

Mistaken Assumptions About Child Development and Children's Services

1. There are several negative consequences of the disconnection between research, policy and practice. These have been described in the previous presentation. In this presentation, more attention is given to one of the consequences, namely mistaken assumptions that emerge about children's development and children's services. These mistaken assumptions are functional in that they allow the continuation of policy, practice and research approaches. But they also corrupt an already limited evidence base and so stand as a significant barrier to improving child outcomes.
2. In this presentation a series of illustrations is given. Each is attributed to policy makers, practitioners, researchers or to the three groups collectively. In reality, there is more overlap than is suggested here.
3. Much policy rest on mistaken assumptions about children's development. For example, it is assumed that anti-social behaviour peaks in adolescence. For some forms of anti-social behaviour, such as crime, it does. But for other forms, such as lying, cheating, stealing and not paying attention, problems are significant in the early years of primary school (as children struggle to cope with the massive transition from home). These data bear on the effectiveness of policies to reduce anti-social behaviour.
4. Policy makers make a number of assumptions about 'what works' that are not born out by strong evidence. The most obvious example are assumptions that services not evaluated are effective. Much existing provision is unlikely to contribute to better outcomes for children, and some will be harmful. Present evaluation strategies, that concentrate on new services, wrongly favour existing provision.
5. Policy in most economically developed nations has supported a disproportionately high amount of investment in the 'tail' of distribution of impairments in children's development, for example with persistently anti-social young people, children who cannot live with their parents or drug dependent adolescents. Much less attention is paid to the middle of the distribution. Such attention would encourage more work to improve the behaviour of the average child and greater support for ordinary parenting. It is wrongly assumed that concentration on the 'tail' will reap better results than focus on the 'mean' of the distribution.
6. Generally speaking, in the absence of good data to the contrary, practitioners operate under the mistaken assumption that outcomes for children they support are more often poor than positive. In fact, very little is known about the value added by practitioners to child outcomes, and development exercises -for example during the introduction of assessment packages- indicates that cases outcomes are as likely to be positive with at least the same frequency as they are negative.
7. Practitioners can wrongly assume that doing something on behalf of a child or family is better than doing nothing. Any reflection on past practice will reveal to most practitioners instances where well intentioned actions have contributed to the child's development deteriorating or failing to improve as planned. The ethical principle of 'first do no harm' is too often overlooked by children's services practitioners.
8. Practitioner can work under the assumption that there an 'end point' in each case when behaviour will have improved, emotions will be level or relationships stable. Like our own children, those supported by children's services develop. As one problem subsides,

another emerges. The 'end point' comes when desired outcomes have or have not been achieved in a time specified when the assessment was first completed. The 'end point' may mark the beginning of a new round of work.

9. Researchers can find themselves drawn into situations where evidence drawn from a service sample (say children in care, or children receiving mental health services) is used to say something about the prevalence of risks to child development in the broader population (say the proportion of children being maltreated or the proportion with conduct or emotional disorders). This can lead to many mistaken assumptions about the development of children.

10. The rise of research on the process of children's services has produced many mistaken assumptions about impact on child outcomes. For example, some research centres know very well how to help children's services reduce the rate of children in state care. Such reductions may represent an important output to children's services, but there is no evidence that it either enhances or causes a deterioration in child outcomes.

11. With the increasing emphasis on 'what works', and the need for more robust evaluations, researchers can give the impression that experimental evaluations (random controlled trials) are the only way to evaluate. A badly done experiment, or one based on insufficient sample to prove the effects being sought, or one lacking 'ecological validity' (meaning that there is no way of replicating results in the real world) is as likely to produce misleading results as a quasi-experimental design or one based on other evaluation methods.

12. Too many people assume that only positive results are important. Epidemiological findings that levels of impairment in a community are not as high as were expected or results from experimental evaluations that a programme has no impact on child outcomes are as important to policy, practice and science as findings that confirm the pre-conceptions of the those commissioning the research.

13. As outcomes takes a more prominent place in the language of those working in or for children's services, an assumption can develop that there is a solution to every problem. In the U.S. they talk of finding the 'silver bullet'. In reality, even the most productive liaisons between research, policy and practice, for example in the health world, have only managed to change the pattern of the problem, not eradicate it. Even the most effective intervention will not work for all. It can be helpful to think of the rule of three; a third of children receiving a good intervention will experience improved outcomes as a result of that intervention; for another third good outcomes would have occurred anyway; and for a third the intervention will not have an effect.

14. With the increased interest in the child's voice and other consumer rights, it can be wrongly assumed that 'want' is equivalent to 'need'. It is important to understand the child's perspective, and to listen to what he or she wants. But the child may not have a good insight into what he or she needs. This assessment will involve examination of several sources of information, as well as the child.

15. It can be wrongly assumed that because something is written -for example in a learned journal, a newspaper or on a website- it must be true. All findings require interpretation. As new evidence comes on stream, or as the context changes -for example as nations become richer or poorer- interpretations will alter. All evidence, no matter how lofty the

author, how much confidence is attached to the results or how much coverage is given to the publication requires interpretation in the context in which it is applied.

Sources of Data Used in Service Design

Government statistics

e.g. rates of children whose name on child protection register

Census data

e.g. reports, and re-analysis

Government data sets

e.g. local authority databases and central government indicators

Data set connections

e.g. work of Chapin Hall Center for Children, and practice tools like Aggregated Data & Matching Needs and Services

Research

e.g. Epidemiology and evaluation

Data collected for specific tasks

e.g. need audits

Four Stages of Dartington Common Language Service Design Approach

1. Strategy Development
2. Service Design
3. Manual Preparation
4. Evaluation Planning

What do we see when we look at proven models?

Features of Effective Services (Conditions):

1. Clear target group
2. Realistic about change (modest effect sizes)
3. Strong logic model
4. Attention to ethics
5. Design is treated as a hypothesis that needs to be evaluated

(Consequences) Effective Services Tend to:

1. Have strong match between need and services
2. Support children at home
3. Be multi-modal
4. Be thick not thin
5. Show a clear relationship between investment and outcome
6. Be supported by well-trained and motivated staff
7. Have a manual

Effective services also tend to have 'smart' components, for example the use of dinner ladies to ask the children if they had read last night (in the New York school turnaround programme) and Harrington's algorithm to better link services that are partially successful in responding to adolescent depression.

Features of Service Design Methods

Strong service design methods tend to have the following components, that can be followed in roughly the order described:

1. Strong stakeholder group, including commissioners, providers, cross-agency, consumers and experts
2. Agree scope and develop strategy. Is it for a local authority, state, community or agency. What is the broad focus of outcomes to be achieved?
3. Supported by strong evidence on well-being, influences on well-being and services (as in the epidemiology slides)
4. Prioritise an outcome and a group of children to support, generally focusing on children with similar needs
5. Identify the way risks and protective factors interact for the children in focus, as in the example linking housing and anti-social behaviour
6. Agree broad sets of interventions that logically will reduce risks or interrupt connection between risks at the previous stage. This process will involve good support from (a) local experts; (b) consumers; (c) databases of good practice, such as those signposted on the Prevention Action site; (d) study tours to see proven models; (e) international experts.
7. Agree service options to: (a) design a new services, such as the intervention for children looked after given in the slide; (b) use the logic model(s) of a proven or several proven models as the basis of a new intervention; (c) implement a proven model, as in the case of the use of Incredible Years as part of Sure Start provision in Wales (see Prevention Action coverage)
8. Tighten up those interventions by asking hard questions about (a) who will deliver the services; (b) who the service will be delivered to; and (c) when it will be delivered, including the start and finish of the intervention.
9. Check with the consumer and in so doing think about (a) the 'my child' test; (b) bedside manner; (c) cultural competence; (d) unintended effects.
10. Document for fidelity in a manual, and be aware of the negative impacts of outcomes when strategies and service designs are implemented without fidelity.
11. Tender the design to potential providers, and look for good value added and committment to fidelity
12. Evaluate the hypothesis, bearing in mind the need to get a good match between the question being answered and the evaluation method to be used. When the question is impact on child outcomes, generally speaking randomised controlled trials (RCT) or

experimental methods represent the best method. Where demand for a new service exceeds supply, it is generally straightforward to implement with an experimental evaluation or RCT.

And finally! Disseminate to others and learn from others, as in Ireland.

What can you do?

1. Collect less information and do more with it. Try to avoid data-sets on service populations. Strong evidence on well-being, influences on well-being and services, as in the Birmingham epidemiology, is a more reliable cost-effective strategy.

2. Make a service! If we want better outcomes, we have to do different things. Commissioning should be about designing services. Look for (a) strong community ownership; (b) supported by good prevention science; that (c) contributes to a locally agreed outcome.

3. Bring a stakeholder group together. Get people who will stay the course, work together and be accountable for implementing the result.

4. Evaluate properly; don't use a cosmetic!

5. Introduce common language (small c, small l) training, or child development training, to help staff develop a common way of thinking about children's needs, services and outcomes.

6. Use an established service design methodology such as Results Based Accountability, Communities that Care or Common Language

<http://www.communitiesthatcare.org.uk/>

<http://www.raguide.org/>

<http://www.commonlanguage.org.uk/>

7. Be strategic, think about leverage and learning for other communities and future generations

8. Get good technical support appropriate for all parts of the process; most attempts to design children's services fail.

9. Why not think about sharing resources across the Eastern region and doing this work collectively?