Design & Refine

Developing effective interventions for children and young people
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The Social Research Unit at Dartington is an independent charity that seeks to increase the use of evidence of what works in designing and delivering services for children and their families. We are also a strong advocate of prevention and early intervention approaches. We have over 50 years’ experience of researching what works in improving children’s outcomes across the education, health, social care and youth justice systems.

This guide has been produced as part of the Realising Ambition project, a £25m Big Lottery Fund programme intended to take a preventative approach to youth offending by improving outcomes for children and young people aged 8-14. It seeks to do this by replicating evidence-based interventions that are proven to reduce youth offending, and by supporting charities to refine and evaluate promising interventions – those not yet proven to work but excellent candidates to become evidence-based interventions. The Social Research Unit is part of a consortium delivering the programme, alongside Catch 22, the Young Foundation and Substance. Its role includes evaluating the impact of the programme as a whole and supporting the portfolio of 25 charities being funded as part of the programme to refine and develop their intervention and evaluate their impact. For more information visit www.dartington.org.uk/projects/realising-ambition.

The guide has been written by Nick Axford, Vashti Berry, Sarah Blower, Michael Little, Tim Hobbs and Sonia Sodha. Together we have extensive first-hand experience of working with managers and practitioners in children’s services in Europe and the US to develop, implement and evaluate evidence-based interventions. We are very grateful to colleagues for helpful comments on an earlier draft, in particular Louise Morpeth (SRU), Lynette Basha (Oxford Brookes University), Angela Gentile (YMCA Scotland), Lindsey Higgins (Winston’s Wish) and Sam Pashley (Trelya). Thanks are also due to Beth Truesdale for editing and to colleagues at Dartington for their assistance with the guide, especially Daniel Ellis, Rebeca Sandu and Laura Whybra.
Introduction

If you work in an organisation delivering interventions that aim to improve outcomes for children and young people, then this guide is for you. It is designed to help you think about how to strengthen the impact of what you do to improve children’s lives, and focuses on designing an intervention and planning for its implementation, both of which are crucial to maximising the potential impact of any intervention. A future publication from the Social Research Unit at Dartington will look at how to design, implement and use the results of evaluation – also key to being able to improve the impact of what you do.

In the last decade, there has been increasing interest from government, commissioners and funders in understanding what works in improving children’s outcomes and in funding those interventions that have a proven impact on children’s outcomes. If anything, the tough fiscal climate all public bodies are now operating under has augmented this interest, as commissioners seek to understand which services provide the best value for money in terms of the outcomes they achieve.

That of course leads straight to the question ‘how can we tell what works?’ This seems like a simple question at first, but when decision-makers try to apply it to the field of potential interventions they could theoretically spend money on, it quickly becomes very complex. How do you tell if there is evidence whether an intervention does what it claims to do? How do you compare and contrast the very different types of evidence that may be presented to support these claims? If a decision maker is trying to reduce youth crime, are they better off spending money on interventions that say they improve young people’s behaviour or their school results?

This is why the Social Research Unit at Dartington – together with our international partners – developed a set of clear, transparent ‘what works’ standards of evidence to determine a list of interventions that are well-designed, proven to improve child outcomes and ready for implementation. These standards are aimed at a range of different people involved in funding, commissioning, designing and delivering children’s services:

- For local commissioners, when applied to a field of interventions, the standards can be used to generate a list of ‘tried and tested’ approaches to inform commissioning at the local level.
- For charities and other organisations that work with children who are committed to increasing the impact of their work, the standards represent a set of criteria that they can use to assess their own work and move towards over the long-term through the design, refinement and evaluation of what they do.
- For trusts and foundations that fund organisations working with children and young people and want to support those organisations to increase the impact of their work, the standards can be used to inform how they invest in evaluation and can also help them think about how to achieve impact from their own grant-making strategies.
The standards of evidence focus on four key dimensions, which are outlined in more detail in Chapter 1:

- **Intervention specificity** – This relates to the design of an intervention. Is it focused, practical, logical and designed using the best available evidence about what types of factors affect child outcomes and what works in improving outcomes?

- **System readiness** – This relates to the way in which an intervention is implemented. Is there enough information and resources that come with an intervention – like manuals, training material and implementation procedures – so that it can be rolled out within public service systems, like the education, health, youth justice and social care systems? Is there sufficient information about what financial and human resources are needed to deliver an intervention?

- **Evaluation quality** – Are the impact evaluation/evaluations of an intervention robust enough in their design and execution to give us confidence in the results? This dimension hinges on the premise that in social science impact evaluation requires a control group to compare the effect of getting the intervention versus not getting the intervention.

- **Impact** – What do robust evaluations tell us about how much impact the intervention has on key developmental outcomes for children – those outcomes that really matter in terms of children’s future life chances?

The Social Research Unit at Dartington is a collaborator on Blueprints for Healthy Youth Development, a project with the University of Colorado at Boulder to apply a version of these standards to the field of interventions designed to improve children’s outcomes across the education, health, youth justice, education and social care systems. As part of this project, reviewers examine all the available international evidence on different interventions to see which ones meet the Blueprints standards of evidence. There is a rigorous, independent process for determining which interventions meet the standards, including an independent board of international experts in evidence-based prevention and early intervention that meets twice a year to review programmes.

The standards represent a very demanding test, and it is most appropriate to apply them to interventions where there are already results from a robust impact evaluation that uses a control group. But we believe the standards also help organisations who have not yet robustly tested their work using experimental evaluation to think about how they can improve the impact of their work and to get their interventions ready to be experimentally evaluated. We can think of a ‘pipeline’ that spans innovations to interventions with proven impact. It is only through well-designed, logical and evidenced innovation that we can test what works in improving children’s outcomes, and refine and improve the impact of those interventions already proven to work. To move along the pipeline, organisations can benefit from thinking about how all four dimensions of the standards apply to their own work, for example:

- How their intervention is designed and refined.
- What needs to be done to get it ready to be implemented within public service systems.
- How to design, carry out and use the results from impact evaluations.
In an ideal world, organisations would bear the standards in mind when designing a new intervention from scratch. So, you might start off with how to design an intervention, then think about implementation, then carry out evaluation and, depending on the results of that, go back to refine your original intervention – and so on, in an iterative improvement cycle.

Of course, in the real world, many organisations are already delivering an intervention to a large group of children and come to the standards of evidence at the point they are starting to think about evaluation. But then the standards offer an opportunity to step back and think about how your intervention is designed and implemented – and whether there are refinements you would want to make before subjecting it to a robust evaluation to give it the best possible chance of success.

This guide is focused on supporting organisations in thinking about how to meet the first two standards – intervention specificity (focusing on the design and refinement stages) and system readiness (focused on implementation, and the resources that would enable an intervention to be implemented within public service systems). We will be producing another guide that focuses on the third and fourth dimensions of the standards, which concern evaluation and the measurement of impact.

Other resources we are producing at the Social Research Unit at Dartington that complement this guide and may be of interest include:

- A guide to the standards of evidence, explaining each standard in more depth. This will shortly be available on our website (www.dartington.org.uk).
- A standards of evidence self-rating app. This will shortly be available on our website (www.dartington.org.uk) and will allow charities and other organisations to self-assess their interventions against our standards of evidence.
- A series of webinars for the portfolio of youth charities being funded as part of the Big Lottery Fund’s Realising Ambition project, available online at http://dartington.org.uk/projects/realising-ambition/. These webinars cover much of the material in this guide and may be a useful further resource.

The rest of this guide is structured as follows:

- Chapter 1 outlines our ‘what works’ standards of evidence in more detail.
- Chapter 2 describes the intervention specificity dimension of the standards in more detail, and sets out practical steps for what you should consider when you are in the process of designing and/or refining your intervention.
- Chapter 3 describes the public service system readiness dimension of the standards in more detail, and sets out practical steps for what you should consider when you are in the process of making your intervention deliverable within the education, health, social care or youth justice systems.
- The Glossary sets out some of the technical terms used in this guide.
The ‘what works’ standards of evidence
Chapter 1

The ‘what works’ standards of evidence

We have standards in many walks of life – standards of hygiene in restaurants, standards of quality in manufacturing, standards of proficiency for professionals. People or organisations meeting the standards are known to be ‘sound’ or good. Equally, these standards serve as a guide to others who aspire to reach that level of quality. This chapter describes the standards we have developed to assess interventions designed to improve child outcomes – to help with identifying the best today, and to help those who wish to be the best tomorrow.

The Social Research Unit at Dartington’s ‘what works’ standards of evidence revolve around four questions. As outlined in the Introduction, they are related to determining if an intervention has an effect – positive or negative – on relevant outcomes and whether it is feasible to implement that intervention in a public service system. The four questions are:

1. Is the intervention focused, practical, logical and designed based on the best available evidence? We call this ‘intervention specificity’.

2. Can the intervention be implemented in the ‘real world’ context of a public service system? We call this ‘system readiness’.

3. Is the evaluation design and execution robust enough to permit confidence in the results? We call this ‘evaluation quality’.

4. What do robust evaluations tell us about how much impact the intervention has on key developmental outcomes for children? We call this ‘impact’.

These standards of evidence set out some clear criteria that help us to understand the extent to which an intervention designed to improve the outcomes that matter for child development has the potential to improve children’s lives. This chapter describes in more detail the criteria we use to judge the extent to which an intervention meets each standard.

1. Is the intervention focused, practical, logical and based on the best available evidence?

There have been a large number of quality evaluations examining how much impact different interventions have on children’s lives. These studies do not tell us precisely what to do. But they do reveal features that are shared by successful interventions.

Put plainly, interventions that are successful in improving child well-being are specific about whom they are trying to reach, what they are trying to achieve, what they actually consist of (what is delivered) and the rationale underpinning the intervention – whether its ‘theory of change’ is based on the best-available evidence about what factors impact on child outcomes and what works in improving those outcomes.

The question ‘is the intervention focused, practical and logical?’ can be asked before any evaluation of impact on children’s lives takes place. In fact, people commissioning, developing and providing new interventions should consider these issues during the design phase.

2. Can the intervention be implemented in the ‘real world’ context of a public service system?

Some interventions have been proven to improve the well-being of children and young people, but few have been implemented at scale. Even the best-known evidence-based interventions are not widely implemented. An important reason for this is that although interventions are often designed to be delivered through
education, youth justice, mental health or social care systems, few have succeeded in becoming core to a system. Many children who would benefit from these interventions therefore miss out. As a result, evidence-based interventions are some way from realising their full potential. Only a tiny proportion of children benefit from evidence-based interventions, and for many who do it is as subjects in evaluation trials. What can be done?

In order for interventions to be delivered at scale, interventions have to be made ready for public service systems. The standards are designed to help find out to what extent an intervention is ‘system ready’. Are the information and resources that would enable its successful implementation in a system readily available? Or, put another way, would a decision-maker interested in implementing the intervention in question know what was needed to do this and where to get that information? Being system ready mean fitting seamlessly into a school curriculum or harmonising with the work of highly skilled practitioners, for example.

Since it is now established that when interventions are delivered with what is called ‘fidelity’ – meaning they are implemented as intended by their designers – they achieve the best results, resources and activities that promote fidelity are included in the standards. These include manuals, training materials, implementation procedures, technical support and fidelity protocols or checklists.

By definition, interventions can only succeed if they are used. They need to engage children and families, and children and families need to find interventions easy to access. Too often this is not the case. Methods to engage children and families are therefore increasingly common traits of evidence-based interventions, and the standards encourage evidence of explicit processes for ensuring that the intervention gets to the right people.

Lastly, decision-makers need to know how much interventions are going to cost, and who is needed to deliver the interventions. This information is often so hard to obtain that commissioners give up in frustration and decide to implement something else. The standards therefore require there to be information about the financial and human resources required to deliver the intervention.

3. **Is the evaluation design and execution robust enough to permit confidence in the results?**

Lots of evaluations are commissioned to estimate the impact of interventions on children’s lives. But studies often leave people unsure about whether or not the intervention is effective. This is partly because many commissioners of evaluations are hazy about what makes for high-quality impact evaluation.

The standards value evaluations that use a comparison or control group, meaning that the progress of children experiencing the intervention is compared with that of another group of children not receiving that intervention. If the children in the intervention and control groups are assigned to these conditions at random, in a randomised controlled trial (RCT), it helps increase confidence that differences observed in outcomes as the trial develops are due to the intervention and not pre-existing differences between the children in different groups.

The standards also pay attention to the tools used to monitor key developmental outcomes, the way in which the data are analysed, the number of participants (children, families, schools and so on) that drop out of the evaluation, and other important methodological issues.

**4. What do robust evaluations tell us about how much impact the intervention has on key developmental outcomes for children?**

The bottom line of any outcome evaluation is how much difference the intervention makes to children’s lives, and whether the difference is positive or negative. We call this ‘impact’. The standards require clear evidence of a positive impact of the intervention on child outcomes of interest and no evidence of a harmful effect.
Intervention impact has been measured in several ways. Researchers sometimes talk about the odds of better outcomes for children receiving an intervention compared with those not receiving the intervention. Some evaluations compare the prevalence or proportion of those in each group who engage in a specific behaviour like smoking or who achieve a specific outcome like going to university. Some evaluations refer to moving children from, say, the 50th to the 60th percentile on a given outcome.

The standards encourage more widespread use of a way of measuring impact known as ‘effect size’. Effect size is increasingly used in good evaluations and, with some important caveats, permits like-with-like comparisons of intervention impact across geography and service sectors. An added advantage of effect size is that it is used in cost-benefit analysis, which translates impact on child outcomes into monetary terms. It is expected that cost-benefit data will increasingly be required as decision-makers seek to make the best use of scarce resources.
Designing your intervention: how to improve intervention specificity
What is intervention specificity?

Successful interventions are clear about what they are, what they aim to achieve, and how they aim to do it. So the first dimension of the standards is concerned with whether an intervention is focused, practical and logical. This chapter describes the criteria used in the standards of evidence to assess intervention specificity and then looks at how it can be improved for a given intervention.

In the design phase, an intervention will most likely be delivered by the people who developed it. But if the intervention is to have a lasting and widespread impact on children’s health and development, it will need to be delivered by people who know next to nothing about how the intervention was first assembled. Future providers, practitioners and, in some cases, children and families will need to know what the intervention comprises, why it has been designed as it has, what is the logic behind it, what aspects are essential to its success, and what aspects are adaptable. It may be necessary to document the skills and procedures upon which success depends. But it is as important to express the spirit with which the intervention was designed, setting out why there was a need, what is different and the driving force behind its creation.

There are three key aspects to intervention specificity:

1. What the intervention is
2. What the intervention tries to achieve, and for whom
3. How the intervention is supposed to work

1. What the intervention is

There is clarity and documentation about what the intervention comprises

It can be surprisingly difficult to establish what an intervention actually ‘is’. The people who are most familiar with it tend to know intuitively what it is but they often struggle to explain it simply to others. This is not necessarily a problem for a small, local intervention, although when you delve deeper it is common to find that different people involved in delivering the intervention have different understandings of what it is they delivering. But when designers seek to replicate the intervention or increase its scope, clarity about what the intervention comprises is essential for success.

Clarity about the intervention involves stating what is provided, by whom, over what period, for how long, with what frequency, where and how. Put another way, you need to spell out: content (e.g. information, advice, training, money, advocacy); provider (e.g. social worker, teacher, psychologist, volunteer); duration (e.g. 3 hours, 6 weeks, a school year); length of inputs (e.g. 2 hours); frequency of inputs (e.g. daily, weekly, monthly); setting for delivery (e.g. school, health clinic); and mode of delivery (e.g. group-based, one-to-one).
2. What the intervention tries to achieve, and for whom

The outcomes of the intervention are relevant and clearly specified

There are sadly no silver bullets in the world of improving child outcomes. Effective interventions designed to improve child outcomes tackle one or two or at most three or four outcomes at a time. They do not try to solve all ills. It is therefore worth reflecting on the aspect of health or development that an intervention is designed to impact on, for example emotional health, intellectual development or behaviour. There may be broader benefits to the child if the targeted outcome is improved.

Precision is necessary. It should be possible from previous research to establish how much progress is possible for the target group, and over what period, and in setting these goals to be aspirant but realistic, not over-promising. It is helpful to say how such decisions were arrived at – in other words, to show your working out. For example, suppose you are trying to reduce alcohol consumption. You find that other interventions have managed to do this by 30%. However, they have been more intensive and with heavy drinkers only. Your intervention is lighter touch and targeted at a wider group. You might conclude it is reasonable to expect your intervention to have a weaker effect – perhaps achieving a 10% reduction.

The intended population of focus is clearly defined

Effective interventions are selective about who is being helped with what. It should be clear which stage of children’s development is being targeted, and whether the intervention is going to reach all children of a particular age group, or a selected group – for example, those at risk of developing mental health problems or those displaying certain risk factors. It should be obvious if the intervention is seeking to prevent problems from occurring or get in early when the first signs of difficulty appear, or treat fully-established problems. If there are reasons why certain children or families might be excluded from receiving the intervention – for example, because of their age or the nature of their difficulties – this should be stated as well.

3. How the intervention is supposed to work

There is a clear, logical theory of change explaining why the intervention will lead to better outcomes

Good innovation is underpinned by a simple, clear and logical ‘theory of change’ – a description of why the intervention is expected to achieve the desired outcomes with the target population. Usually, this will involve spelling out the chain of effects that result in improved outcomes. For example an intervention might be designed to reduce the risk of living overcrowded housing to a child’s educational outcomes. Or it might try to boost the protection offered by a significant adult to offset the risk of poor parenting to a child’s behaviour. Or it might try to boost a child’s resilience to adversity, for example by helping children to manage stress.

Again, precision is essential. It should be possible to use evidence to quantify how much change to risk, protective factors or resilience is anticipated.

There is a research base that supports the theory of change

The evidence should be set out at each stage in the specification of the intervention. The target population should be quantified using local population statistics and epidemiological data. The amount of improvement in outcomes should be estimated using reviews of similar endeavours as a guide. The risk and protective factors that the innovation seeks to affect should be linked to research showing how they connect to the outcomes. An estimation of the intervention’s potential impact should be supported by existing research on how the outcomes in question can be improved. Confidence in the intervention’s potential impact will reflect the quality of the underpinning evidence.
Improving intervention specificity requires asking five questions about an intervention:

1. Who are you trying to help?

There are at least two things to consider as you define what group of children you are trying to help. The first is what stage of child development you are focusing on: pre-school (from antenatal to four or five years old), primary school years, secondary school or early adulthood? These four categories are crudely defined, and you might want to be more refined about your choice.

2. What are you trying to achieve?

The second is at what stage of a problem you want to intervene. Roughly speaking, do you want to prevent a problem from occurring, to intervene early in its development, or to promote the best possible recovery – or at least minimise harm – after a problem has occurred? For instance, if your concern is child anti-social behaviour, you might want to improve parenting skills to decrease the risk of poor behaviour, or intervene with counselling when the first signs of misbehaviour appear, or change the way that schools respond to children who have a conduct disorder. To use more technical terms, you need to think whether you are interested in prevention – stopping the problem happening in the first place; early intervention – getting in at the first signs of trouble; or treatment – responding once something has gone wrong.

An example of a preventative intervention is the PATHS programme, a social and emotional learning curriculum for children in the primary school years that prevents the onset of emotional and behavioural problems (and indirectly getting behind in school work). An example of an early intervention is the Incredible Years parenting programme, which seeks to support parents of children at high risk of developing a conduct disorder, thus reducing its incidence. (Note how early means early in the stage of development of the problem, not always early in the child’s life.) An example of a treatment-based approach is Functional Family Therapy, which involves treating young people who have already developed conduct disorders.

Having made these important distinctions, you should seek a more fine-grained description of your target group. If the intervention is for primary school children, is it for all children in that age-group or, say, 9-11 year-olds? If it is seeking to reduce anti-social behaviour among ‘at risk’ adolescents, how is ‘at risk’ defined – do participants need to display certain risks, such as impulsivity or doing badly at school? If it is aiming to prevent suicide is it unsuitable for some young people for whom it will only make matters worse? Is it for boys and girls? Is it targeted at families who are financially hard-up, or all families? Answering such questions will minimise any ambiguity there might be about whom your intervention is for.
2. What are you trying to achieve?

There is no pre-determined list of outcomes, but it is helpful to focus on selected developmental outcomes. These are ordinary landmarks in a child’s development which, if not achieved, will likely affect a child well into adulthood. For example, if a child’s reading is well behind by entry to secondary school, we know the negative consequences can be long-lasting. If there is sufficient attachment in the relationship between mother and child such that the child can behave autonomously in the pre-school years, there will likely be some positive benefit at least through childhood.

An emphasis on a particular developmental outcome can help to keep the intervention focused. Because outcomes are often linked, it is easy to get distracted by the possibility of improving a whole chain of outcomes. For example, improving emotional and behavioural development in the primary school years may have a knock-on impact on improving reading and writing, on the basis that happy, more attentive students learn more! This is good of course, but such spin-off benefits are more likely when an intervention has a disciplined focus on achieving the outcomes it is designed to achieve. Paradoxically, trying to achieve lots of outcomes makes it less likely that any will be achieved. The objective of keeping your focus precise is to increase your odds of doing one thing well (while giving you an outside chance in other areas).

Establishing what change you expect to see in the target outcomes should draw on previous research. It should be possible to estimate how much progress is possible for the target group over a given period. To what degree have similar interventions improved relevant outcomes? Is there anything about your intervention or target group that leads you to expect more or less impact? You will need to consult experts and the scientific literature to help determine this. The more precise you can be, the better, as it will give the design team and your backers confidence that your intervention can achieve what you set out to achieve.

3. What is the logic underpinning your intervention?

Even the most complicated of successful interventions will be underpinned by a simple, clear and logical description of how the anticipated outcomes will be achieved with the target population. This description is called a ‘theory of change’: what makes us think that the proposed intervention will produce the results we desire? Of course, it is not difficult to justify most ideas. Many proposed interventions are simply an existing idea retrospectively fitted into a logical sequence. To be useful, a theory of change must push the intervention designer to test the emerging ideas robustly. This critical thinking should be the first test of an intervention – long before the intervention ever takes place.

There are essentially two steps to create your theory of change. First, you need to articulate a theory of the problem. Typically this begins with an outline of the risks that make the poor outcome you want to improve more likely. This list of risks may be drawn from experience, local evidence, national and international studies or, possibly, some composite of the three. The task often extends to a description of any protective factors that ameliorate the impact of risks on child well-being. You are likely to need experts to help you find and appraise the most appropriate research.

These connections can be tested for their logic. Is there really a connection between X and Y? Is the suggested connection intuitive, and does it ring true for practitioners and family members? These points of connection are generally referred to as ‘chains of effects’ in a child’s development.

The second step is to create your theory of change to propose activities that will prevent the risk from happening in the first place, reduce the impact of the risk, break its connection with another risk in the chain of effects, or boost the protective factors known to offset risks in some way. Your proposed activities might do all of these or only one or two. Essentially this is your theory of the solution. It also needs to be tested for its logic.
There will always be a tendency to allow enthusiasm for the proposed intervention or new ways of doing things to override the need for subjecting it to this kind of test. But generally speaking, the greater the investment in these early design stages, the more accurate the drawing of the chains of effects, and the more logical and evidence-based the proposed intervention components, the more likely it is that the proposed intervention will have its desired effect.

4. What is the evidence underpinning your intervention?

Both steps in creating the theory of change for your intervention also need to draw on the best-available evidence about what negatively impacts on child outcomes and what works in improving them.

Our standards place a lot of stress on understanding the patterns of risk and protection that lead to poor outcomes, on the basis that reducing risk or boosting protection against that risk will lead to better outcomes. This kind of evidence, which essentially traces the potential causes of impairments to children’s health and development, demands some exploration of existing research that has focused on the outcomes your intervention is seeking to change.

The standards place a similar emphasis on research into ‘what works’. For most outcomes there will already be a body of knowledge indicating the kinds of things that are likely to achieve the desired change in outcomes for the chosen target group. For example, we know that certain types of parent skills training can improve parenting behaviour, which in turn can improve children’s behaviour. We know what makes for good social-emotional teaching in schools, and what is less effective. We also know when mentoring works and when it doesn’t, and what makes the difference. In many cases the research literature on these and similar topics is vast but there are helpful summaries, which you should consult.

With good quality evidence it should be possible to inject precision into the equation about what matters and what works. There should be evidence on the difference in risks, protective factors and outcomes between the target group and general population of children. This should lead to a hypothesis about the extent to which risk can be reduced, protective factors boosted and outcomes improved. A glance at the literature on effective interventions will remind you to maintain modest aspirations.

Evidence used in the design and early implementation stages should be collated, summarised and made accessible. This will have several benefits. It will form a barometer of confidence for potential investors and users. The stronger the evidence base, the stronger will be the reason to think it may work. It will also help future pioneers. Even the best-planned initiatives can sometimes fail. Even the most effective interventions fall short of complete success: there is always room to do better. Those wanting to know why something doesn’t work, or seeking to improve on existing interventions, will be served by having access to all of the available evidence.

5. How will you communicate what the intervention is to a broad audience?

In the design phase there is a natural tendency to look to what will happen in the first months or years of an intervention. But if the intervention is to be sustained – to spread and make a lasting difference to children’s lives – it is necessary to think longer-term. In initial tests, the intervention will most likely be delivered by those who have been involved in designing it, bringing to the mix all the enthusiasm and excitement often associated with a new venture. But longer term, the intervention will need to be delivered by people who were not involved in its design and who, far from being enthusiastic, may actually be hostile to the prospect of taking on something new.

Three steps can be built into the design stage to give the intervention the best chance of long-term success. First, at the most basic level, designers need to provide the factual information commissioners need when making decisions. At a minimum, this
information includes: whom the innovation is for; what is delivered; how it is delivered; what kinds of staff resource it requires, and how it is deployed; how long the intervention lasts; where it should take place; and how much it costs. This information should be well packaged, engaging and freely available.

Second, developers can help to engage and motivate would-be users by attempting to re-create the emotional charge that produced the innovation. What was the driving force behind the design of the intervention? What individual stories or case studies led to the development of the idea? You might use these to help create an intrinsic demand or ‘pull’ for the intervention.

Third, the success of an intervention rests on both fidelity and versatility: it must be possible to repeat the ‘key ingredients’ that make the intervention work while moulding the intervention to fit local contexts. So, a vital part of conveying an intervention to a broader audience is a clear exposition of what is core and therefore immutable, and what is peripheral and therefore adaptable. The key is to be clear about what can and cannot be changed, and why. It will be helpful if you specify which components do not influence the final outcome but can be adapted to allow service providers in other areas to make the innovation ‘their own’.

As the next chapter shows, this information then needs to be translated into good documentation and training materials that are accessible and meaningful to people working in contexts quite different from that in which the intervention was originally delivered. Well-prepared manuals will retain their vitality, becoming a source of useful information for managers and practitioners even when the intervention becomes a routine part of their work.
Planning for implementation: how to improve system readiness
If a successful intervention is to have a positive impact at scale, it needs to be implemented by people other than those who designed it – in other words, by regular staff in regular services. Put another way, an intervention is of limited use if it can only be delivered by a small and select number of highly-trained people in one place. So the second dimension of the standards is concerned with whether the intervention can be implemented within public service systems - such as the education, health, youth justice and social care systems. This chapter describes the criteria in the standards of evidence used to assess system readiness and then looks at how it can be improved for a given intervention.

There are four key aspects to system readiness:

1. Reaching the right people – targeting, recruitment and retention

There are explicit processes for ensuring that the intervention gets to the right people.

The most effective intervention for improving the behaviour of pre-school children will have little chance of widespread impact if it is delivered to primary school pupils. Similarly, an intervention designed for children with a conduct disorder is likely to be of limited value if offered to children with minor emotional problems. Having gone to the trouble of getting focus into the intervention, you need to ensure that it reaches the children for whom it is intended. This might be as simple as being absolutely clear about the conditions in which the intervention can be delivered. Or it may require using standardised screening instruments to select those children or families eligible for the proposed support. It may also involve setting up processes for connecting participants to the intervention, such as referral pathways for partner service agencies, and developing strategies for recruitment and retention – to help eligible participants access the intervention initially and then continue accessing it.

2. Supporting the people delivering the intervention

There are one or more manuals detailing the intervention.

Most interventions will require that specific strategies are followed by a practitioner, whether it is a teacher, youth justice expert, volunteer, psychologist or social worker. The people managing, delivering and monitoring the intervention have to know what is expected of them. This part of the standards therefore focuses on the different types of support that should be available to practitioners delivering the intervention.

Generally the practitioner will have been trained and know what is expected of them. But when they are enmeshed in their day-to-day work they will benefit from
manuals setting out in detail how the intervention works, what needs to be done when and by whom, and how to respond to unusual but predictable circumstances. Manuals are also a useful place for collating all materials needed to run an intervention (for example, lesson plans, curriculum, worksheets, games, exercises, vignettes and DVDs). Effective practitioners will refer to the manual less and less as they become more skilled and confident, but they will find reassurance in knowing that the information is available should they need it. You should write the manual bearing in mind the context in which the intervention will be delivered and the norms of the responsible professional group. If an existing intervention is adapted for a new context it is common to explain in the new version what has changed and why, or to produce a supplement containing changes to sit alongside the original (old) manual.

There are training materials and implementation procedures

Effective interventions lose their power if they are delivered in a haphazard way. Support will be required for those implementing the intervention for the first time. The greater the spread of the intervention, the less direct contact the designers of that intervention will have with the people implementing it. High-quality training materials and implementation procedures will therefore become a means to eventual success. These materials should be designed for the public service systems in which the intervention will need to fit, reflecting professional, organisational and community norms. You should be clear about whom the training is for, what the content is, how long it lasts, how often it needs to be, who delivers it, and when and where it typically happens.

Technical support is available to help implement the intervention in new settings

Few interventions are glitch-free. People delivering the programme will require ongoing specialist assistance, or ‘technical support’ – more as agencies begin with implementation, less as the intervention becomes established. Some support is high level and intensive, such as that provided by a good supervisor, while some is low level and routine, such as answers to frequently asked questions. Imagining from the outset how the intervention will work if it were delivered in another country can help develop strategies that will be sustainable during rapid scale-up. The use of new information technologies now becoming freely available to most families and all practitioners is recommended. Whichever model of technical support is selected, you should be clear about its audience, content, frequency, duration, medium of provision and availability.

There is a fidelity protocol or assessment checklist to accompany the intervention

The most effective interventions can fail when they are not delivered as intended. Fidelity to the design has repeatedly been shown to be an essential element of an intervention’s success. However, a product’s scaleability depends in part on its ability to be adapted by users. In the design process you must therefore find the fertile ground between fidelity and adaptability, setting out what is essential to impact and therefore unchangeable, while also establishing adaptations that will help promote the wider take-up of the intervention. (The smartphone is a good exemplar: the electronics are essential and practically impossible to change, whereas the screen and the applications can be changed to meet users’ personal preferences.) Having found the fertile ground, you can then work out a protocol or a simple checklist that practitioners, supervisors, managers or independent observers can use to ensure that the core elements are delivered as intended. The type of fidelity information that needs to be recorded and the means of recording and using it should be made clear.
3. Financial and human resources

There is reported information on the financial resources required to deliver the intervention

To be sustainable and scalable your intervention will need ongoing and sustainable sources of funding, such as from commissioners of children’s services in the health, education, social care or youth justice systems. Commissioners depend on reliable information about unit cost and good data about additional start-up costs, such as getting practitioners trained or creating new processes to reach the target population. Financial information should be accurate and represent the true cost of delivering the intervention in real world contexts, and be packaged in a way that is understandable to commissioners and funders.

There is reported information on the human resources required to deliver the intervention

Commissioners also need information about human resources. Most interventions rely on skilled practitioners and/or volunteers. There will also be important roles for managers, finance staff, monitoring and evaluation specialists and others.

By default, most people working to support children’s health and development are stretched by their current obligations. A designer must therefore specify what is expected from the people responsible for delivering the intervention, including their qualifications, skills, experience and values. It should also be clear how much time is needed for delivering the intervention. Such information helps commissioners and funders to figure out how the work can be incorporated into existing practice or what types of new staff will need to be employed.

4. Capacity for scale

The intervention that was evaluated is still available

Designing an intervention to improve children’s health and development is exciting. Sustaining that innovation over many years is less exhilarating but as essential to its eventual success. The great majority of effective interventions are no longer supported by a viable organisation. Effectively this means they are no longer available.

Part of the journey from initial innovation to proven impact is therefore ensuring that there is an infrastructure in place to support the intervention. This should major on testing and evaluation in the early stages, and shift to the ability to deliver consistently at scale in the later stages. Successfully embedding interventions within the mainstream systems responsible for most children’s services will help promote sustainability.

Once an intervention has been tested and found to be effective its developers often start to adapt it. This is often for good reason, for instance to meet cultural needs or make training and technical support more affordable. But it can mean that today’s version of the intervention may deviate significantly from what was found to work. In such cases it may be necessary to test the new adapted version to see if it is effective before deciding if it is ready for widespread dissemination.

The intervention is currently being widely disseminated

Many effective interventions fail because they cannot respond to significant demand. What happens if, following success in one area, 20, 50 or 100 sites in other areas seek to buy into the idea? When interventions are being pushed by their creator we call it ‘dissemination’. When demand reflects intrinsic demand or ‘pull’ we call it ‘diffusion’. The design process should include consideration of both processes. Generally speaking, the type of organisation that develops around a new innovation
is always designed with dissemination or diffusion in mind. A failure to engage with challenges around dissemination and diffusion will limit the intervention’s reach. The extent to which an intervention has been implemented widely – that is, in several places and with numerous people – is an indicator of capacity for scaling an intervention.

**The intervention has been tested in ‘real world’ conditions**

Evaluations of interventions often take place in artificially-controlled conditions – where the intervention is delivered by people on or working for the research team, the developer is closely involved in delivery, the setting is not an everyday service setting and support for the people delivering the intervention is so intensive it could never be provided at scale.

These conditions cannot be replicated in the real world, where the intervention needs to be delivered by regular people working for children’s services, the developer is not heavily involved, the work takes place in everyday service settings and the support offered needs to be affordable and manageable.

As a result, it is not possible to be confident that results found in an evaluation in artificial conditions will be replicable more widely. It is therefore important to try to show that the intervention works in the real world. In the real world some practitioners follow the manual while others don’t, organisational support for the work waxes and wanes, and there are a host of complicating factors that have to be contended with – for example policy changes, budget cuts and turnover in leadership. The version of the intervention that is available for commissioners to implement should be tested and found effective in real-world conditions.
Improving system readiness

Improving system readiness requires thinking about seven questions:

1. How do you make sure the intervention reaches the right people?

2. How do you ensure that the people who implement the intervention are equipped with the necessary skills and knowledge?

3. How do you make sure that different stakeholders understand what the intervention is and what their role is in its delivery?

4. How do you make sure you have costed the intervention properly so that it is clear what things cost and who is paying for them, thereby avoiding hidden costs?

5. How do you work out the staff resources needed to deliver the intervention, and how do you get those staff in place?

6. How do you support the people who deliver the intervention to deliver it well?

7. How do you measure whether the intervention is being delivered well?

1. How do you make sure the intervention reaches the right people?

After you have worked on intervention specificity, it will be clear whom the intervention is for. But connecting the children or families who are the intended beneficiaries with the intervention can be a long and roundabout journey. Ensuring that the right people receive the intervention is critical, otherwise the impact on outcomes will be reduced or non-existent. The intervention may even be harmful.

A good place to start is by working out the level of need for the intervention. This means trying to establish roughly how many children or families in a given population fit the target group. Put another way, approximately how many potential beneficiaries are there? To answer this question, you need either to do some research or to find relevant research that other people have done.

One option is to conduct a representative survey in order to identify the proportion of people in the population who meet the target group criteria. For example, a survey might show that 15% of children aged 8-10 have high levels of conduct problems. Or you might analyse case file data collected by social services, health, education and youth justice and find that 10% of 12-14 year-olds show anti-social behaviour at home, in school or in the community and have one of three risk factors you are interested in changing (for example, poor parenting, anti-social peers, or impulsivity). Even better if you have additional information – for example, about where, geographically, the children who fit your target group live, or which agencies serve the largest number of potential users.

Of course, not everyone who fits the target group will want the intervention or be able to take part. So the next step is to estimate the level of demand. How many of those who need the intervention will participate? You could establish this through market research – for example, by asking potential users if they would take part in an intervention like the one you are offering. Equally, it may be necessary to make some educated assumptions – informed, perhaps, by experience or more informal soundings from colleagues, partner agencies or potential users. You may conclude,
for instance, that only one in three of those who need the intervention are likely to use it.

When you put these two pieces of information together – need and demand – you have a strong starting point for working out how to get the intervention to the right people. Let’s say that you have spaces for one hundred 8-10 year-olds with conduct problems on your intervention. You know that 15% of children in that age range fit your target group. In a population of 1,000 8-10 year-olds this means that there are 150 such children – on face value, more than enough. However, you also estimate that only one in three (50 out of 150) will take up the intervention. So you need to reach a population of at least 2,000 to be able to serve 100 children out of an eligible group of 300.

You also need to decide how you are going to identify the 300 eligible cases, and the 100 ‘take-up’ cases. Essentially, there are two routes into an intervention: self-referral or referral by someone else (typically another service or professional). What processes enable the people who need and want the intervention to sign up for it or be referred to it? First, you need to set out what information is needed about individuals who are candidates for the intervention. In most cases, this includes obtaining basic personal data (name, age, gender, ethnicity, contact details) and data relevant to the target group criteria. You want to know that they fulfill any criteria for being included in the intervention, and also that they don’t tick any boxes that would exclude them. In the above example it might be, for instance, that the intervention can do nothing for – and may even make worse – conduct problems associated with brain dysfunction. Second, you need to set out who will provide the information and who will collect it. Sometimes the child or young person might provide the information, but sometimes it needs to come from someone else – a parent or carer, perhaps, or a professional from another organisation.

Third, you need to determine how the information should be collected: should it come from an interview, or a brief tried-and-tested screening measure, or some other method? A flowchart can be a useful way of mapping out this process, showing who gets and gives information, on what basis, and in what order.

It is all very well mapping this out, but three groups of stakeholders need to be on board if you are going to recruit the right people to your intervention and keep them involved. In engaging these stakeholders you need to think partly like a marketer and partly like a logistics expert: this will help you to understand what will make your intervention attractive to intended providers and users and easy for them to buy into or use. You need to get inside their heads, see the world how they do, and figure out how your intervention can be desirable in their world. So, who are these stakeholders?

First, you need to sell your intervention to the agencies, and professionals in those agencies, who might buy it, advertise it, or refer clients to it. What will make it attractive to them? As a rule, a commissioner is more likely to want to buy an intervention that would fit comfortably into current arrangements – meaning, for example, that it could be delivered by existing staff or fill a slot in the timetable currently occupied by a less promising approach. They will also be more interested if it is clearly specified how the intervention helps with meeting statutory targets and inspection requirements. A professional will be more likely to refer a client if the target group criteria are clear and the client appears to fit, if they believe their client will benefit from the intervention, if they know and trust someone involved in delivering the intervention, and if they know they will be told what happens to the referral and client.

Second, you need the people you are relying on to deliver the intervention to be on board – which will be easier if they want to deliver it. A practitioner will generally be more enthusiastic about delivering an intervention that allows them freedom to be creative, respects and leaves room for their professional judgement, and involves lots of face time with children and families. Most practitioners also want to develop their skills and qualifications, see evidence that what they are doing actually improves outcomes and further the cause of social justice.
Third, you need the children and families to come to the intervention – not just once or twice but for its duration. You might break this down into how to get people involved in the first place ('recruitment') and how to keep them involved ('retention'). To risk stating the obvious, they will only come if they have heard about the intervention. Since they are unlikely to come knocking on the door, this means that someone involved in the intervention needs to go to them. Once they know about it, people are more likely to come along if it fits their lifestyle and is easy and pleasant to do so. They will want to feel it isn’t going to be threatening, and that it is going to help. They will feel more comfortable if they have spoken with and built an acquaintance with someone who will be delivering the intervention. However, getting people along once is no guarantee that they will keep attending: people often need ongoing practical and emotional support to enable them to stay involved.

It is vital, then, that enough money and time are earmarked to connect people to interventions: empty spaces are resources down the drain, so this is not an area to scrimp on. While these general principles about the needs and desires of agencies, professionals, practitioners, and children and families can help when introducing an intervention, it is probably also worth doing some additional market research on your intervention. This need not be complicated or onerous. You want to understand what potential ‘consumers’ of your intervention think about the intervention – whether they think people like them are likely to want to implement or use it, and what changes might improve their view. This research will generate useful insights about how to ‘package’ the intervention, how to do the public relations, and how to make your intervention relevant to those who will buy, refer, deliver or participate.

2. How do you ensure that the people who implement the intervention are equipped with the necessary skills and knowledge?

Most interventions come with manuals and associated materials – lesson plans, checklists, routines and so on. And the people delivering those interventions come with experience, knowledge and skills – some relevant, some less so. However, simply connecting the two – giving the materials to the people implementing the intervention – is rarely sufficient to ensure that the intervention is delivered well. Training is an essential bridge between the two, enabling people to acquire the necessary knowledge and practice the relevant skills so that they can use the materials appropriately.

If you look at evidence-based interventions in children’s services, you will quickly see that the type of training offered varies. Some interventions require a group of practitioners to meet whereas others involve a lone practitioner working their way through a DVD or computer instructions. Some training takes a few days, other options take as little as a couple of hours. The media used also differ, although typically training includes some combination of presentation, reading materials, video segments, group discussion, role play (or other practice) and homework. Obviously the best or most suitable option depends largely on the intervention and the people who are being trained. For example, intensive interventions will likely require intensive training, and a seasoned professional will probably need less training than an inexperienced volunteer.

You therefore need to do some careful thinking and planning to work out the optimal training for your intervention. Existing evidence-based interventions tend to have a training package already, which in many ways makes life easier, but you will still need to decide if it is fit for purpose. Is it right for the kind of people who will be delivering the intervention (taking into account their existing knowledge and skills)? Where and when should it be delivered? How does it fit with existing training commitments that people might have? Should the external people brought in to conduct the initial training always do it, or is there scope for a more sustainable model – for instance, by developing internal training capacity?

Developing training for a new intervention is more of a challenge. Inevitably there are several generic guides for developing training, and we strongly recommend that you consult these. They can provide a helpful structure to guide your thinking, from
analysing training needs and developing a course outline, to writing the content of inputs and arranging necessary equipment and supports. They also offer advice on issues such as selecting suitable trainers and assessing the progress of the people being trained. Most guides also give insights into how adults learn and how this should affect the design and delivery of training. It is important to bear these in mind. For example, adults need training to connect with their existing life experience and knowledge. They need it to be practical and relevant for the tasks they will be doing. They also need to be self-directed rather than spoon-fed.

At a very general level, there are four stages to planning the training for your intervention. First, you need to analyse training needs – in other words, to think about what the people who will deliver the intervention need to know and be able to do. It helps to break the intervention down into smaller components and think about what tasks need to be completed and to what standard. You might think about the range of topics that are covered and the style of input and type of skills that these require. If you know the kind of person who will be delivering the intervention it soon starts to become clear what training they will need.

The second step is to develop a training course. It helps to break this down into sections, or ‘modules’. For each module you need to think about the objectives and how you will know if these objectives have been met. Then you need to decide on things like the medium of delivery (for example, lecture, video, facilitated discussion, role play), the materials or equipment that will be needed (for example, chairs, handouts, vignettes, DVD, laptop, projector), how long inputs should last, any additional support that will be needed (for example, an IT expert), if and how participants will be assessed (for example, quiz or observation), and how learning can be consolidated. The training can also take different forms. In industry a helpful distinction is made between formal training (a lecture on how to drive a train), simulator-based training (pulling levers in a mocked-up cabin), and training on the job (driving a train under supervision). A lot of training in interventions in children’s services is fairly formal but role play, a kind of simulation, is common, as is coaching, a form of on-the-job training. It is also worth bearing in mind that different people involved in delivering the intervention might need different training, depending on their role and tasks. For example, a teacher delivering 30 lessons of social and emotional learning needs different training to their head teacher, whose task is to encourage teachers and promote a caring and inclusive ethos.

The third step when planning training involves deciding who will make a suitable trainer. Of course, this will vary depending on the subject area and type of intervention. But the following are always likely to be needed: essential training skills, including an ability to impart knowledge clearly and help others to develop competencies; adequate and current competence in the subject they are training in (the trainer should be able to deliver the intervention well, and do so regularly – or at least have done so very recently); an ability to assess the knowledge and skills of others; a pastoral side, so that they can respond sensitively and helpfully to questions and concerns raised by trainees; where relevant, the ability to manage a group; and key qualifications. You should also think about how trainers will be properly supported and given the resources they need, and how their competence will be monitored.

Lastly, there are some practical things to think about when planning training. Where and when will the training be delivered? If someone who has been trained then leaves, how will new staff be trained? Is basic training enough, or is some top-up training likely to be needed?

3. How do you make sure that different stakeholders understand what the intervention is and what their role is in its delivery?

No one manual or handbook will fit all the stakeholders in an intervention, and materials need to be tailored for their users. For example, a potential funder or commissioner needs to understand the outcomes and group targeted by the intervention, and the costs and likely returns on investment, but probably does not require the same detailed curriculum materials that practitioners need.
We distinguish between two types of documents: intervention manuals and implementation handbooks. Intervention manuals cover all the things about the intervention that are relevant wherever and whenever the intervention is implemented. This will include the research base for the intervention, the desired outcomes, the logical connection between activities and these outcomes, the target group, and all of the relevant training or delivery materials. Implementation handbooks describe the processes and agreements for replicating an intervention in a new context. They do not re-specify the target group or intervention components, unless these have been altered. Instead, they focus on the processes and protocols that will be adopted for the replication. For example, handbooks would detail the processes for recruiting participants and monitoring fidelity. The human and financial resources required for replication are also included.

Sometimes one document can fulfill both functions, so projects without an intervention manual could produce one document that combines all the items from the manual and handbook. On the other hand, projects replicating interventions that already have manuals need only develop the implementation handbook. This is because it is important to specify how it will operate in the new context.

The process for drawing up a manual or a handbook should be iterative. In other words, there will be changes and edits over time as the intervention develops and gets refined. In doing this it is a good idea to involve as many stakeholders as possible. Involve people in different capacities – for example, people who deliver the intervention, people who manage it, people who pay for it, and people who receive it. That said, you will need a clear leader, in other words a nominated person whose task is to coordinate the process and write significant amounts of copy. In the case of a manual, this person should be an ‘expert’ in the intervention (usually its developer). They understand the intervention’s logic and the research and theory that underpin it, and have an in-depth knowledge of its activities. This person may be different from the person who writes the handbook. They should be someone who understands the systems where the intervention will be delivered. Often they will be a service manager. They will know what resources are available and the constraints and challenges that will be faced.

It is unlikely that you need to start from scratch in writing a manual or handbook. Even for interventions that are relatively new, some material has probably already been written. It may even be a case of assembling and editing together existing documents. A worthwhile first step is therefore to identify potentially relevant documents – notes, annual reports, presentations, slides, evaluations, and so on – and to map out how these can contribute to different sections.

If adaptations are being made to an existing intervention manual for a new cultural context, different setting or new target population, there will need to be a process for ensuring revisions are appropriate. A judgement will need to be made about whether the changes will be surface – for example, simple amendments to language or cultural reference – or deep – for example, suggesting the addition of a new intervention component or removing a component. Having someone expert in the new system/context to review the original intervention materials and highlight required changes will be an important first step. Ideally any changes should also be agreed with the developer of the intervention.

4. How do you make sure you have costed the intervention properly so that it is clear what things cost and who is paying for them, thereby avoiding hidden costs?

Commissioners and funders interested in purchasing an intervention or replicating it in a new setting will be concerned with the cost of the intervention. It is common to talk about the ‘unit cost’ of an intervention, which refers to the average cost of the intervention per unit served (where the ‘unit’ is a child or parent, for example). Unit costs include fixed costs, like equipment, as well as variable costs, like salaries and training. Unit costs allow commissioners to think about different options for
delivery; for example, rather than saying that a intervention costs £30,000 and you can serve 100 children, a unit cost would indicate that the minimum cost per child served is £300, with a capacity of 100 children. If you were to serve fewer than 100 children in a year, the unit cost would increase because some of the costs, such as building rental, would have to be paid regardless of whether you served 50 children or 100 children. Likewise, if you were to serve more than 100 children in a year, other costs might increase because you would need to recruit additional staff to meet demand.

A distinction can be made between start-up costs (the initial investments needed to get the intervention set up in a new location) and recurrent costs (the year-on-year costs of running the intervention). Start-up costs might include purchasing the license for an existing intervention, recruiting practitioners, providing initial training and purchasing materials or equipment. Recurrent costs are those items that are required every year of delivery, for example staff time, rental costs of office space and any regular training or supervision. If further support, advice or training are purchased from the original provider on an annual basis, this would also be a recurrent cost. If the intervention involves volunteers then their recruitment, training and support should be costed.

Recurrent costs might also include staff time or materials needed to monitor the fidelity of implementation, or to collect routine outcome data to monitor the progress of recipients over time. For example, if observations of staff delivering the intervention are undertaken routinely to ensure an adequate quality of delivery, or if practitioners or recipients regularly complete and analyse outcome measures, then such costs should be captured in the project budget.

It should also be clear in the budget who is expected to pay for different line items. For example, will intervention recipients be expected to cover any of the costs, or is the commissioning agency entirely responsible? If an intervention includes non-mandatory items, such as a crèche or transport, these items should still be costed in the budget and highlighted as optional.

5. How do you work out the staff resources needed to deliver the intervention, and how do you get those staff in place?

We have discussed how improving system readiness means figuring out how to recruit and retain participants, how to design and deliver training, how to get all stakeholders on board, and how to ensure the costs are clear. We turn now to another critical part of any intervention for children and families: the people who deliver it. It is important to be clear about the number and types of people needed to deliver the intervention and what their roles and responsibilities will be.

First, how many people will be needed? This calculation needs to take into account the key responsibilities people will be expected to fulfill, extras like training and supervision, and any requirements about ratios of staff to users. When doing this exercise, it is easy to focus on contact time with users and forget essentials like travel, preparation and existing commitments (people often deliver more than one intervention at a time). For example, a two-hour session with families might require two hours of preparation (reading materials, preparing props, setting up the room) and a further half-day for clearing-up and follow-up calls with non-attenders.

Second, the experience, knowledge, qualifications and skills that people will need for different positions should be spelled out. In some situations, the right people will already be in post and simply need training in the new intervention. In other cases, recruitment will be necessary, starting with drawing up job descriptions and person specifications. A line management structure and, as appropriate, the make-up and role of an advisory or steering group will also need to be worked out. If there is a human resources department or designated person they will be able to ensure that the correct process is followed.

If the intervention exists and is being imported or adapted, it makes a lot of sense to discuss the human resource requirements with the person who developed the intervention. They will often have extensive experience of what makes for the ideal person to deliver or supervise their intervention. If the intervention is to be
implemented at arm’s length, in other words in a service for which you are not
directly responsible, the human resource requirements should be discussed with the
manager of that service. For example, if you are looking to implement a parent
training intervention via children’s centres you need to explain to the centre
managers what is needed in terms of staffing and, possibly, help identify the right
staff.

6. How do you support the people who deliver the intervention to
deliver it well?

In many respects the people who deliver an intervention in children’s services are the
intervention. There is usually guidance and training to inform practitioners and
volunteers about when and how they interact with users, but ultimately it is their
words and actions that count. For that reason, every effort should be made to help
them to be as knowledgeable and skilled as possible. Training is obviously critical
but it tends to focus on developing entry-level skills and knowledge. The challenge
comes when people try to put these skills and knowledge into practice. People
usually need help to do this. They need ongoing technical support to help them
apply their segmented basic knowledge and skills in different combinations and in
varied real world situations. Training and support should therefore be seen as part of
the same set of activities: one without the other is insufficient.

Ongoing support needs to fulfil at least three functions. The first and most important
is to help people delivering the intervention to develop and hone a functional and
adaptable set of skills. Put another way, they learn to supplement their ‘formal
knowledge’ – obtained through reading the manual and attending training – with
‘craft knowledge’. They develop their own personal style while still delivering core
components of the intervention.

Second, ongoing support should provide basic information in response to questions
and suggest potential solutions in the event of any particular problems. For example,
a teacher might want to know if they can adapt an element of the intervention, or
request advice on how to deal with a particular child.

Third, support should provide people delivering the intervention with some
emotional and personal help (as needed). Perhaps they have had a difficult
encounter with a user and need a shoulder to cry on, or doubt their ability and need
some encouragement.

The support we are talking about can take several different forms. It can be delivered
by different people, in different settings, through different media and with different
degrees of intensity. The approach you choose should depend on the nature of the
intervention and the resources available. You might consider several options. A
popular method involves one-to-one guidance from an expert, either in person or
over the phone. Another option involves developing a peer network among people
delivering the intervention and meeting in a group to identify and share best practice
or troubleshoot problems. Webinars offer a convenient alternative because they can
be done remotely. There is also reading material: a simple strategy could be a regular
newsletter that covers a new topic each edition and answers frequently asked
questions.

The person providing the support may be the intervention developer or a trainer. As
time passes, however, other people might take on part of the role. For instance,
experienced teachers could act as in-school coordinators for a school-based
intervention, liaising with external consultants as necessary. The amount and
frequency of support offered tends to vary depending on the intervention, but it is
not uncommon for it to take something like two hours every week or every month,
at least initially. This might be reduced as people delivering the intervention become
more experienced and skilled.

Some ongoing support takes the form of coaching. As with helping people to
exercise more, smoke less or eat better, a coach working in children’s services is
trying to help people, in this case those delivering an intervention, to change their
behaviour. Coaching includes a number of elements: giving people an opportunity to
stand back from their work and reflect on how well they are doing it (sometimes
called ‘supervision’); teaching people while they are actually ‘on the job’ (delivering
the intervention); assessing how well the person concerned is delivering the
intervention and giving them some constructive feedback; and, as already
mentioned, providing emotional support as necessary. The person doing the
coaching shares their ‘craft knowledge’ as they observe and tutor the person
delivering the intervention. It is generally thought to be good if coaching is work-
based and opportunistic – that is, if it seizes on ‘teachable moments’ rather than
following a rigid structure – and if it is readily available and allows room for
reflection. Ideally, a coaching relationship should start during training.

The expectations for ideal coaches are high. Certainly, they should be expert in the
content, techniques and rationale of the intervention. The best evidence-based
interventions usually require that coaches have extensive experience of delivering
the intervention. In the case of in-person support, coaches should also have excellent
personal skills: you want to find people for this role who are supportive, committed,
sensitive, flexible, respectful, enthusiastic, diplomatic and patient! They also need to
be given adequate time to do their job properly, and should be the kind of people
who focus on outcomes, not paperwork.

7. How do you measure whether the intervention is being delivered
well?

Having developed an intervention, or after deciding to use one developed by
someone else, you want to know that it is going to be delivered well. Even the best
intervention delivered badly or not at all is of little use – and may even be harmful.
So you need to measure how well the intervention is implemented in comparison
with the original design. Put another way, you need to see if there is a close fit
between the intervention as designed and the intervention as implemented. We call
this ‘fidelity’. Measuring fidelity is just part of the package of supports designed to
get the right people well prepared to do an effective job. Depending on what you
find, you might need to make some adjustments to how people are delivering the
intervention.

Before developing a method for measuring fidelity you need to decide what to
measure. We think it is helpful to focus on four elements. First, we can look at
whether the core components are being delivered as designed: are the right sessions
going to the right people in the right order, using the right materials and delivered in
the right place by someone with the right training? This is called ‘adherence’. Second,
we can test if the intervention is being delivered in the right dose. Just as
courses of medical treatment usually stipulate how many pills must be taken over
what period in order to make the patient better, so interventions in children’s
services increasingly say how many sessions of what length and frequency must be
delivered. This is called ‘dose’. Third, we can measure the manner in which the
intervention is delivered – in other words, its ‘quality’. This includes the
practitioner’s preparedness, attitude, enthusiasm and ability to respond to
participants. Fourth, it can be helpful to measure the extent to which the children,
parents or families receiving the intervention are engaged and involved. This is
called ‘user responsiveness’.

There is no set way to measure fidelity, so you can choose to do it in the way that
works best for your intervention and the people delivering it. Whatever you do, you
need to spell out who is measuring fidelity, what information is being collected (and
how), whom it will be shared with (and in what format) and how it will be used.

One common method involves finding out what it is like to receive the intervention.
You can give intervention users a list of core components and ask them to say what
they received. You can also ask them about their subjective experience of the
intervention – did they like it, find it useful, think the staff were helpful? This could
be done in a face-to-face interview, or over the phone, or by asking people to fill in a
written questionnaire. In another popular method, independent observers watch the
intervention actually being delivered and rate how good it is. For instance, they
might sit at the back of the room while a session is being delivered to a group of young people and their parents and score how well different elements are delivered. They would be looking for evidence that core intervention elements are covered and that the person delivering the group session knows the content and structure and says and does the right things when interacting with users. A variation on this approach involves videoing sessions and then having the trainer or an independent observer do ratings remotely. Perhaps the simplest method is to ask the person delivering the intervention to complete a checklist after each session to indicate what they did in the session and how well it went. As you decide how to measure fidelity you need to ask yourself ‘How practical is it?’ (for example, will people actually do it?) and ‘Will the information be useful?’ (for example, will it be trustworthy and will it help to improve delivery?).

If you are designing measures of fidelity for a new intervention, its theory of change is a good starting point, as this should specify the main components of the intervention. Then you can decide for each component how to measure adherence, dose, quality and user responsiveness. If you are implementing an intervention that already exists, you may find that it comes with an existing method for measuring fidelity. If this can be used it will save you a lot of work, but make this decision carefully. On the plus side, it is likely that the method is tried and tested and that it covers the core intervention elements. But be alert to potential drawbacks. If you want to use the method in a different context you might need to adapt it. For example, the measures may need to be simplified if there is little time to gather the information. Similarly, depending on what the method looks like, you might find it appropriate to use a more collaborative and less ‘judgmental’ approach – for instance, undertaking a teacher’s performance rating with rather than on them.

As you think about measuring fidelity you also want to consider how the emerging data will be used, and by whom. At minimum you want it to help the people delivering the intervention to deliver it better – in other words, to know when they are delivering it well so that they can continue in that vein, but also to help them strengthen areas in which they might be weak. Information about fidelity can also help the person or people providing technical assistance or coaching to work out what they should focus on. The service manager will find it helpful to have an overview of how well staff are doing, not least because it gives a sense of how effective the training and technical assistance are.

Information on fidelity should be fed back to the relevant person who is monitoring it (practitioner, coach or manager) in the most appropriate way. In the case of communicating it to the people delivering the intervention, feedback needs to be timely – ideally fairly frequent and in some kind of recurring loop (say monthly). It is probably best when given in person by a respected source but with some accompanying written material. The individual giving the feedback should tailor the feedback according to the likely motivations of the person delivering the intervention – for example, framing it in terms of how to improve the experience of the user.

Information on fidelity will allow you to ensure that the intervention is being delivered as intended to the right people. It will allow you to reflect on the quality of delivery and respond to situations where it is not optimal. All of this will contribute to improved outcomes for those receiving the intervention.
Glossary

Cost-benefit analysis – A process by which expected costs are weighed against expected benefits to determine whether the course of action is profitable. In the context of social interventions, the technique adds up the value of the benefits of an intervention, and subtracts the costs associated with it (both expressed in monetary terms).

Demand – In the context of social interventions the number of individuals who (a) match the particular target group within a given population and (b) actually want to participate in the intervention.

Diffusion – When there is intrinsic demand or pull for an intervention, meaning that users, providers or commissioners are proactively requesting the intervention.

Dissemination – When interventions are being pushed by their creator (in contrast with ‘diffusion’).

Early intervention – Intervening in the early stages of impairment. Aimed at stopping those children and young people at highest risk of developing social or psychological problems, or those who show the first signs of difficulty, from displaying unnecessarily long or serious symptom (see also ‘Prevention’ and ‘Treatment’).

Effect size – A standardised measure of the effect of an intervention on child outcomes. It represents the change (measured in standard deviations) in an average child’s outcome that can be expected if that child is given the intervention.

Evaluation – Various aspects of an intervention can be evaluated, including the process of delivery, user satisfaction and impact. Here evaluation refers to the use of social research procedures to investigate systematically the effectiveness of interventions in terms of improving children’s health and development.

Evaluation quality – Whether the evaluation of an intervention is robust enough in its design and execution to give us confidence in what it tells us about intervention impact (see also ‘Standards of evidence’).

Evidence-based – When an intervention is ‘tested and effective’: ‘tested’ means that the intervention has been put through its paces by a high-quality impact evaluation; ‘effective’ means that there is strong evidence from that evaluation that the intervention makes life better for children or families. An intervention is therefore ‘evidence-based’ when it has been evaluated robustly and found to have a clear positive effect on a relevant outcome for children or families.

Fidelity – The extent to which an intervention is implemented in accordance with intentions, or as designed.

Impact – The impact (positive or negative) of an intervention on relevant outcomes according to one or more robust impact evaluations (see also ‘Standards of evidence’).

Implementation handbook – A document that describes the processes and agreements for replicating an intervention in a new context (see also ‘Intervention manual’).

Innovation – When service designers develop a new intervention, drawing on a mixture of evidence and logic (the contrast is with the decision to adopt an existing evidence-based intervention).

Intervention – An activity (programme, policy, practice or process) aimed at achieving an outcome.

Intervention manual – A document that covers all the things about the intervention that are relevant wherever and whenever the intervention is implemented. This includes the research base for the intervention, the desired outcomes, the logical connection between activities and these outcomes, the target group and all of the relevant training or delivery materials (see also ‘Implementation handbook’).

Intervention specificity – The extent to which an intervention is focused, practical, logical and designed using the best available evidence (see also ‘Standards of evidence’).
**Key developmental outcomes** – Child outcomes that are most critical for children’s subsequent health and development across five broad areas: behaviour, emotions, relationships, physical health and educational skills and attainment. If children are not achieving these outcomes at particular stages of development, there is a strong likelihood that their future health and development will suffer (see also ‘Outcome’).

**Need** – In relation to an intervention this refers to how many individuals in a specified population match the target group for the intervention.

**Outcome** – The effect of an intervention on a child’s health and development (see also ‘Key developmental outcomes’).

**Prevention** – Activity to stop a social or psychological problem happening in the first place (see also ‘Early intervention’ and ‘Treatment’).

**Protective factor** – An attribute of an individual or their environment that works in certain contexts to reduce or modify the individual’s response to particular combinations of risk and thereby reduces their susceptibility to a range of social or psychological problems.

**Public service system** – The infrastructure that facilitates state involvement in children’s lives, including health, education, social care and youth justice services.

**Real world** – Conditions in which an intervention is delivered by regular people working for children’s services, when the developer is not heavily involved, when the work takes place in orthodox service settings, and when the support offered is affordable and manageable.

**Risk** – An aspect of an individual or their environment that predisposes the individual to specific social or psychological problems.

**Scale** – An intervention is ‘at scale’ when it is available to many if not most of the children and families for whom it is intended within a given jurisdiction. Usually this requires that it be embedded in a public service system.

**Standards of evidence** – A set of criteria for determining whether an intervention can be regarded as ‘evidence-based’. At the Social Research Unit our standards of evidence have four dimensions (see ‘Evaluation quality’, ‘Impact’, ‘Intervention specificity’, and ‘System readiness’).

**System readiness** – The extent to which an intervention is ready for implementation in public service systems (see also ‘Standards of evidence’).

**Technical support** – Help that is offered to the people delivering interventions to help them implement the intervention as well as possible.

**Theory of change** – The logic that connects an intervention to its intended outcomes and the rationale for why it should achieve what it seeks to achieve.

**Treatment** – The response to an identified impairment: seeks to stabilise or achieve realistic outcomes among those who develop serious manifestation of a social or psychological problem (see also ‘Early intervention’ and ‘Prevention’).

**Unit cost** – The cost of everything required to deliver an intervention to a participant or a family.
The Social Research Unit at Dartington is an independent charity that seeks to increase the use of evidence of what works in designing and delivering services for children and their families. We are also a strong advocate of prevention and early intervention based approaches.