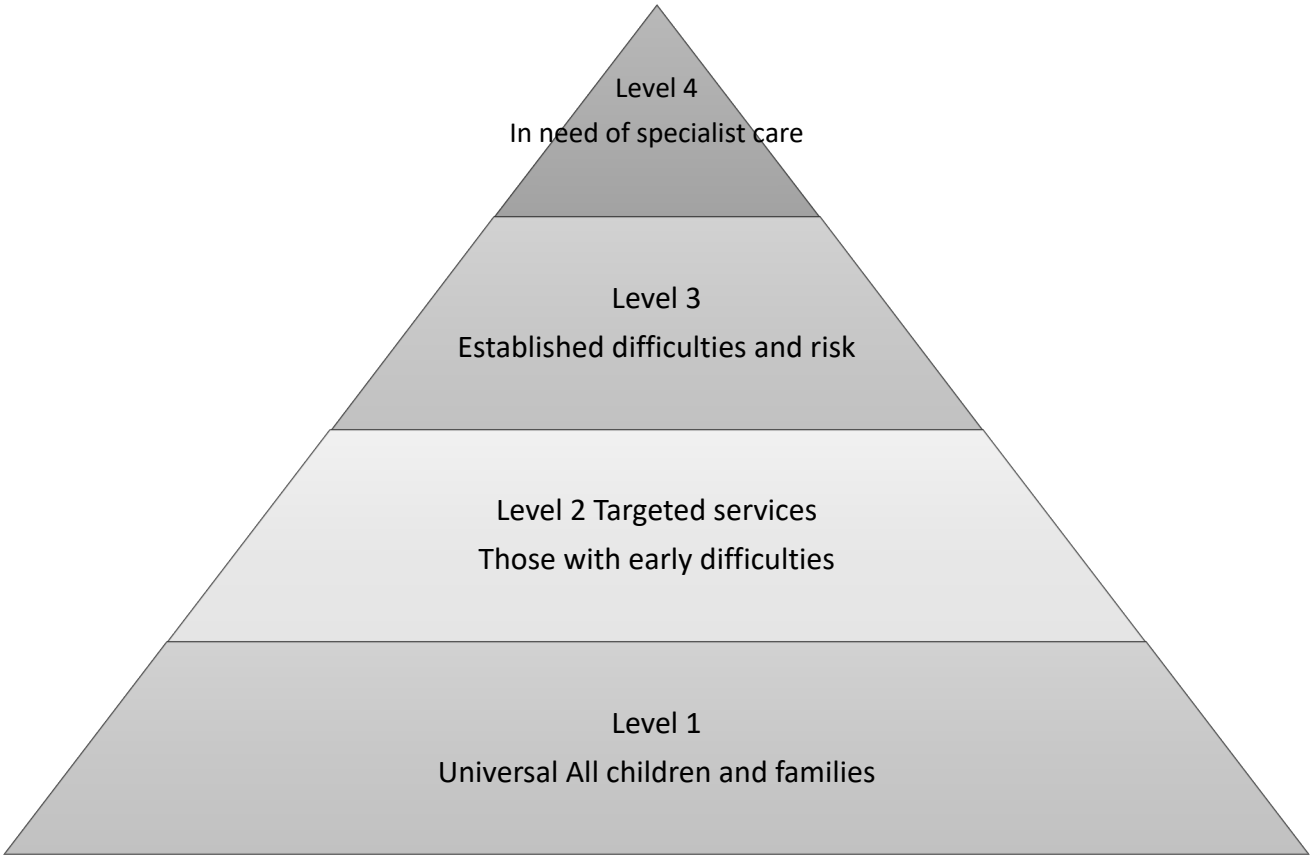

Figure 2: Flow chart to illustrate the delivery model of EISS

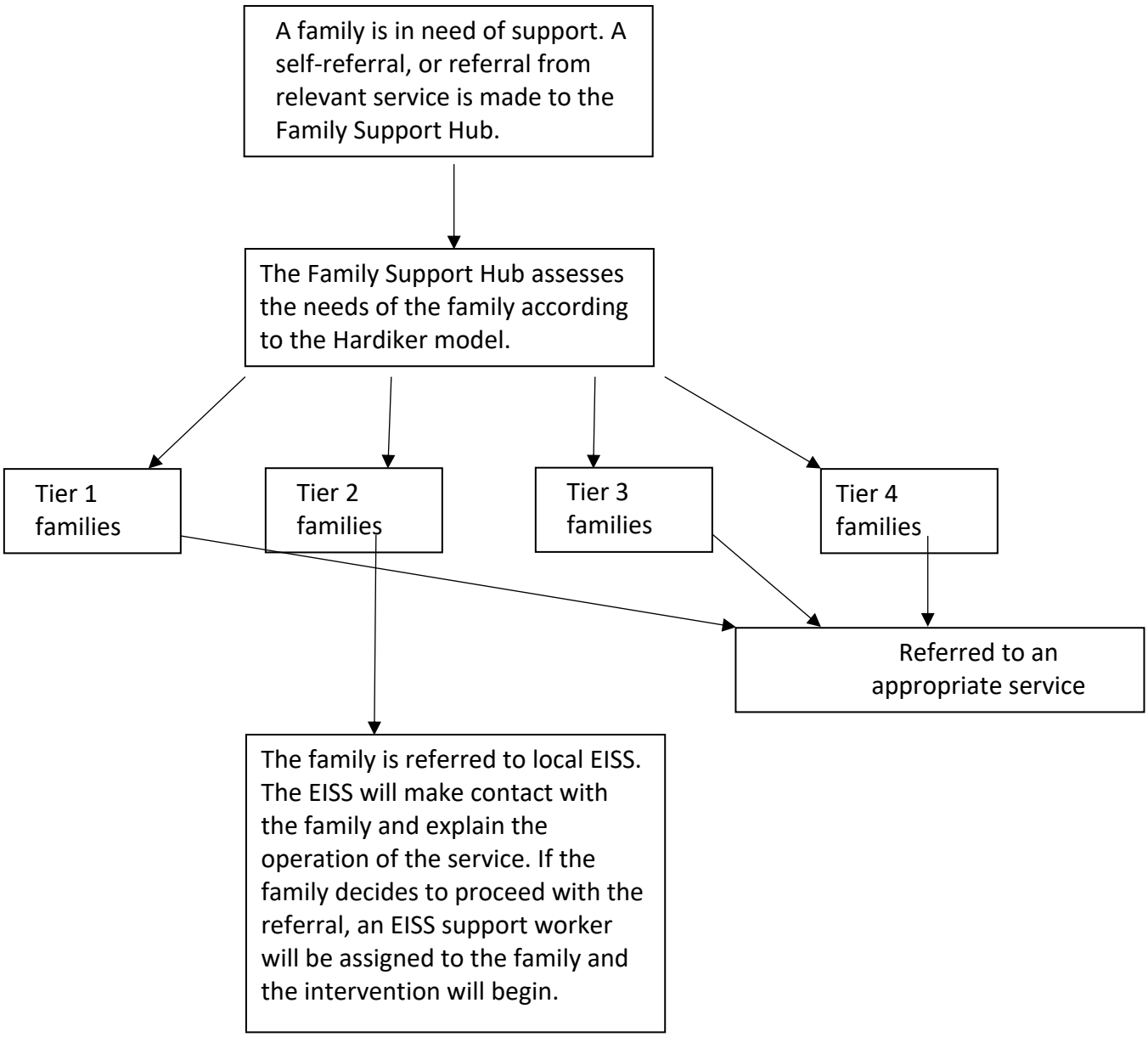

Figure 3: The EISS Model