Enabling help

How social provision can work better for the people it serves

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The Iceberg Model https://ecochallenge.org/iceberg-model/ adapted from http://donellameadows.org/systems-thinking-resources/

Triangle

Triangle is a social enterprise with a vision of a society in which everyone is able to thrive. Triangle's mission is to help service providers transform lives by creating engaging tools and promoting enabling approaches.

Through tools like the Outcomes Star, Triangle works to make the principles of Enabling Help described in this report a reality in front-line delivery, service management, commissioning and policy-making. If you would like to join Triangle in advocating for Enabling Help or tell us about what you are doing to promote an enabling approach to social provision please get in touch:
www.outcomesstar.org.uk/enablinghelp

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Thanks also to the over one hundred organisations that have collaborated with us to create different versions of the Outcomes Star and the over one thousand organisations that we have trained and supported to use the Star. It has been a very rich journey learning about your work, how you make a difference, what helps and what gets in the way.

Joy MacKeith

enabling

in British English

(ɪnˈeɪbəlɪŋ)

ADJECTIVE

providing the power, means, opportunity, or authority to allow someone to do something

Summary

This report builds on Triangle's twenty years' experience of helping organisations to support and measure change for people receiving services. It presents a critique of the ideas and practices that currently hold sway in social provision and suggests an alternative vision for delivering services that make a real difference.

The main messages are:

Part 1: **Social provision does not achieve as much as it could because it draws on ideas borrowed from other fields which are based on flawed assumptions and focus attention on the delivery mechanisms rather than the person being helped:**

- The **medical paradigm** focuses on the helper. It assumes the person is sick or flawed and the helper has the answers
- The **bureaucratic paradigm** focuses on the organisation delivering help. It assumes that fairness and risk management are best served through standardisation
- The **market paradigm** focuses on the commissioner. It assumes that performance is maximised through competition and financial incentives
- The **natural sciences paradigm** focuses on the intervention. It assumes that what works can be identified and replicated independently of context.

Triangle's experience of training and supporting over one thousand organisations to support and measure change using the Outcomes Star indicates is that these ideas drive service delivery off course. Social provision is concerned with human well-being and behaviour. Therefore the primary body of knowledge that should shape policy, service design and service delivery is our knowledge of human needs and behaviour – the **human sciences paradigm**. This focuses on the service user and is based on the assumption that relationships and on-going learning are the key to change for individuals, organisations and systems.

Part 2: This body of knowledge and Triangle's experience of modeling change to create Outcomes Stars with over one hundred collaborators indicate that **when helping people with ongoing and often complex issues it is vital that helpers take an enabling approach which puts the person's aspirations, concerns and sense of agency at the heart of everything**. This means offering help which is:

- **Relational** – building trust to engage with help
- **Motivational** – building belief that change is possible
- **Developmental** – valuing and building capabilities to do things differently
- **Holistic** – looking at the whole picture and joining the dots

- **Flexible** – tailoring the help to the person
- **Contextual** – highlighting the impact of the wider environment

Help that follows these six principles is referred to here as "Enabling Help".

Part 3: **The enabling approach has implications for all levels of social provision delivery:**

At the **front line** it means a shift from seeing service users as recipients to working with them as collaborators.

In **management** it means shifting focus from procedures and protocols to enabling those at the front line to take a flexible, responsive, problem-solving approach.

In **commissioning** it means working collaboratively with service providers, looking at how the whole service delivery system functions, and shifting the focus of monitoring from numbers to narratives.

At **research and policy level** it means shifting the focus from intervention recipes to creative, responsive service delivery systems in which the Enabling Help principles apply in practice.

Part 4: The service delivery system is like an iceberg. The service which the end user experiences is the visible part above the water line. Beneath the water is the way the service is managed and commissioned, the policy and research on which it is based, and the ideas that drive practice at all these levels. These aspects are not visible to the service user but they powerfully shape their experience. **To make Enabling Help a reality above the water line in service delivery we need to base services on what we know about human needs and behaviour and ensure that all parts of the service delivery system work together to apply this knowledge and keep the service user in view**. There are no quick fixes, but with a clear vision, sustained effort and our eyes firmly on the end user, it is possible to create real change.

Contents

Introduction

"Crises offer ripe opportunities for systems change because the patterns and processes by which we organise ourselves suddenly cease, and the parameters—the 'control mechanisms' of the system—are blown apart, making possible things that were previously constrained by them." (Reynolds, 2020)

Time for change

There is much to be proud of in the social provision that we have in the UK. There is our NHS, the range of services and skilled professionals, the rich mix of statutory, third sector and community-based services, and the dedication of so many to making a difference. However many people working in these sectors believe that it could be so much better (Cottam, 2018; Cornwell, Flanagan, Nielsen, Khan & Wilson, 2018; Christie, 2011). They are frustrated by bureaucracy and the disjointed nature of the system. They are cynical about big new policy initiatives that don't add up on the ground. They are fed up of funding requirements that get in the way, frequent disruptive reorganisations and cuts that cause pain now and dig problems in deeper for the future. It is disheartening to see people come back into services again and again following quick fixes that never really address the issues.

We are at a very particular moment in time. Before Covid, the pressures for change in our service delivery system were already powerful – the aging population, the number of people living with chronic health conditions, the growing evidence of the link between poverty, adverse childhood experiences and multiple disadvantage in adulthood. Now the pandemic has increased the level of need and both highlighted and increased inequalities. There is more of an appetite for fundamental and systemic change than there has been for a long time, possibly since the Second World War. But seizing the moment and creating that change will require more than motivation. It requires analysis of what is not working, and a well-informed vision for how to do things differently.

This report will attempt to provide some of that analysis and to contribute to a new vision for social provision.

Our business is human needs and behaviour

I have had a unique opportunity to engage with these issues across a wide range of organisations and sectors. Over the last 20 years, my role as co-author of the Outcomes Star tools has required me to learn in depth about how front-line services work in many sectors including addiction, vulnerable families, homelessness, end of life care and employment. And as the Stars have become more mainstream, I have learned about service management, commissioning and the ideas that shape policy and practice, through Triangle's work in supporting implementation of the Stars and helping central and local government with reporting frameworks. This engagement has given me a rare overview of the ideas that guide professional training, management, commissioning and policy within social provision; how they help and how they can hinder the social outcomes that these services exist to achieve.

I have come to the conclusion that a key reason why our system of social provision does not fulfil its potential is that it draws too heavily on ideas that do not really fit this sector. These ideas are drawn from other fields, including medicine, economics and the natural sciences. They do not work well when applied to social provision because they are based on assumptions that often do not hold in the very different world of human behaviour and relationships. Crucially, they put the focus on the helper, organisation or commissioner, rather than on the person being helped.

The problems that most health and social services are dealing with now are chronic rather than acute (Cottam, 2018). They require changes in behaviour, routines, circumstances and lifestyle rather than a quick fix or cure. Therefore a core task of the service delivery system is to support these kinds of changes. Sometimes that means supporting personal change – a diabetic changing their diet, someone with an addiction struggling to recognise the impact on their children, or a disaffected teenager reengaging with the education system. Sometimes it means making wider changes – addressing social, structural and physical factors in the environment (Bramley et al., 2015; Maertens, Desmet & Defrenne, 2015). My contention is that if change is to happen, then every aspect of service delivery, not just front-line delivery but also policy, commissioning and management, must keep the service user clearly in view.

Social provision is fundamentally about people and human relationships. So the heart of my case is that the core thinking to be applied is our understanding of what people need and how they change. Research and theory from other fields such as economics and the natural sciences may be relevant and useful, but is secondary.

In this report I provide the evidence for this analysis and present a vision for a different approach rooted in research and theory about human needs and behaviour, that points to the importance of relationships, trust, motivation, skills and flexibility, in a context of access to the resources and opportunities that we all need to thrive. I call this "Enabling Help" – in other words, help that enables the recipient to play an active role in achieving their own goals. I describe the six principles of Enabling Help and also look at how service management, commissioning and policy-making need to change in order to facilitate the delivery of this kind of help at the front line.[1]

The report is organised in four parts:

Part 1 looks at the paradigms that currently shape our service delivery: the medical paradigm, the bureaucratic paradigm, the market paradigm and the natural sciences paradigm.

Part 2 introduces Enabling Help, an approach rooted instead in the human sciences paradigm, that draws together learning about human behaviour, what people need to thrive and how to support change in sustainable ways. It outlines the six principles of Enabling Help – help that is relational, motivational, developmental, flexible, holistic and contextual.

Part 3 imagines Enabling Help in practice – what it means at the front line, for management, commissioning and research and policy-making.

Part 4 looks at why the principles of Enabling Help are not applied more widely given the groundswell of interest in these ideas, and what it could take to make Enabling Help a reality at scale.

1 There is a growing recognition of the importance of informal networks and connections in promoting well-being and resilience and the role of public policy in facilitating these networks. I very much support this direction of travel but the focus in this report is primarily on formal service delivery systems.

Part 1

Borrowed ideas

Key messages

Social provision does not achieve as much as it could because it draws on ideas borrowed from other fields which focus attention on the delivery mechanisms rather than the person being helped:

- The **medical paradigm** focuses on the helper
- The **bureaucratic paradigm** focuses on the organisation delivering help
- The **market paradigm** focuses on the commissioner
- The **natural sciences** paradigm focuses on the intervention.

Triangle's experience of training and supporting over one thousand organisations to support and measure change using the Outcomes Star indicates is that these ideas drive service delivery in the wrong direction. Social provision is concerned with human well-being and behaviour. Therefore the primary body of knowledge that should shape policy, service design and service delivery is our knowledge of human needs and behaviour – the **human sciences paradigm** - which focuses on the service user.

This part describes the ideas that have been borrowed from other spheres of study and applied to social provision in the UK and beyond. It looks at the underlying assumptions of each paradigm and draws on Triangle's experience of training and supporting organisations to implement the Outcomes Star[2] to question their applicability and usefulness in the context of social provision, particularly for people with chronic or complex difficulties.

2 See Appendix for brief details of the Outcomes Star suite of tools and a full list of organisations that have collaborated with Triangle to develop versions of the Outcomes Star

The medical paradigm:
focusing on the helper

The medical paradigm has its roots in health care, where the doctor diagnoses and treats the largely passive patient. The focus in this paradigm is on the person providing the help. The person receiving help is a patient and the service they are receiving is conceptualised as a treatment (see Figure 1). This approach to health care has been enormously successful in addressing many acute health problems and so has been adopted, at least to some extent, in other fields such as psychology and psychiatry. Professionals in these fields undertake training to become expert in the problems experienced by the service user whose "condition" is diagnosed and then treated.

However, many of the issues our system of social provision is grappling with demand changes in beliefs, skills and habits by the service user. And there is now a wealth of evidence that these changes are born out of positive, enabling relationships that recognise people's strengths and harness their motivation for change (Lieberman, 2013).

The problem with the medical paradigm when applied to social issues is that it assumes change can be done to another person in the way a doctor can prescribe an antibiotic to kill an infection. It puts the focus on the helper and the expertise they have to offer, rather than on the ability to change of the person being helped. It does not highlight strengths and it frames the service as treatment rather than collaboration.

"Clinicians, and those who train them, should learn how to ask less 'What is the matter with you?' and more, 'What matters to you?'"

(Berwick, 2016)

Paradigm	Focus	Person receiving the service	The service	Key assumptions
Medical	**The helper**	**Patient**	**Treatment**	**The person is sick or flawed and the helper has the answers**
Bureaucratic	The organisation providing the service	Recipient	Process	Fairness and risk management are best served through standardisation
Market	The commissioner	Consumer	Product	Performance is maximised through competition and financial incentives
Natural Sciences	The type of intervention	Subject	Formula	What works can be identified and replicated independently of context
Human Sciences	The person being helped	Collaborator	Enablement	Relationships and on-going learning are the key to change for individuals, organisations and systems

Figure 1: The medical paradigm

The medical paradigm can also risk pathologising the individual receiving help. It can cast them as flawed or needing to be cured, rather than as experiencing challenges and in many cases suffering the effects of trauma or multiple disadvantage (Bramley et al., 2015). It can also be narrow in focus and because of this, opportunities to address other underlying issues may be missed.

There are of course circumstances where people in helping roles need to make independent assessments, particularly when there are safeguarding issues. But when it comes to addressing social issues, the primary role is an enabling one.

Even in health care there is wide recognition that the traditional model is not suitable for the chronic lifestyle conditions that absorb most time and money within the health system (Gannotta et al., 2018; Lascalzo, Kohane & Barabasi, 2007). Conditions such as diabetes and obesity require the participation of patients in the lifestyle changes that are needed to manage or cure chronic problems. The rise of social prescribing in the UK is testament to an increasing recognition of the importance of a more holistic and collaborative approach. And there is a growing body of evidence that person-centred health care which ensures that health care plans are based on people's priorities and personal circumstances leads to better outcomes (Moore et al., 2020).

Many professionals and services do work collaboratively and few would argue against these values. In the social work profession it has been claimed that "empowerment" rather than "client treatment" has become the dominant paradigm since the late 1980s and early 1990s (Adams, 2008). More recently there has been a strong move towards strengths-based working and more collaborative approaches (Price et al., 2020) and increasing understanding of the importance of working in a trauma-informed way (Breedvelt, 2016). However, these values have proved difficult to realise in practice, as evidenced by the recent publications that advocate for more collaborative, strengths-based and enabling approaches (for example Cottam, 2018, Department of Health and Social Care, 2019; Wilson et al., 2018). In the words of Wilson et al., "…many mainstream public services and social programmes continue to offer 'bad help' that tries to fix things for people in the short term or encourages them to take action that fits with the service's priorities and not their own".

Triangle's experience of training front-line workers to use the Outcomes Star is that some workers have not learnt the skills to work in an enabling, collaborative way. When they need to play a range of roles, such as enforcer, safeguarder, enabler or provider, they don't know how to navigate between these different roles. Those with substantial professional education may still have been trained within the medical paradigm, at least to some extent. Others may only have brief on-the-job training focused on specific aspects of the role.

Even when the desire and skills for strengths-based working are there, organisational and resource constraints can make this difficult (Price et al., 2020). The result can be despondency on the part of workers when things don't improve, and a sense of hopelessness that change is not possible.

In summary, the medical paradigm is rooted in the desire to bring professional expertise to meet real needs. Professional expertise is important within social provision, but it needs to be focused more on collaboration and enablement and less on diagnosis and prescription.

The bureaucratic paradigm:
focusing on the organisation

Weber (1921) described bureaucracy as being the most efficient and economically effective way to design an organisation. He identified six core characteristics of bureaucracy, including hierarchical organisation, task specialisation, and rules and procedures that are administered in an impersonal way. Although alternative organisational forms have been tried and advocated (Laloux, 2014), the "Weberian bureaucracy" is the still the standard template for medium and large organisations.

"How do we manage the tension between impartiality and consistency, and intuition and empathy?"

(Unwin, 2018)

The bureaucratic paradigm puts the focus on the organisation providing a service and the requirement that it do this in a standard and accountable way, according to agreed systems and processes. The person receiving help is a recipient and the service they receive is a standardised process (see Figure 2).

The delivery of public service is intended to be fair, transparent and accountable, with services provided on the basis of need and entitlement rather than request or favour, and hence the bureaucratic paradigm is very relevant. However, when the principles of bureaucratic organisation are applied at the front line, these positive intentions for fairness, transparency and accountability can translate into inflexible uniformity – treating everyone in the same way, rather than responding to individual needs. Staff compliance to

Paradigm	Focus	Person receiving the service	The service	Key assumptions
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Human Sciences	The person being helped	Collaborator	Enablement	Relationships and on-going learning are the key to change for individuals, organisations and systems

Figure 2: The bureaucratic paradigm

organisational rules and procedures can become a stronger driver of behaviour than effectiveness.

In this kind of bureaucracy the value of human warmth and relationships may not be recognised or may be trumped by the needs of the bureaucracy. Service users and workers alike may feel powerless in the face of rules that do not allow the service to flex to the user. Like the medical paradigm, bureaucracy can cast the person being helped as a passive recipient and can compartmentalise the service response. Creative problem solving, joined-up working and responsiveness can be difficult when things have to be done according to a narrowly defined procedure or contract.

Voluntary agencies are often valued because they are less bureaucratic. However even smaller voluntary organisations can be drawn into this way of working when they are delivering commissioned services, because of the requirements of their contract. This enforced "professionalism" can work against the original ethos of the organisation for flexibility, responsiveness and a user-centred approach.

Of course, procedures and protocols are needed, particularly in aspects of care such as safeguarding. However it is vital to ensure that the focus does not slide from minimising risk to minimising the risk of someone being shown to have behaved outside of the protocol (Munro, 2011).

Our experience when introducing the Outcomes Star to front-line workers in training is that many raise concerns about the number of procedures and the volume of paperwork they have already. Some feel straitjacketed by the procedural requirements of their roles. They are hungry to help, but overwhelmed by the administrative burden and frustrated by the way it limits their time with service users. In the words of one senior mental health worker: "I fill in reams of monitoring forms but no one actually knows what it is I'm doing all day or how I'm treating my clients. It is management by Excel spreadsheet".

In summary, the bureaucratic paradigm is rooted in the desire for equality, fairness, transparency and risk minimisation. These values are important but need to be balanced with responsiveness to particular needs and circumstances, with the creation of opportunity, and with human warmth and connection. Julia Unwin has described this as a need for services to be "bilingual" – fluent in both the language of the rational bureaucracy and in the language of human relationships – the rational lexicon and the relational lexicon (Unwin, 2018). See Figure 3.

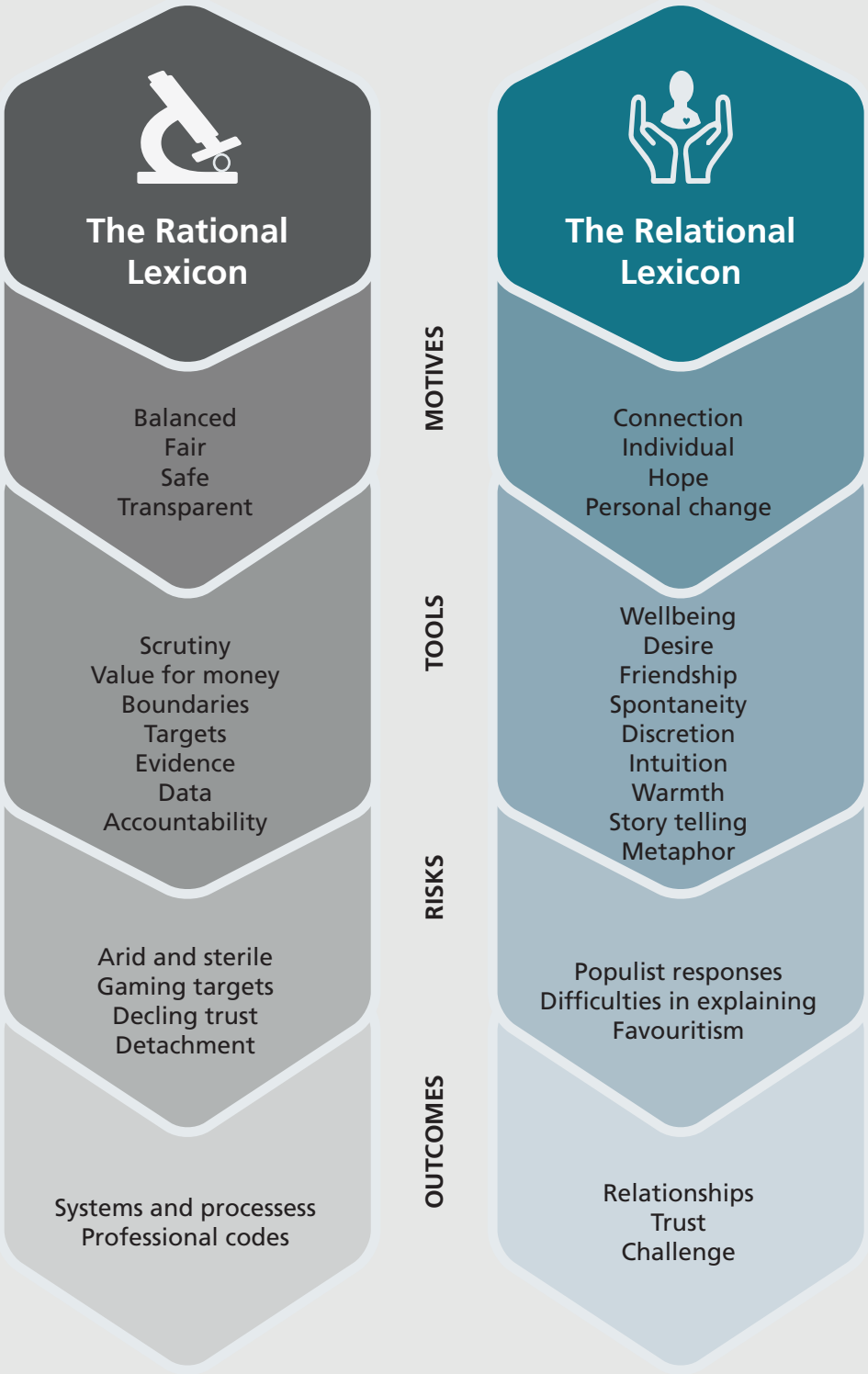

Figure 3: The two lexicons of public policy

Julia Unwin (2018) *Kindness, emotions and human relationships: The blind spot in public policy*. Carnegie UK Trust

The market paradigm:
focusing on the commissioner

In the 1980s a new approach to public management was developed and implemented in the UK, USA and beyond. Called "New Public Management", it aimed to improve on bureaucratic approaches by making services more "business-like", bringing private sector management models and the logic of the market to bear on public services.

In the UK the purchaser-provider split was introduced, first in local government service delivery, and then in the NHS in order to create a ''quasi-market". Later the market approach was taken further with Payment by Results contracts and Social Impact Bonds.

This market approach puts the focus on the commissioner and the need for a cost-effective, responsive service. The person receiving help is a consumer or customer and the service they are receiving is a product (see Figure 4). The logic is that competition breeds innovation, drives down prices and increases choice. To some extent this move can be seen as a reaction against the rigidity of the bureaucratic approach. The theory is that it can provide greater value for money for the taxpayer because competition between providers will give the state access to more effective, cheaper services and greater choice for the end user.

"They started going for all the government contracts … All the projects went out the windows, and it was basically… bums on seats, let's get paid for numbers... I just felt really bad for the young people."

(Youth worker quoted in de St Croix, 2018)

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Human Sciences	The person being helped	Collaborator	Enablement	Relationships and on-going learning are the key to change for individuals, organisations and systems

Figure 4: The market paradigm

The market paradigm has brought a helpful focus on the desired outcomes of services rather than the inputs, procedures and outputs. It has also created space for innovation, tailored provision and for some disabled people it has meant much more choice and control over the care they receive. However the mechanism by which markets drive innovation and value – the consumer's ability to choose to buy or not to buy – does not work in the same way in the market for social care when the buyer is the commissioner as they do not directly "consume" the product. This means that a lot of the time the market feedback loop is at best weak and at worst non-existent. Furthermore, most of the time service users themselves do not have a choice of providers. Even if they have a choice, they may not have the expertise, information or resources to assess and choose the best provider.

In the absence of a direct feedback mechanism, commissioners have to find ways to assess the quality and effectiveness of different providers. This has proved much more difficult than anticipated. Commissioners are most interested in end outcomes, such as people housed or in work. But focusing on these end outcomes makes invisible the small, often hard-won changes that provide a foundation for them. In addition, the fact that providers often use different measurement approaches makes comparison between providers very difficult. There can be a temptation to focus too heavily on metrics, the most readily understandable being money. If this means that the services are not effective, or wages are so low that it is hard to find and keep staff, then reducing prices may not in practice represent good value for the taxpayer (Fotaki, 2013).

For the market mechanism to deliver value, it is also necessary for there to be a range of providers competing for business. In practice, however, there is not always a suitable choice of providers for the commissioner, despite efforts to manage the market and help third sector providers to become "contract ready" (Ainsworth, 2012).

All in all, the market conditions that are so effective in giving us choice and value in consumer products such as mobile phones and toasters often do not exist in the health and social care market. The result can be a lot of time and bureaucracy spent on the commissioning and monitoring process (both for the commissioner and for those submitting tenders and monitoring information) without realising the intended benefits.

In fact there are often disadvantages. The market approach breaks the service delivery system down into a number of discrete services rather than ensuring that the whole thing works well together. It can result in the loss of collaboration between providers who are required to compete for contracts. And our experience in supporting local authorities to implement the Outcomes Star is that contract-switching between providers can disrupt the complex ecosystem of service delivery and take attention away from the front line.

The market approach can also result in workers and their managers being held accountable for the completion of paperwork and the achievement of targets rather than for less tangible things like the quality of their collaboration. Judgements about success can be based on a limited data set rather than a fuller and more rounded appraisal of responsiveness, problem solving and capabilities. Finally there is a wealth of evidence that Payment by Results approaches can lead to perverse incentives if a few simple metrics are given primacy over everything else (de St Croix, 2018; Lowe & Wilson, 2017). For example, service providers can be unintentionally incentivised to "cherry-pick" – to prioritise working with those who are close to achieving the outcome to which payment is linked.

The assumption on which the Payment by Results approach is based is that the best way for commissioners to improve service efficiency and effectiveness is to provide performance incentives. However, I am not aware of research that shows that service providers lack motivation to deliver outcomes, or that financial incentives would increase that motivation. Even in the sphere of economics, the idea of "homo economicus", a person whose decisions are always governed by an assessment of narrow material advantage, has been criticised on a wide range of grounds (Benartzi & Thaler, 1995; Frey & Iselin, 2017; Goldelier, 1999; Schmitz, Köszegi, Enzenhofer & Harrer, 2015).

The market paradigm, then, is rooted in the desire to create flexibility, responsiveness and cost-effectiveness. These aspirations are of course important, but the focus should be on how to deliver this at the front line, where these qualities will make a difference to service users. And outcome monitoring will be most useful if it allows for nuanced conclusions based on a range of types of data, including experience and observation, rather than giving too much weight to a small number of metrics.

The natural sciences paradigm:
focusing on the intervention

The natural sciences paradigm has come to the fore recently in discussions about social provision. It puts the focus on the intervention and the evidence base to support its effectiveness. The person receiving the service is the subject of the intervention and the service is a formula which, if successful, can be replicated in the same form elsewhere, regardless of context (see Figure 5).

This paradigm is based on the natural sciences, in which experiments are carried out in controlled conditions to identify cause and effect relationships. The logic goes something like this: "if I do x to y then the result is z". This works well in chemistry and physics where conditions can be controlled tightly. It has also been applied successfully in medicine through the use of randomised control trials (RCTs).

The natural sciences paradigm is being used to explore how to intervene effectively across a range of types of services including services to improve parenting skills, reduce offending and help people back into employment. The rapid establishment of What Works Centres in the UK is a sign of the excitement and enthusiasm for this approach. Equally, the fact that RCTs are often put forward as the most desirable form of evidence also signals that many institutions in this arena are firmly rooted in this paradigm (Bagshaw & Bellomo, 2008; Petticrew & Roberts, 2003).

"The key feature of complex systems is that they produce non-repeatable results…. Therefore the same intervention delivered to two different people, or to the same person, but at different times, may well have a completely different outcome."

(Lowe, 2015)

Paradigm	Focus	Person receiving the service	The service	Key assumptions
Medical	The helper	Patient	Treatment	The person is sick or flawed and the helper has the answers
Bureaucratic	The organisation providing the service	Recipient	Process	Fairness and risk management are best served through standardisation
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Human Sciences	The person being helped	Collaborator	Enablement	Relationships and on-going learning are the key to change for individuals, organisations and systems

Figure 5: The natural sciences paradigm

The logic of this approach is strong, but it is based on assumptions that may not hold with many social and some health care interventions. Here implementation and context may have as much impact as the design of the intervention itself. Factors such as the commitment of those in charge to the values and principles underpinning the model, how "joined up" the service ecosystem is, and the skills and personal qualities of both the person providing the intervention and the person receiving it may be key to the achievement of outcomes. But these things are usually not measured in the experiment. In addition, aspects of the environment in which the service is being delivered (for example whether there is a park locally, the strength of the local economy, the availability of housing) may be critical. But again they may not be taken into account and are not always replicable. Furthermore, in real practice settings it may not be ethical to assign some people to a control group that does not receive any support.

Many issues in this field are highly complex and impacted by more variables than can be identified, let alone controlled for. They do not reduce easily to linear models of cause and effect (Lowe & Wilson, 2015). As a result, designing an intervention that can be documented and replicated is often problematic. Sometimes it is not the specific form of the intervention but the energy, commitment, resources and joined-up working within the programme that delivers results. And while meta-analyses can look at overall effects across similar intervention types to reduce the impact of particular features in one study, these too have their limitations (Lee, 2019).

In summary, the natural sciences paradigm seeks to ensure that services are built on a body of knowledge about what works. However it can focus attention on the more visible form of the intervention rather than aspects that are vital but harder to specify and engineer. What is needed is an approach to building an evidence base that recognises that outcomes result from the interaction of numerous variables in complex systems. For that reason it is unlikely that there will be simple service delivery formulae that can be rolled out.

We do, however, already have a considerable amount of evidence about the key principles that govern effective work with people who need help. It is to that that we now turn in Part 2.

Part 2

Enabling Help

Key messages

The latest research and Triangle's experience of modelling change to create Outcomes Stars with over one hundred collaborators indicate that **when helping people with ongoing and often complex issues it is vital that helpers take an enabling approach which puts the person's aspirations, concerns and sense of agency are at the heart of everything.** This means offering help which is:

- **Relational** – building trust to engage with help
- **Motivational** – building belief that change is possible
- **Developmental** – valuing and building capabilities to do things differently
- **Holistic** – looking at the whole picture and joining the dots
- **Flexible** – tailoring the help to the person
- **Contextual** – highlighting the impact of the wider environment

Help that follows these six principles is referred to here as "Enabling Help".

Each of the paradigms described within Part 1 has important values and aspirations – to provide useful expertise, to be fair and transparent, to be cost-effective and to evidence what works. But the assumptions they are built on often do not hold in the field of human needs and behaviour. These paradigms do not build collaboration or focus on harnessing the agency of the person receiving the service. They do not draw on the rich body of knowledge about people and how they change, especially when facing multiple, long-term barriers. They put the focus on the helper, organisation or commissioner, rather than on the person being helped.

A different set of ideas is needed – one that draws on the wealth of knowledge about human needs and behaviour, rather than on ideas borrowed from other contexts.

"Encouraging behaviour change is neither linear nor easy. But it is at the heart of so much public policy."

(Unwin, 2018)

The approach I am proposing is Enabling Help. Enabling Help focuses on the service user, who is seen as a collaborator or partner, and on enabling them to achieve their goals (see Figure 6). Their motivation, skills and self-determination are at the heart of this approach. So the key theories and evidence that are most relevant are those about human needs and behaviour, drawn from psychology and the human sciences.

Those theories and evidence tell us is that relationships are central to being human. And the quality of our relationships is key to change – both for people receiving services, and for organisations and systems delivering them.

The principles of Enabling Help

What does Enabling Help look like? To answer that question I draw on two key sources. The first is the evidence base that examines what people need to thrive and how people change. The second is Triangle's collaboration with service providers and commissioners to create versions of the Outcomes Star[3], to support them to implement the Stars in their services and to train workers to integrate the Star into the support they provide. Drawing on these two rich sources, I argue that to be truly effective in supporting change for the people they serve, services should offer help that is:

1 Relational (building trust to engage with help)

2 Motivational (building belief that change is possible)

3 Developmental (valuing and building capabilities to do things differently)

4 Flexible (tailoring the help to the person)

5 Holistic (looking at the whole picture and joining the dots)

6 Contextual (highlighting the impact of the wider environment).

3 See Appendix for a full list of organisations that have collaborated with Triangle to develop versions of the Outcomes Star

Figure 6: The human sciences paradigm

Paradigm	Focus	Person receiving the service	The service	Key assumptions
Medical	The helper	Patient	Treatment	The person is sick or flawed and the helper has the answers
Bureaucratic	The organisation providing the service	Recipient	Process	Fairness and risk management are best served through standardisation
Market	The commissioner	Consumer	Product	Performance is maximised through competition and financial incentives
Natural Sciences	The type of intervention	Subject	Formula	What works can be identified and replicated independently of context
Human Sciences	**The person being helped**	**Collaborator**	**Enablement**	**Relationships and on-going learning are the key to change for individuals, organisations and systems**

1. Relational: building trust to engage with help

The Psychologically Informed Environments (PIE) movement has for some years been making the case for an approach to service delivery that gives a central place to trusting relationships. In the words of J.S. Levy, progress "hinges on two people developing a trusting relationship and an effective communication" (Levy, 2013). Now recent research in social cognitive neuroscience is adding weight to this case. This research provides objective evidence for what we know from our subjective experience – that human relationships are at the heart of our well-being and therefore our motivations and ability to act (Lieberman, 2013).

Services that are intended to engage and inspire change will need to have kind, committed, reliable, trusting, empathic human relationships at their core.

The substantial research literature on counselling and psychotherapy also confirms that it is the quality of the relationship between helper and helped that determines effectiveness, rather than the particular therapeutic approach being employed (BACP, 2020).

When Triangle runs workshops with workers and service users to develop new versions of the Outcomes Star, the importance of developing a trusting collaboration between worker and service user is always a key message from participants. Independent research has found that a particularly appreciated feature of the Outcomes Star is the collaborative approach to completion which supports the development of a shared perspective (Arvidson & Kara, 2013; Esan et al., 2012; Frost et al., 2017; Joy-Johnson, 2016; Tickle, Cheung & Walker, 2013).

Emerging trauma-informed approaches point to the centrality of listening, understanding, responding and "putting people before protocols" (Wilton & Williams, 2019). Research in the criminal justice sector (McNeill, 2006) and the mental health sector (Leamy, Bird, Le Boutillier, Williams & Slade, 2011) also supports the crucial role of relationships in enabling change.

It follows that services that are intended to engage and inspire change will need to have kind, committed, reliable, trusting, empathic human relationships at their core. Services that are impersonal, poorly coordinated or where the personnel keep changing are less able to foster this kind of warm and trusting relationship. They are unlikely to succeed in achieving long-term outcomes because the people on the receiving end do not feel safe or supported enough to begin the challenging process of change.

2. Motivational: building belief that change is possible

Since Bandura published his theory of self-efficacy in 1977, the importance of having a sense of agency when trying to change behaviour has been widely recognised (Wilson et al., 2018). There are a range of theories of behaviour change, including protection motivation theory (Rogers, 1983), the health belief model (Rosenstock, Strecher & Becker, 1988), the transtheoretical model (Prochaska & DiClemente, 1983) and the theory of planned behaviour (Ajzen,1991:2002). Despite their different emphases, they all give a central place to self-efficacy or the related idea of perceived behavioural control.

As well as self-efficacy, hope has also been shown to be critical. Weingarten (2010) has pointed to the importance of "reasonable hope" in building motivation. This refers to hoping for something attainable and is seen as an important first step in achieving goals that are personally important. Westaway, Nolte and Brown (2017) propose that services must be mindful of the difficulty many people have in picturing a better future, and they see this as an essential precondition to taking action. Levy (2013) argues that "best practice can be seen in professionals recognising the fragility of hope for many service users and maintaining hope, even when service users cannot". Similarly, a sense of hope has emerged as a vital ingredient in recovery in the mental health field (Andersen, Oades & Caputi, 2003).

Many service providers train staff in motivational interviewing, a well-evidenced approach that emphasises the importance of motivation (Miller & Rollnick, 2012). More recently, strengths-based approaches have been found to be effective, partly because they build hope and trust in people's thoughts and judgments (Ralph, Lambric & Steele, 1996).

Another powerful way to build hope and agency is through services being delivered by people with lived experience of the issues they are helping with. These people can empathise and support from direct experience, which helps to build trust. And the very fact of their being in the role is witness to the fact that change is possible.

Building a sense of hope and belief that change is possible is often a critical stage in the model of change that emerges in workshops with collaborators to develop new versions of the Outcomes Star. In addition, research with service users working with the Outcomes Star has found that they value the fact that the Star makes progress visible and so builds a sense of hope and self belief (Game, 2021; Joy-Johnson, 2016; MHPF, 2009; Onifade, 2011).

We all know how challenging it is to change a habit, let alone a whole way of life. The evidence shows that in order to enable change, services need to build a sense of belief and personal agency. They must inspire hope that change is possible, keep the faith even when the person themselves finds belief hard to sustain, and focus on the person's strengths and achievements as much as or more than on the challenges they currently face.

3. Developmental: valuing and building capabilities to do things differently

New skills are often key in enabling people to rise to the challenges they face.

Writing about services for young people, McNeil, Rich and Reeder (2012) conclude that there is "substantial and growing evidence that developing social and emotional capabilities supports the achievement of positive life outcomes, including educational attainment, employment and health". This includes capabilities such as resilience, communication and negotiation.

Susan Michie identifies the development of capabilities as one of three core conditions for behaviour change (Michie, Van Stralen & West, 2011). Similarly, Cottam (2018) gives the development of capabilities a central role in her book Radical Help, which is based on a series of innovative service delivery experiments (Cottam, 2018). She traces the roots of this focus on capabilities back to the influential work of the Nobel Prize-winning economist Amartya Sen (Sen, 1980).

Developing new skills and behaviours and the social connections that support them is also a frequent theme in Star development workshops that Triangle runs with service providers and service users. Out of these workshops there often emerges a clear sequence in the model of change. This starts with building trust, moves on to developing hope and a sense of agency, and then proceeds to action and learning new skills and behaviours (Adamou et al. 2016). Practitioners involved in piloting new versions of the Star report finding it easy to identify where service users are on this "Journey of Change" (MacKeith, Burns, Good & Greaves, 2020).

New skills are often key in enabling people to rise to the challenges they face and change their behaviour. This suggests that services need to identify capabilities that people have already and help them to apply these capabilities to new situations. They should also identify capabilities that are needed and provide opportunities to develop them. That means sometimes giving people the chance to try new things and to make and learn from mistakes, rather than playing it safe. It means knowing when to do things for people, when to try and do things together, and when to stand back and let people try on their own.

4. Flexible: tailoring the help to the person

The latest literature on trauma-informed approaches stresses the importance of responsiveness in service delivery – responding to what this person needs today rather than following pre-conceived protocols, no matter how well researched (Wilton & Williams, 2019). The Psychologically Informed Environments movement also presents a wealth of evidence about the importance of tailoring the help to the person (Breedvelt, 2016).

As well as being responsive to the person's particular circumstances and priorities, interventions must also be sensitive to the person's relationship with the issue they are facing. For example, one cannot take the same approach with someone who does not see their addiction as a problem and someone who is actively engaged in reducing their addictive behaviour.

Cottam (2018) describes how, when helping people into employment, she and colleagues sorted people according to how much sense of direction and motivation they had towards work that they really wanted to do. They found that people in different categories needed different kinds of help. This echoes Triangle's learning from training and supporting people to use the Outcomes Star – that the type of intervention needs to be matched to where someone is in their change process and that making the change process explicit helps people to do this.

When it comes to changing behaviour, one size absolutely does not fit all. Services must take into account each person's priorities and preferences, their strengths and capabilities, and how they are engaging with the difficulties that they face.

5. Holistic: looking at the whole picture and joining the dots

There is a wealth of evidence that social challenges do not occur in isolation. Issues in one area of someone's life are usually part of a system of difficulties that are mutually reinforcing. For example, in the criminal justice sector there is evidence that around a third of people in prison do not have settled accommodation before entering custody (NOMS, 2009). Around half report a history of debt that often gets worse during custody (NOMS, 2007). And those who go through the criminal justice system are disproportionately more likely than the general population to experience low self-esteem and mental health problems such as anxiety and depression (Bramley et al., 2019, Marshall, Anderson & Champagne, 1997; Ministry of Justice, 2010; Vaughn, DeLisi, Beaver, Perron & Abdon, 2012).

These kinds of findings are mirrored in other sectors. For example, having supportive social connections and being able to participate fully in the community have been identified as being key to mental health recovery (Johnson, 2000; Liberman, Kopelowicz, Ventura &

Gutkind, 2002). Mental health service users also identify secure and adequate housing as an important factor in their recovery (Borg et al., 2005; Kyle & Dunn, 2008).

Triangle has developed versions of the Outcomes Star for services in a very wide range of fields including homelessness, disability, parenting, mental health, addictions and employment. The workers and service users who participate in the development process always stress the importance of looking right across the person's life to build up a rounded picture of their strengths and the challenges they are facing. Even when the service exists to help with a particular issue such as mental health, this is invariably closely connected with other aspects of life such as family, work and physical health.

Organisations report that the holistic nature of the Star helps to identify the links between the different areas of a person's life, providing a good overview of service users' situations and helping to highlight important issues that might otherwise have been missed (Onifade, 2011). For example, in one parenting service it revealed an issue with debt which was causing the mother a lot of stress. It wasn't until this problem was addressed and a repayment plan put in place that she was able to engage productively with the need to manage boundaries and behaviour with her children.

The evidence indicates that effective services will look at the person in the round, not just the presenting problem. Whilst some universal services can focus helpfully on a single area of need, those dealing with complex and ongoing issues must join the dots across key areas such as housing, employment, income, social connections and mental and physical health.

6. Contextual: highlighting the impact of the wider environment

People need the right kind of help, but they also have basic needs for housing, work, income and safety. Disadvantage undermines people's self-efficacy, skills, supportive networks and opportunities. Lack of self-efficacy, skills, supportive networks or opportunities results in further disadvantage. People need the basics in place to enable them to thrive and contribute.

In 2019/20, approximately 1.9 million people used a food bank in the United Kingdom (Clark, 2021). In 2019, 2.4 million people, including more than half a million children, were destitute at some point in the year (Joseph Rowntree Foundation, 2021). This was defined as "going without the essentials we all need to eat, stay warm and dry, and keep clean". These circumstances are a major obstacle to achieving most social outcomes. No amount of behaviour change can make up for the lack of basic essentials.

Furthermore, sustained deprivation can contribute to more entrenched issues such as mental illness, addiction, debt, family breakdown, poor health and poor education outcomes. Bramley et al. (2015) found that whilst poverty on its own did not lead to Severe Multiple Disadvantage (SMD)[4], when combined with Adverse Childhood Experiences (ACE)[5] and family stress the link was very strong. For example, 85% of people with SMD had experienced traumatic experiences in childhood and 42% had run away as children. This kind of systemic disadvantage can pass down through the generations, resulting in children coming into the world with the odds stacked against them. In addition to being unjust and cruel, it is also bad economics to allow problems to occur that could be averted through better basic provision and preventive action. Bramley et al. estimated that "the current SMD population have incurred cumulative costs to date of the order of £45–58bn".

4 Severe Multiple Disadvantage was defined as "a shorthand term used to signify the problems faced by adults involved in the homelessness, substance misuse and criminal justice systems in England".

5 Adverse Childhood Experiences (ACEs) are defined by Public Health Scotland as "stressful events occurring in childhood including:
- domestic violence
- parental abandonment through separation or divorce
- a parent with a mental health condition
- being the victim of abuse (physical, sexual and/or emotional)
- being the victim of neglect (physical and emotional)
- a member of the household being in prison
- growing up in a household in which there are adults experiencing alcohol and drug use problems."

It is vital that services, commissioners and policy-makers recognise that individual difficulties often exist in a wider context of disadvantage and poverty. That means it is important both to support people's sense of agency and also to recognise contextual factors so that people do not personalise difficulties that are the result of wider structural issues. It may not be within the power of the individual or the service to change these wider circumstances on their own, but it is important that these contextual factors are on the map and part of the conversation.

Effective services have their eye on the bigger picture and see part of their role as raising societal issues.

Sometimes bringing people together and supporting a community that is facing shared issues can be even more powerful than supporting individuals. Cottam (2018) describes inspiring examples of working with communities to help them decide their priorities and direct the work to achieve them. These stories show how much can be achieved when a group of people are given the reins, recognise their shared needs and have resources, opportunities and help to achieve their goals.

Services can also use their outcomes data to shed light on wider factors hindering progress. For example a homelessness agency using the Outcomes Star found that service users living in hostels made progress in addressing a range of issues such as mental health, how they spent their time, and their drinking and drug use in the first year in hostel accommodation. However a lack of move-on accommodation often resulted in people staying in the hostel too long. The Star showed progress starting to reverse after a year, with worse outcomes for those who were in hostel accommodation for two years or more.

Effective services have their eye on the bigger picture and see part of their role as raising societal issues like these in order to create a more effective service delivery system that addresses people's needs in the round.

Part 3

Enabling Help in practice

Key messages

The enabling approach has implications for all levels of social provision delivery:

At the **front line** it means a shift from seeing service users as recipients to working with them as collaborators.

In **management** it means shifting focus from procedures and protocols to enabling those at the front line to take a flexible, responsive, problem-solving approach.

In **commissioning** it means working collaboratively with service providers, looking at how the whole service delivery system functions, and shifting the focus of monitoring from numbers to narratives.

At **research and policy** level it means shifting the focus from intervention recipes to creative, responsive service delivery systems in which the Enabling Help principles apply in practice.

The term Enabling Help refers to a set of principles for front-line service delivery which promote sustained change by putting the service user's priorities, motivation and capabilities at the heart of the engagement. The enabling approach also has relevance for other aspects of the service delivery system. So what does it look like to put these principles into practice not only at the front line, but also in management, commissioning, and research and policy-making?

1 An enabling approach to service delivery – from recipient to collaborator

The enabling approach recasts the person receiving help from recipient to collaborator. Those helping them become facilitators, rather than experts. The relationship between helper and helped becomes one of collaboration rather than provision.

This has many implications for the way in which services are provided. It becomes more important to know how ready and equipped the person is to collaborate than to know how severe their problems are (McMurran & Ward, 2010). It becomes more important for the person needing help and the person helping them to build a shared understanding of the issues they face than to assign a diagnosis. Providing help is more about listening and coming up with ideas together than having a ready-made solution. It can be about highlighting external barriers as well as unlocking internal ones. It can be about collective action as well as individual support.

Taking an enabling approach means putting more emphasis on building the relationship between helper and helped. It implies understanding why people behave as they do and supporting them in ways that work for them rather than expecting compliance. It means focusing on the spirit of the service at least as much as the letter of the service. It requires warmth, understanding, trust and empathy to create real collaboration. Relationship quality isn't something that can be reduced down to a formula or turned into a commodity. It is something that is rooted in our humanity rather than in our knowledge or role.

This approach does not imply that people always have the capability or desire to be supported to do something themselves. Sometimes people simply need a service provided in a standard way or by an expert. However it can be helpful to check assumptions about this and have a conversation about what is wanted and what the service user's capabilities might be.

The enabling approach recasts the person receiving help from recipient to collaborator. Those helping them become facilitators, rather than experts.

It is also important to bear in mind that, although based on human connection, the relationship between helper and service user is different to that between family members or friends. There needs to be clarity of roles, appropriate boundaries, and support to maintain them. There must also be a clear recognition and acknowledgement of the different "hats" that helpers wear. Sometimes workers have a risk assessment or rule-enforcer role as well as the more obviously supportive roles. When this is the case, the person providing help needs to be clear about when they are switching roles. This is no easy task. It means uniting warmth, kindness and genuine human connection with clear professional boundaries. It means knowing when to enable and when to protect.

The enabling approach means knowing when to act for someone and when to support them to act for themselves, co-creating a way forward, rather than following a template. Creating an enabling collaboration at the front line is a complex task that demands a wide range of skills and knowledge. This requires training and supervision to support reflective practice and to help front-line workers navigate the different roles they have to play. It also means paying enough to retain staff and investing in their well-being.

2 An enabling approach to management – from procedures to problem solving

Taking an enabling approach to management means focusing on delivering relational, developmental, motivational, flexible and holistic work at the front line rather than focusing on the organisation and its procedures. Protocols and forms still have their place, but they are servants of the work rather than the master. The key task for managers is to enable staff to take the initiative and solve problems in order to help service users rise to the challenges they are facing. This means creating a culture in which workers believe that they can make a positive difference to the people they are helping and to the way their organisation works.

Taking an enabling approach to management means focusing on delivering relational, developmental, motivational, flexible and holistic work at the front line.

This is echoed by Haigh and colleagues who highlight a service culture of learning and enquiry as being key to effective service management (Haigh, Harrison, Johnson, Paget & Williams, 2012). One chief executive of a second-tier organisation in the health sector reported that, in her experience, the extent to which front-line staff

feel empowered to solve problems and take the initiative is the single most important factor in the quality and effectiveness of services. The conditions for this are created by managers – through the messages they send, the behaviour that gets rewarded, the people who get promoted, the way rules are interpreted.

The enabling manager asks "What is working with this person and what is getting in the way?". They encourage reflective practice and enable others to achieve collectively agreed outcomes. They recognise that part of their role is to nurture staff resilience and capacity, because this translates into a more skilled workforce who are better equipped to stay in the role.

The enabling manager highlights external barriers and contributes towards systems change. They monitor what is changing for the person (individual outcomes) at least as much as organisational budgets and processes. They offer workers the flexibility to support groups as well as individuals, if shared issues mean people can benefit from peer support and taking action together.

The enabling manager balances the management of risk with the creation of opportunity. They avoid a blame culture that makes it too risky to be creative or to take the initiative. To do this they themselves need to be managed and the services they run commissioned in a way that encourages openness and problem solving.

3 An enabling approach to commissioning – from services to systems and from numbers to narratives

Taking an enabling approach to commissioning means looking at everything through the eye of the service user. That means thinking through how the requirements of the contract will play out on the ground. Will those requirements support work at the front line that is relational and developmental – or will they pull service delivery towards a more procedural or target-driven approach?

The enabling commissioner designs and funds a coordinated service delivery system in which service providers can work together

effectively and people can move easily between services without having to repeat their stories. This kind of well-coordinated service delivery ecosystem takes time to develop. Every time a service is recommissioned, the whole service delivery system has to reconfigure to adapt to new people and structures, taking energy away from direct delivery. As a result, the kind of coordinated response that service users need may be easier to achieve when contracts are made for the long term or services are directly managed.

The enabling commissioner takes a relational approach to working with service providers.

The enabling commissioner takes a relational approach to working with service providers. That means an emphasis on collaboration to achieve outcomes and building mutual trust and commitment, a shared vision and a learning, problem-solving approach. It means focusing on the service provider's intrinsic motivation to do a good job and achieve outcomes rather than offering carrots and sticks. It means designing contracts that focus on how to work together and adapt to changing circumstances rather than exactly what will be done (Brown, Potoski & Van Slyke, 2016).

The enabling commissioner listens to service users and understands their most pressing needs and the best way they can be met. Co-designing and co-producing services is not easy but there is a wealth of evidence that it achieves results (Hampson, Baeck & Langford, 2013).

When it comes to monitoring, an enabling approach to commissioning means less emphasis on holding the provider to account for achieving particular targets and more on curiosity and learning. Measuring end outcomes such as people housed or employed is both possible and useful, but it gives only partial information, because these outcomes may take years to achieve and are influenced by many factors outside the service's control. A clearer picture can be developed by gathering different kinds of data, including end outcomes, distance-travelled outcomes and service user feedback and using it to create a coherent narrative about what is working and what needs to change. It is these narratives rather than the numbers used to create them that enable learning and improvement. Lowe and colleagues also make the case for learning rather than accountability as the primary purpose of performance management and stress the importance of taking a systems approach to understanding the complex web of factors that underpin social outcomes (Lowe, French, Hawkins, Hesselgreaves & Wilson, 2020).

The enabling commissioner collaborates with service providers to achieve agreed outcomes.

They ask "can you share your outcomes data with me and show me what you have learnt and how you are applying your learning?" rather than simply "have you achieved the outcomes targets?". In the complex arena of human services and human change there is rarely the luxury of clear metrics and benchmarks that can be interpreted free from an understanding of context.

4 An enabling approach to policy-making – from intervention recipe to system responsivity

Taking an enabling approach to research and policy-making means recognising that in the field of human behaviour "what works" is the product of a complex system of relationships, resources and environmental factors. Since most of these things cannot be controlled for, a "pure" randomised control trial is not possible in practice. Approximations can be made, but even the most carefully designed study could lead to ambiguous or false conclusions. There have been attempts to code the content of particular interventions and conduct meta-analyses to identify active ingredients, but even then, there can be factors that are unaccounted for. For example, analysis may find that certain techniques appear important in behaviour change when in reality these techniques are only used with people with less severe problems.

There are many examples of experiments in human behaviour that led to conclusions that were later found to be erroneous. One of the most famous is the Hawthorne experiment (Mayo, 1949). Lighting and other aspects of work organisation were changed in a factory and productivity was found to increase. The obvious conclusion was that the new working conditions were more conducive to productivity. However, when the researchers changed back to the original conditions, they found that productivity increased again. It turned out that the critical factor was simply making a change and perhaps being the subject of observation and special attention, rather than the particular way that work was organised.

Researchers in this field must be careful not to make the error of breaking things down into their component parts and thinking that these can be studied independently. This may result in promising findings that are then difficult to replicate. When dealing with chronic and complex human issues, searching for the holy grail of the perfect intervention for particular categories of person or need is time-consuming, costly, and unlikely to succeed.

We already have a wealth of evidence about what makes people susceptible to difficulties. For example, issues such as addiction, homelessness and offending are strongly linked to poverty, trauma and family stress (Bramley et al., 2015). We also have a wealth of evidence about what works in addressing these needs – relational, motivational, developmental, holistic and flexible service delivery. A much more difficult question is how to create responsive service delivery systems that can deliver this kind of help consistently.

Instead of trying to identify recipes for what works in service delivery, researchers and policy-makers would be better to ask the question, "how can we create learning systems that respond effectively to what each person needs?" This means taking the analysis up a level and looking beyond the specific intervention to the environment in which it was implemented and the quality of relationships at all levels of management and delivery.

We have a wealth of evidence about what works.

A much more difficult question is how to create responsive service delivery systems that can deliver this kind of help consistently.

Part 4

From aspiration to realisation

Key messages

The service delivery system is like an iceberg. The service which the end user experiences is the visible part above the water line. Beneath the water are the way the service is managed and commissioned, the policy and research on which it is based, and the ideas that drive practice at all these levels. These are not visible to the service user but they powerfully shape their experience

To make Enabling Help a reality in service delivery we need to base services on what we know about human needs and behaviour and ensure that all parts of the service delivery system work together to apply this knowledge and keep the service user in view. There are no quick fixes, but with a clear vision, sustained effort and our eyes firmly on the end user, it is possible to create real change.

There are others who have made similar cases for change, particularly in relation to creating relational, strengths-based and empowering front-line services. Narrative approaches developed in the 1980s advocate helping people to construct their own accounts in a way that support self-esteem and a sense of agency (White & Epston, 1990). The Strengths Approach proposes an equal partnership in the helping relationship which, it is argued, is key to effective human service delivery (McCashen, 2005). The Psychologically Informed Environments movement encourages services to bring a greater psychological awareness to one-to-one work, staff training and support, and to the physical environment in which services are delivered (Levy, 2013). Trauma-informed approaches emphasise the importance of the relationship between helper and helped and a flexible approach.

More recently, in their report *Good and bad help: How purpose and confidence transform lives*, Richard Wilson and colleagues identify seven key principles underpinning good help, the first four of which focus on individual agency and supporting people to achieve the goals they have identified. Similarly Cottam argues for a capabilities approach which recognises and builds individual capabilities and support networks (Cottam, 2018).

Julia Unwin and the Carnegie Foundation have argued for the need to give space to kindness, emotions and relationships in public

services (Unwin, 2018). In another Carnegie Foundation report, *The Enabling State: A discussion paper*, Sir John Elvidge argues that the state needs to build an understanding of how to support families and communities to develop their capacity to support themselves (Elvidge, 2013).

Enablement has been a key theme in many government reviews and policies in health and social care. For example, the Christie Commission into public services in Scotland pointed to the problem of short-termism and fragmentation of service delivery and proposed a new approach characterised by collaboration between organisations and partnerships with people and communities (Scottish Government, 2019).

Enablement is a reality in some front-line services and an aspiration in many others, but it is difficult to deliver in practice. If there is a groundswell of support for this approach, why has it not yet become a reality at scale?

New mental models – embracing the human dimension

There are many reasons for a service or a service delivery system not operating in an enabling way. There may be a lack of funding or not enough investment in staff training, or a lack of understanding or skills to change ways of working. However, I believe that at a deeper level the biggest barriers are the mental models that shape our thinking about service delivery. The medical, bureaucratic, market and natural sciences paradigms are borrowed from other spheres of study. They are based on assumptions that do not hold in the field of social provision, and they draw attention away from the needs and experience of the service user.

Figure 7 summarises the points made in Part 1 about the key features of each of these paradigms and the alternative presented here.

Figure 7: Summary of the different paradigms shaping service delivery

Paradigm	Focus	Person receiving the service	Service	Key assumptions
Medical	The helper	Patient	Treatment	The person is sick or flawed and the helper has the answers
Bureaucratic	The organisation providing the service	Recipient	Process	Fairness and risk management are best served through standardisation
Market/ economic	The commissioner	Consumer	Product	Performance is maximised through competition and financial incentives
Natural Sciences	The type of intervention	Subject	Formula	What works can be identified and replicated independently of context
Human Sciences	The person being helped	Collaborator/ partner	Enablement	Relationships and on-going learning are the key to change for individuals, organisations and systems

My experience has been that many people working in service delivery want to operate according to the principles of Enabling Help. However the systems that they are working in make this difficult, sometimes impossible.

For example, new initiatives to make services more joined up are likely to have limited impact when the wider system is being shaped by ideas that inadvertently work against cooperation between services. Market pressures can limit management time to support reflective practice and favour shorter-term services, making it harder to build the trust, motivation and skills that are essential to sustainable change. Effectiveness is also reduced when workers' wages are squeezed and staff turnover is high.

These initiatives are put in place with the best of intentions but the impact on the front line is damaging and this often goes unrecognised. Without mental models that embrace the human dimension of delivering as well as receiving services, organisations will struggle to put into practice the wealth of knowledge that exists about how to support well-being and change.

As Donella Meadows, the pioneering environmentalist and systems thinker proposed, observable events are like the tip of an iceberg. Under the surface of the water, these events are driven by repeated patterns of behaviour and the structures, dynamics and relationships within our systems. Underneath it all lie the mental models that shape and create what happens in our world (see Figure 8).

In order to move from the aspiration for Enabling Help to its realisation, we must attend to the thinking and models that drive systems, structures, behaviour patterns, and ultimately what actually happens. Just tweaking things within the existing paradigms won't work, because the incorrect underlying assumptions and approaches will continue to exert their negative influence.

The service delivery system is like Meadows' iceberg. The service which the end user experiences is the visible part above the water line. Beneath the water is the way the service is managed and commissioned, the policy and research on which it is based, and the ideas that drive practice at all these levels. These are not visible to the service user but they powerfully shape their experience. Figure 9 shows how the wrong mental models below the water line can result in help that does not enable. Figure 10 illustrates the way in which the right mental model – i.e. the human sciences paradigm – enables the right kind of help.

Figure 8: Mental models drive observable events

Credit: The Iceberg Model https://ecochallenge.org/iceberg-model/
adapted from http://donellameadows.org/systems-thinking-resources/

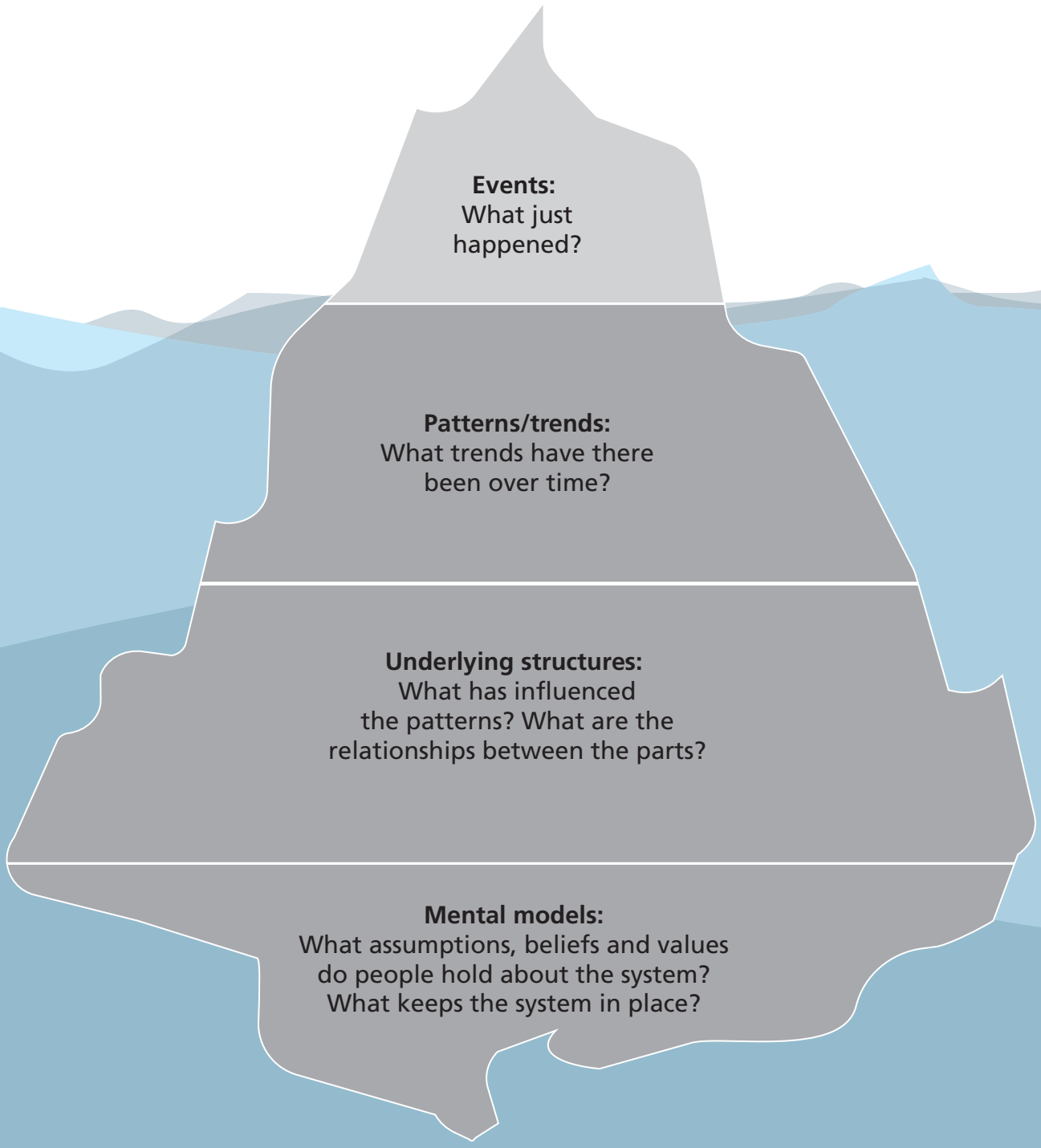


Figure 9: Help that does not enable

How mental models 'below the water line' shape the help people receive

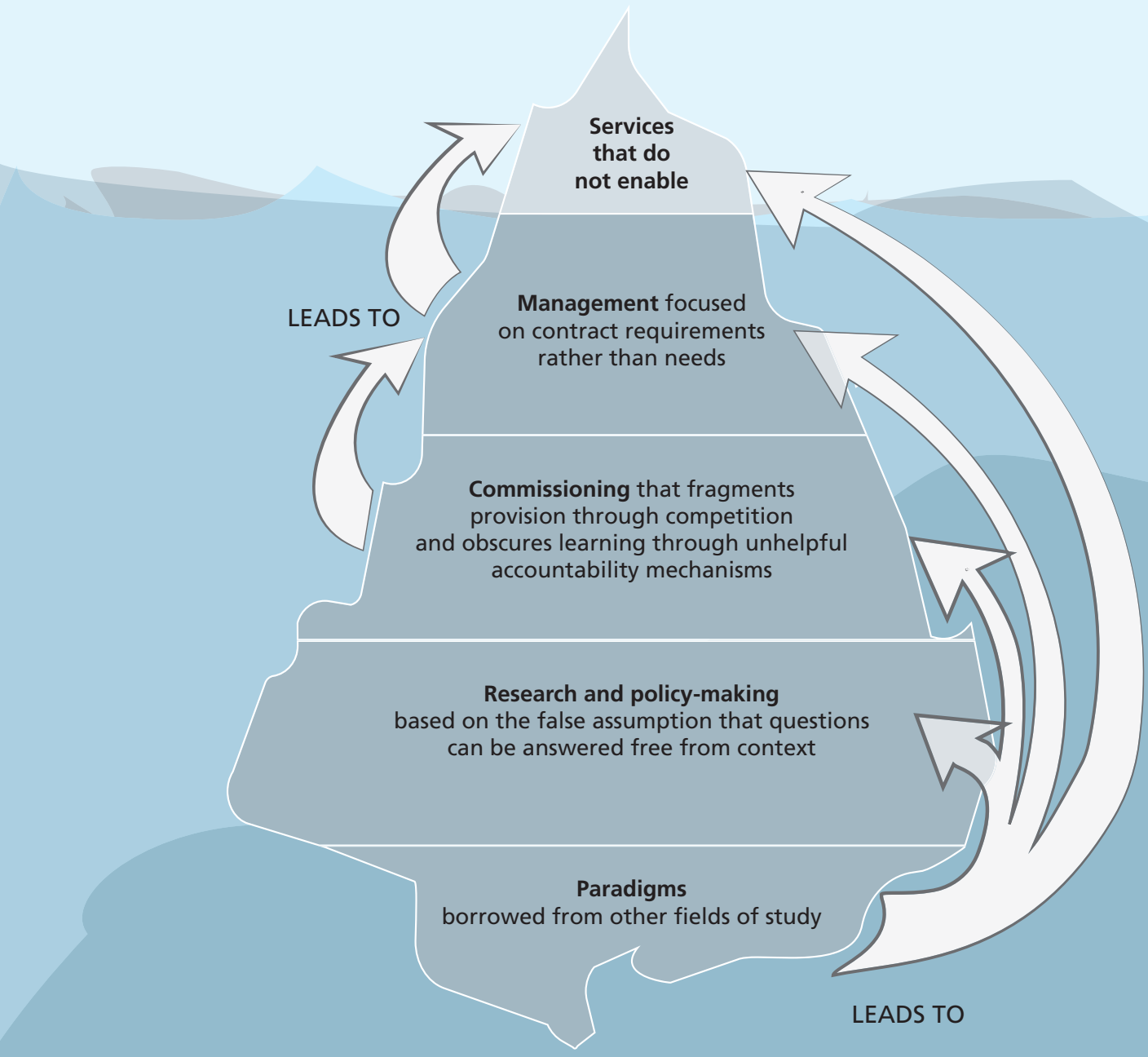
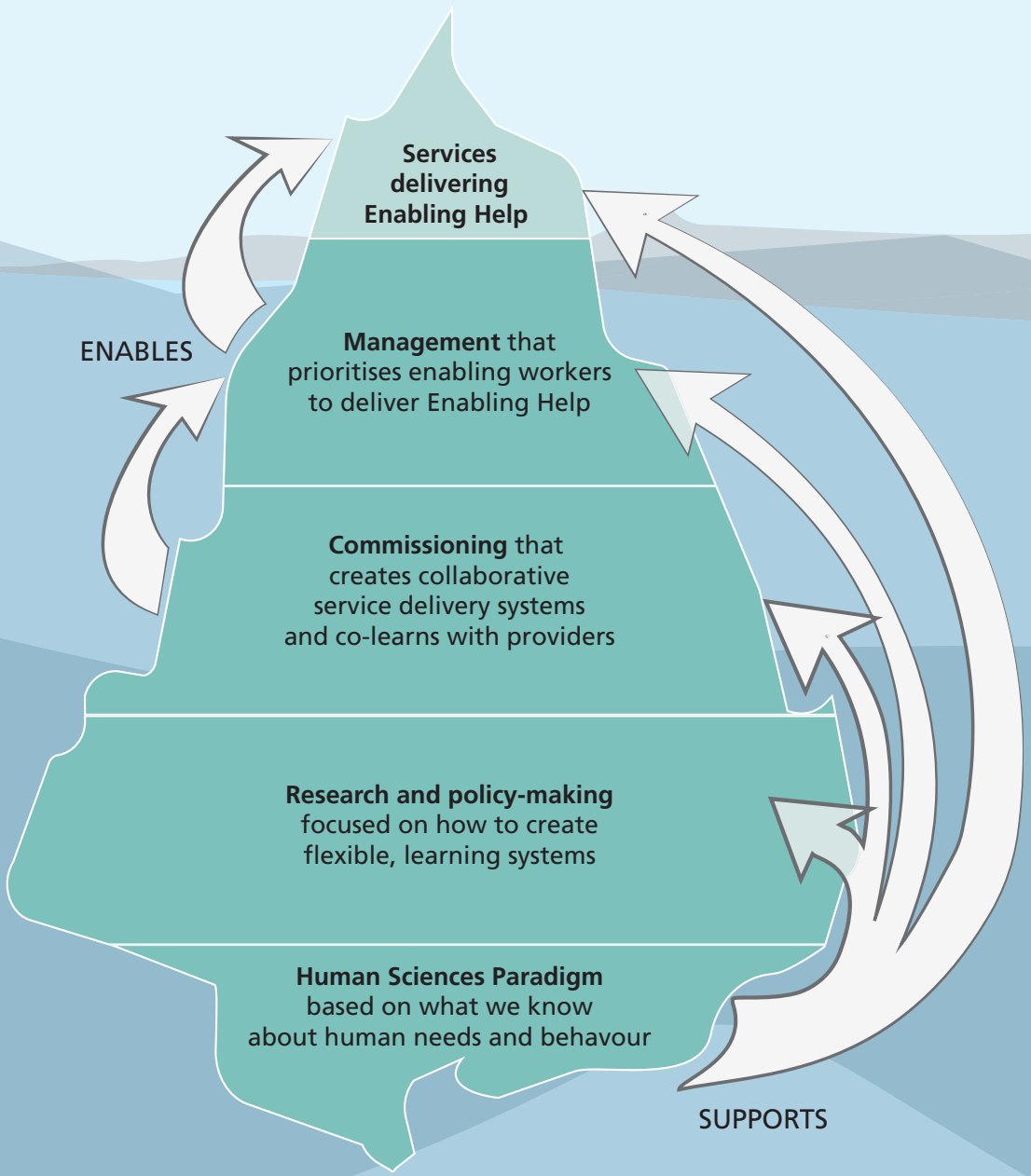


Figure 10: Enabling Help
How the right mental model enables the right kind of help



Congruence in the service delivery system

We need congruence in the service delivery system. If services are to operate in an enabling way at the front line, then they also need to be managed and commissioned in an enabling way. Schwarz and Sharpe (2010) identified two typical responses to problems in organisations – create more rules and create more incentives. We want to try and eliminate the possibility of human error and we don't trust people to want to do the right thing. But in doing that we also eliminate human responsiveness, creativity and problem solving. We need to counteract that natural tendency to try to codify and legislate problems out of existence. Instead we need to cultivate responsive, curious, confident people and responsive, learning-oriented, confidence-inspiring organisations.

If services are to operate in an enabling way at the front line, then they also need to be managed and commissioned in an enabling way.

Each layer of the service delivery system is intimately connected to the other layers. The ideas that inform commissioning impact on how services are managed. How services are managed impacts on how services are delivered at the front line. If managers are under pressure to achieve certain targets in order to fund the service, they are likely to pass that pressure on to front-line workers. Hard as they might try, protecting those they manage from these pressures is a near impossible task. What that means at the front line is that services can be driven by targets rather than the needs of the people they are intended to serve.

Commissioning and management are human processes, delivered within human systems. The principles of Enabling Help at the front line also apply to the rest of the service delivery system. That means that moving to an enabling approach is a paradigm shift in the fullest sense, implying change at all levels of the system.

Keeping the service user in view

The more commissioners, managers and workers follow the principles of Enabling Help, the more everyone will enjoy being a creative part of a service delivery system that delivers real and sustained results.

However, the people who set the rules by which everyone else has to play have a particular responsibility. It is difficult for someone at the front line to work in an enabling way if they are required to rigidly follow a particular approach or meet a particular target whether or not it is relevant or appropriate to the person they are helping. Those furthest from the front line have the most power but often least information about how their choices impact on service delivery. Despite the considerable investment in providing those at the top with numbers, they can lack a real understanding of the front line narrative. There is an onus on them to seek out that information.

Those furthest from the front line have the most power but often least information about how their choices impact on service delivery.

Those working at the most strategic levels in service delivery need to keep their eye firmly on the service user. That means drawing on service user expertise when designing services, and regularly hearing their feedback about things are working. It means always asking "how will this impact on people receiving services?" when new approaches are considered. It means ensuring that accountability flows both ways – from policy-maker and commissioner to service and service users as well as from service to commissioner to policy-maker.

Leadership, vision, patience and persistence

The kinds of changes described here are not something that can be switched on overnight or even over the course of a year. They will be achieved piece by piece, one worker, manager and commissioner at a time. New tools and models can help support the transition but there are no quick fixes, no restructuring or new funding mechanism that will deliver this kind of change. It is something that must be patiently cultivated throughout the service delivery system through leadership, clarity of purpose, commitment and sustained effort.

A recent Harvard Business Review article on UK academy schools argued that "architect" leaders make long-term sustained improvements in schools (Hill, Mellon, Laker & Goddard, 2016). These are leaders who have a vision and take a long-term, holistic view of the school, its stakeholders and the community. They were contrasted with "surgeons" who took more visible and decisive action, cutting and redirecting staff and other resources, and focusing on test scores.

The "surgeons" achieved short-term results, but their schools did worse over the medium and long term. The "architects" didn't get the same kind of attention and rewards as the "surgeons", but they were the ones whose schools were ultimately most successful.

As with schools, so with wider social provision. The task is to build and sustain adaptive, creative services that work in a sensitive, person-centred way. It is to take a learning approach to understanding what works for this person, in this locality, today. This isn't glamorous and it doesn't attract attention, but it makes a real difference over the long term. Many front-line workers, managers and commissioners are aiming for this every day, but because it isn't easy to quantify or codify, it can be invisible, taken for granted or crushed by more conspicuous but shorter-term approaches. That is why it is important to make visible and explicit what Enabling Help is and how to deliver it. Enabling Help offers fewer certainties than some other approaches and demands more of people delivering services. But it is potentially a much more exciting and rewarding context for us all to work in. Most importantly, with leadership, vision, patience and persistence, it has the potential to transform services, systems and lives.

The task is to build and sustain adaptive, creative services that work in a sensitive, person-centred way.

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Appendix: The Outcomes Star™

The Outcomes Star is a suite of dual purpose tools which both support keywork and measure change when working with people. Triangle has created and published 44 versions of the Outcomes Star over a fifteen year period. Each version has been created in collaboration with one or more organisations providing services in the sector for which that version is intended. The collaborations have involved service users, front-line staff and managers through workshops, interviews and focus groups.

Every version of the Outcomes Star has been piloted to establish its usefulness as a keywork tool and its psychometric properties. More information about the development process for the Outcomes Star and research on different versions carried out by Triangle and others can be found at **www.outcomesstar.org.uk/about-the-star/evidence-and-research/**

There are currently over one thousand organisations that Triangle has trained and licensed to use the Outcomes Star, with well over one million Stars completed on the Outcomes Star online application. The Outcomes Star has been translated into many different languages and is used across the globe.

The following is a complete alphabestical list of organisations that have collaborated with Triangle to create versions of the Outcomes Star.

1625 Independent People

Accomplish (formerly Brookdale Care)

Action for Children

ADASS End of life Network

Addaction

Alcohol Concern

Aquarius

Avon and Wiltshire Mental Health Trust

Barnardo's Family Support Services

Birmingham Drug and Alcohol Team (funder)

Blind Veterans UK

Brent Council

Brook Advisory Service

Brookdale Care

Camden Council

Castlebeck

Cheshire & Wirral NHS Trust

Clic Sargent

Complex Minds

Coram

Dame Vera Lynn Children's Charity

Derbyshire Community Health Services NHS Foundation Trust

Derbyshire Drug and Alcohol Service

Dorset Healthcare University NHS Foundation Trust

East Midlands Drug and Alcohol Team

Eaves Housing

Essex County Council

Family Action

Glasgow Housing Association

Groundwork UK

Haldane Associates

Hammersmith and Fulham Council

Hampshire County Council

Hertfordshire County Council

InMind Healthcare

Islington Council

Jewish Care

Lancashire Women's Centres

Learning to Lead CIC

Leicestershire County Council

Leicestershire Police

Lifeline

Lincolnshire NHS

Liverpool City Region Combined Authority

London Councils

Loretto Housing Association

Lorretto Care

Macmillan Cancer Support

Making Space

Mersey Care NHS Trust

Nesta (funder)

Newham Council

NORCAS

Norfolk and Suffolk NHS Foundation Trust

Norfolk Community Health and Care NHS Trust

North East Essex Clinical Commissioning Group

North London Forensic Service

North London Hospice

Northumberland Tyne and Wear NHS Foundation Trust

Partnerships in Care

Pathways to Independence

Relationships Australia Queensland

Royal Borough of Kensington and Chelsea

Ruskin Mill Trust

Salvation Army Westcare

Second Step

Shaw Trust

Single Homeless Project

Sodexo Justice Service

South West Yorkshire NHS Foundation Trust

St Andrew's Healthcare

St James' House

St Joseph's Hospice

St Mungos

Staffordshire Housing Association

Tees, Esk and Wear Valleys NHS Foundation Trust

Thames Reach

The Aldridge Foundation

The Association of Mental Health Providers (formerly Mental Health Providers Forum)

The Big Lottery Fund

The British Refugee Council

The Carers Trust

The Department for Work and Pensions (funder)

The Department of Health (funder)

The Family Nurse Partnership

The Fortune Society

The Huntercombe Group

The London Housing Foundation

The Officers' Association

The Passage Day Centre

The Paul Hamyln Foundation (funder)

The Stefanou Foundation

Thomas Pocklington Trust

Tulip

Turning Point

United Response

Uniting Care West

UnitingCare Queensland

Warrington Borough Council

West Yorkshire ADHD Support Group

Westminster City Council

Joy MacKeith is co-founder of Triangle, the social enterprise behind the Outcomes Star. This report is the product of twenty years working with service providers, commissioners and policy-makers to measure and improve outcomes for people, including speaking and writing widely on outcomes and creating 44 versions of the Outcomes Star with Star co-author Sara Burns.

In Enabling Help she argues that social provision needs to base practice on the rich and growing body of knowledge about human needs and behaviour rather than borrowing ideas from other fields such as medicine, economics and the natural sciences. That means taking an enabling approach to service delivery which is relational, motivational, developmental, flexible, holistic and contextual. She describes how these principles apply not only at the front line, but also in management, commissioning and policy-making and paints a vision of a congruent service delivery system in which the needs of the service user are the core governing principle at every level. Joy is an outcomes expert and experienced public speaker and has taken the stage at four recent global conferences.

If you would like to share your reflections on the report or invite Joy to come and speak about these ideas, please get in touch **www.outcomesstar.org.uk/enablinghelp** or call +44 (0) 20 7272 8765

Triangle

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