NATIONAL GUIDANCE &
LOCAL IMPLEMENTATION

August 2013

WHAT WORKS IN FAMILY SUPPORT?

Child and Family Agency

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The overall CFA Family Support Programme of work has been supported by The Atlantic Philanthropies.

ISBN: 978-1-905861-14-9

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GLOSSARY OF TERMS

Evidence based practice

An approach to decision making that is transparent, accountable and based on careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities (MacDonald, 2001)

Evidence informed practice

Practice based on the integration of experience, judgement and expertise with the best available external evidence from systematic research (CES, 2011).

Evidence-based programme

A programme that has consistently been shown to produce positive results by independent research studies that have been conducted to a particular degree of scientific quality (CES, 2011).

Meta-analyses

A meta-analysis refers to methods focused on contrasting and combining results from different studies, in the hope of identifying patterns among study results, sources of disagreement among those results, or other interesting relationships that may come to light in the context of multiple studies (Patton, 2002).

Randomised control trial

A randomized control trial is one in which the units are assigned to receive the treatment or an alternative condition by a random process such as toss of a coin or a table of random numbers. (Shadish *et al.,* 2002).

Systematic review

A systematic review is a literature review focused on a research question that tries to identify, appraise, select and synthesize all high quality research evidence relevant to that question (Patton, 2002).

1.0

INTRODUCTION

This document provides an overview of evidence based family support practices and programmes for children and families. It is one component within a suite of work being produced by the Children and Family's Directorate of the HSE. Additional components include:

- **Guidance on an area based approach to Prevention, Partnership and Family Support, and Meitheal - A National Practice Model;**
- **The Child and Family Agency Commissioning Strategy;**
- **a Parenting Support Strategy;**
- **a Children and Young People's Participation Strategy;**
- **a National Survey of Family Support Services;**
- **the new National Service Delivery Model.**

This document particularly complements and is to be used closely in conjunction with the Commissioning Strategy and the Parenting Support Strategy. The Child and Family Agency (CFA) Commissioning Strategy, National Guidance Local Implementation, 2013 is the first national commissioning strategy for child and family services in Ireland. The aim of the strategy is to ensure that the full resources of the CFA are applied to improving outcomes for children and families in the most efficient, effective, equitable, proportionate and sustainable way. The CFA Parenting Support Strategy, Investing in Families: Supporting Parents to Improve Outcomes for Children is the first explicit national parenting support strategy for child and family services in Ireland. The CFA statement of strategy on parenting support suggests that its core business is to invest in all families in order to support parents and improve outcomes for children and young people.

The Child and Family Agency Bill 2013 provides for the bringing together of a range of existing services to children and families into one agency. The Agencies functions will include maintaining and developing support services, including support services in local communities in order to support and promote the development, welfare and protection of children and to support and encourage the effective functioning of families. In so doing the Agency will promote enhanced inter-agency cooperation to ensure that services for children are co-ordinated and provide an integrated response to the needs of children and their families. The Bill also provides that the principles of the best interests of the child and of participation are applied to the Agency's work.

This report is not a systematic review of the literature and research available on evidence based family support programmes and services. Rather, it provides a comprehensive account of the national and international programmes and services that have been evaluated. This document is meant to be a resource for the commissioning process within the CFA as outlined in the Commissioning Strategy and is intended for use by managers and practitioners in the Child and Family Agency.

In order to situate the evidenced based material presented, the report includes a section on evidence itself. This section considers what an evidence base means and what constitutes evidence within social services. The differences between evidence based approaches and traditional evidence informed practice is outlined. A framework for levels of evidence is also presented which ranges from descriptive evidence in observational studies or interviews to causal evidence as obtained through Randomised Control Trials (RCTs)

This report contains **five** sections:

1. Following this introductory section, section two outlines the issues in considering 'what works?' and summarises what we mean by an evidence base and the types and levels of evidence that can be obtained;

2. The third section provides the definition of Family Support and describes the accompanying practice principles. A theoretical framework for Family Support is also presented along with a description of the current framework used to categorise the services delivered within the Irish context;

3. In section four, international and national examples of evidence based programmatic initiatives are provided;

4. Section five considers the issue of implementation in support services and fidelity to programme design;

5. The final section reflects on some of the challenges in gathering evidence and establishing 'what works'? and concludes the report.

This document reflects the evidence base for Family Support programmes and services at a particular point in time. It is intended that it be updated at regular intervals with additional evidence based programmes and services added. It is recommended that information on and examples of emerging, promising and good practice, particularly within the Irish context, be included in this report as they develop. It is also recommended that this report be linked to an online database of Family Support services and programmes.

2.0

WHAT DO WE MEAN BY 'WHAT WORKS?'

This document considers the question of 'what works?'; the nature of the evidence that we can use to establish this; and provides examples of best practice, underpinned by different levels of evidence. It is simply the beginning of the longer term task of ongoing organisational reflection towards providing the best services possible to achieve the best outcomes for children and families. At this point it is useful to consider some of the wider dimensions of this long term task.

To begin, it is worth restating some key concluding points from Buckley and Whelan's recent report on the utilization of research evidence in Irish Children's Services. They argue strongly that: 'If outcomes for service users are to be optimized, then policy, protocols, procedures, assessment, intervention and evaluation must be informed by sound evidence about the impact of social and psychological factors on the lives of children and families' (2009, p.89).

Yet they also highlight that 'there is not uncritical acceptance of the benefits of evidence based practices, particularly in the field of social care, where it is suggested that the dynamics involved in this type of work cannot always be separated from their often fluid and complex contexts' (2009, p.89).

These points highlight the often ambivalent attitude within service-providing organisations, especially in the front-line, toward evidence based or even evidence informed practice.

The experience of the last few years of the Department of Children and Youth Affairs Prevention and Early Intervention Programme and related major interventions funded by the Atlantic Philanthropies is instructive.[1] The Prevention and Early Intervention Programme requires funded services to evaluate the effectiveness of their services in improving outcomes for children. Their goal is to help the communities in which they operate and also to share their learning so that policy makers and those who design and deliver services for children can benefit from their experience. A major dissemination and knowledge exchange is underway to provide a forum to discuss the individual and collective learning from initiatives and to develop and disseminate key messages. In particular, the emergent set of robust research and evaluation reports is a real opportunity to demonstrate the value of evidence to policy and practice. There is clear evidence that it is possible to adapt practices to the specific Irish demographic, cultural and policy context, to implement them effectively and to achieve positive outcomes.

1 This initiative is known as the 'Dissemination Initiative on Prevention and Early Intervention' (DIPEI). A parallel project; 'Capturing the Learning' is also underway under the management of the Centre for Effective Services. This project aims to synthesise the collective overarching learning from the initiative as a whole. (See www.effectiveservices.org for further information)

2.1

A FOCUS ON OUTCOMES

In Ireland, as elsewhere, there is a relatively new focus on the evidence base for achieving outcomes for children and families in both planning and reviewing service provision (The Agenda for Children Services, 2007; Canavan, 2010). The Agenda for Children's Services promotes an aspiration towards good outcomes for children; and defines outcomes as "the best possible conditions, situations and circumstances to live their lives to their full potential. Outcomes are about what is happening now in children's lives and what may happen in the future" (2007, p. 12).

The use of an outcome-focused approach in a search for an evidence base has been advocated by a number of researchers and evaluators in the field as it:

- **Promotes the effectiveness of services and provides clarity and focus in a partnership approach to service delivery (Friedman *et al.,* 2005; Canavan, 2010);**
- **Provides a framework for accountability and specificity in relation to achieving results (Bruner, 2006);**
- **Provides standards that can be adhered to over a period of time (UNICEF, 2007).**

Canavan (2010) has identified outcomes as a technical means towards the realization of children's rights. There is a growing body of literature that links children's rights with outcomes and wellbeing (McAuley *et al.,* 2010; Ben-Arieh, 2010). Bradshaw *et al.,* have defined wellbeing as "the realisation of children's rights and the fulfillment of the opportunity for every child to be all she or he can be. The degree to which this is achieved can be measured in terms of positive child outcomes" (2007, p.6). Canavan highlights policy, services and practices as the means by which outcomes are achieved and rights realised (2010).

As Bruner (2006) points out, there is an increased recognition of the need to focus evaluations on outcomes and results as opposed to measuring inputs. The achievement of better outcomes for children and families is the measure of quality and effectiveness in service design.

2.2

WHAT IS AN EVIDENCE BASE?

The search for evidence based practice, and the debate on what constitutes an evidence base in children and families services, is well underway with a need to demonstrate how services are making a difference (MacDonald, 2001; Pecora, 2006; Whittaker, 2009; Munro, 2011). Bruner (2006) notes, it is essential for Family Support services to build a better evaluation framework because policy makers and funders increasingly require evidence on the effectiveness of funded programmes, and service providers need to know whether what they are doing is making a difference (p.238). Gardner (2003) suggests that in order to demonstrate effectiveness, services need to offer robust evidence that the service is achieving their stated aims in supporting children and families in ways which conform to, or exceed acknowledged practice standards, and at optimal cost (p.3).

The roots of evidence-based practice can be found primarily in evidence-based healthcare, but more recently in social work and child welfare. According to Gambrill (2003) and Cournoyer (2003), empirically-based or evidence-based practice within the social work area promoted a model of social work practice that was built on scientific evidence. A definition of evidenced-based practice suggests that it "indicates an approach to decision making which is transparent, accountable and based on careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities (MacDonald, 2001). As suggested by Rosen (2003), a growing evidence base emanating from the implementation of evidence-based practice can guide the development, implementation and evaluation of new programmes and practices.

Marsh *et al.,* (2005) propose six reasons why we need evidence from research within the knowledge base for social care:

1. **the major impact of decisions made on the immediate lives of services users, with a need for informed practitioners to achieve the best possible outcomes (for example, in child protection);**
2. **the impact over time of decisions on the lives of service users and outcomes achieved (for example, children in care);**
3. **good evidence may challenge assumptions in social care and bring about advantages to service users (for example, the evidence on the Family Welfare Conference model);**
4. **the importance of providing the best available evidence to inform statutory decisions about people's lives;**
5. **the need to inform the public so they can better engage in relevant debates about services;**
6. **evidence is needed to inform service users and carers. Direct involvement in the development and delivery of services requires access to evidence and knowledge (p.4).**

When discussing evidence-based practice, the core question is, of course, what constitutes evidence? Kazdin and Weiss (2003) define evidence as replicable procedures that have outcomes that can be reproduced by others. Within the scientific world, be it social or natural, the most reliable form of evidence is generated using a randomised control trial (RCT) where results lend support to actual effects of interventions by comparing them to outcomes of a control group. Others, such as Woody *et al.,* (2006) and Chaffin and Friedrichs (2004), suggest that evidence can also be generated from qualitative research studies, coherent theories and even from interaction with clients. There is also a growing move towards practice-based evidence where there is a more direct link between research and the direct experience of practice and practitioners (see www.practicebasedevidence.com and www.rtc.pdx.edu).

Table 2.1 is taken from Chaffin and Friedrich (2004). It contrasts an evidence based approach with traditional evidence informed practice. With the traditional approach, knowledge is generated from subjective experience, and assumptions about the outcomes are based on faith rather than on the empirically demonstrated outcomes generated by an evidence based approach. The views and experiences of stakeholders are taken into account and discussed to arrive at a conclusion about the value of a programme or service.

Table 2.1: Contrasting evidence based practice with traditional evidence informed practice

	Traditional evidence informed practice	Evidence based practice
1. Source of knowledge	Accumulated subjective experience with individual cases. Opinion about practice outcomes emphasised, "In my experience..."	Well designed, randomised trials and other controlled clinical research. Facts about practice and outcomes are emphasised. "The data shows that..."
2. Knowledge location and access	Knowledge is possessed by opinion leaders and experts. Charismatic expert driven.	Knowledge is available to anyone willing to read the published scientific research or research reviews. Information technology driven
3. Method of achieving progress	Haphazard, fortuitous, based on changing values, fads, fashions, and leaders	Systematic, predictable, based on incremental and cumulative programmes of outcome research
4. Practitioner expertise	Personal qualities and intuition	Specific, teachable, learnable skills and behaviour
5. View of practice	Creative artistic process with fluid boundaries	Creativity within the boundaries of the supported models and protocols
6. Research - Practice link	Indirect. Inferential	Direct. Integral and fundamental to practice
7. How research is summarised and applied to practice	Individual subjective practitioner synthesis of whatever literature is consumed	Best practices workgroup or collaborative summary based on exhaustive reviews of the outcome research and meta-analysis
8. Programme evaluation	Inputs (credentials of practitioners) and Outputs (number of clients served, number of service units)	Outcomes (measurable 'bottom line' client benefits)
9. Location of research	Mostly in laboratory settings and Removed from practice	In the field clients routinely enrolled in trials in order to test benefits and refine services
10. Quality control	Focuses on rationales for services and the credentials of whoever provides them	Focuses on how well services are delivered vis-à-vis a prescriptive protocol
11. Practice visibility	Actual practice is seldom observed by anyone other than the practitioner and the client	Direct peer or consultant observation of actual practice and specific feedback is common
12. Assumptions about outcomes	Service programmes in general are seen as good and are assumed to be beneficial	Knowledge that interventions may be inert or even harmful. Benefit must be empirically demonstrated, not assumed

Despite the obvious benefits of using evidence based practice, Chaffin and Friedrich (2004) argue that the full implementation of this approach into everyday practice faces a number of barriers. For example, funding is a key issue. Many funders of child-based programmes do not allow costs for adapting new technologies, initial training, supervision and quality monitoring. In addition, limited leadership within specific organisations may lead to no change occurring, further compounded by a lack of incentives that link rewards, such as funding, to client outcomes. These issues will be discussed further in Section 5 where the challenges involved in implementation and programme fidelity are considered.

2.3

A FRAMEWORK FOR LEVELS OF EVIDENCE

Veerman and Van Yperen (2007) suggest that many children and youth services programmes or services have not been sufficiently evaluated and that because of ethical issues and excessive costs most interventions will not be included in Randomised Control Trials. They present a model in which evidence generated from youth and family based projects could be categorised on a 4-point scale, ranging from minimum level evidence to the higher-end RCT gold standard level of evidence. They argue that it is not as simple as providing a Yes/No approach to all interventions with regard to their effectiveness. Instead, four different levels of evidence can be gathered and utilised.

The **four** levels are:

Level 1 – Descriptive evidence
This type of evidence involves a clear description of the core elements of an intervention, such as the goals, activities and target groups. The types of research that can generate this level of evidence range from analysis of documents to descriptive studies. When this descriptive evidence is generated, it can be very relevant to practitioners. It can provide an overview of the interventions, as well as providing an inventory of the core elements that can be communicated to clients, students, colleagues and managers more easily. Descriptive evidence can also provide information on the potential effectiveness of interventions.

Level 2 – Theoretical evidence
Theoretical evidence provides a more sophisticated and higher level of evidence for practitioners than descriptive evidence. With theoretical evidence, a sound theory is identified which underpins the intervention, as well as an identification of how and why this particular intervention will lead to specific outcomes. A well-articulated theory underpinning an intervention will help to explain why a particular course of action may be expected to be beneficial to a client. Reviews, meta-analyses and expert knowledge studies are the main types of research used in generating this level of evidence. Theoretical evidence provides a plausible explanation for the potential effectiveness of interventions.

Level 3 – Indicative evidence
Indicative evidence refers to a situation where a systematic evaluation shows desired changes have occurred with the clients engaged with the intervention. In most cases, a treatment may be considered successful when 95% of the clients are satisfied, in 90% of cases if the treatment goals are achieved and 80% of cases show behaviour within a range according to a standardised assessment instrument. However, at this level of evidence, it is still unclear which elements of the intervention cause the outcome(s). Nevertheless, research at this level can provide good preliminary evidence, when the data have been collected across multiple sites and the research has been replicated on a number of occasions.

Level 4 – Causal evidence

With causal evidence, it is possible to judge if a particular intervention is efficacious or not. The core question that this level of evidence can answer is whether the intervention itself has caused the outcome. An RCT or repeated case studies research approaches can reveal the elements of the intervention that are responsible for certain outcomes being achieved.

While this document primarily details programmes that have proven evidence base, the value of evidence informed programmes and services is also noted. Innovative responses to local need through locally designed and developed initiatives are a necessary and welcome feature in providing services across a continuum of need. Not all needs can or should be met through evidence based initiatives, and there is a high value in continuing with evidence informed practices that are viewed as worthwhile and effective by those providing them and by those in receipt of them. This is the spirit in which this document is intended. The development of a Children and Young Peoples' Participation Strategy which will provide a mechanism for feedback from children and young people (initially) is one way in which the CFA (Child & Family Agency) will be informed as to the effectiveness of programmes and services which are not subject to the higher levels of evidence gathering. Furthermore, the Commissioning Strategy outlines the requirement to continue local initiatives that are responding to local need; however, it also emphasizes the future need for all services to commit to a process of generating evidence with regard to achieving intended outcomes.

2.4

CONCLUSION

The emphasis for an evidence base in the delivery of support services is well underway. There is an expectation that services measure their outputs in terms of achieving defined outcomes for children. Furthermore, the distinction between evidence informed and evidence based practice is increasingly considered in recognising the relative worth of programmes or initiatives. This section has outlined the literature in relation to this debate and also presented the four-level framework used to present the different types of evidence - both evidence informed and evidence based. The requirement to recognise the value of local innovation in service delivery is also emphasised, with the expectation that in the future such services must generate evidence in relation to achieved outcomes.

The next section outlines what we mean by Family Support - an Irish definition and the accompanying practice principles and a theoretical basis. It also describes the typology that is used to categorise and differentiate the types and levels of supports provided to children, young people and their families.

3.0

WHAT IS FAMILY SUPPORT?

A clear understanding of the term Family Support is necessary to ensure a consistent approach in 'thinking about' and 'doing' Family Support. Murphy (1996) provided the first widely accepted definition of Family Support in Ireland, describing it as "the collective title given to a broad range of provisions developed by a combination of statutory and voluntary agencies to promote the welfare of children and families in their own homes and communities. These services are provided mainly to particularly vulnerable children in disadvantaged areas, and often include pre-school, parental education, development, and support activities, as well as homemaker, visiting schemes and youth education and training projects" (p. 78).

McKeown (2000), in his work on Family Support in Ireland, defined Family Support as an umbrella term covering a wide range of interventions that vary along a number of dimensions according to their target group, professional background of service provider, orientation of service provider, problem being addressed, programme of activities and service setting. Such diversity indicates that Family Support is not a homogenous activity but a diverse range of interventions (p.4). As Pinkerton (2000) suggests, "Family Support can be used as a synthesising term to create something which is more than the sum of the parts" (p. 218). To this end, the term 'Family Support' is used as an umbrella term under which clusters a broad range of family focused services and programmes.

The current definition used in an Irish context from a theoretical, policy, and practice perspective was developed on request for the [then] Department of Health and Children and describes Family Support as:

> "both a style of work and a set of activities which reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary and community and private services and are generally provided to families in their own homes and communities. The primary focus is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families, paying particular attention to those who are vulnerable or at risk. **(Pinkerton *et al.,* 2004, p.22)**

3.1

THE PRINCIPLES OF FAMILY SUPPORT

In the Irish context, Gilligan (1995) outlined the principles of Family Support and suggested that Family Support is about recognising and responding to the needs of families, especially during a time of difficulty. The family must define their own need or problem, and the necessary support must be available when needed. Logically, Family Support must be supportive; it must not be experienced as threatening, alienating or demeaning. It must be offered and available on terms that make sense in the lived reality of the service user. In practice, this will mean a low-key, local, non-clinical, unfussy, user-friendly approach. To be effective, it will be offered within 'pram pushing' distance and operate on a principle of consent rather than coercion. Families must be left with a clear sense of benefiting from their involvement, with the service presented in an enticing and attractive manner. Family Support should aim to enhance rather than diminish the confidence of those being helped. Of note, it will require professionals behaving as respectful allies, as opposed to patronising experts. Finally, Family Support needs to "wrap around" the particular circumstances and child rearing stage of the family (pp.71-72).

Linked to the 2004 work on definitions for the [then] Department of Health and Children, Pinkerton *et al.,* also developed a set of practice principles based on the national and international evidence available to inform practice. These principles are used in the current policy document on children's services and in the Irish literature on Family Support (the Agenda, 2007; Dolan *et al.,* 2006).

The **principles** of Family Support are:

1. **Working in partnership with children, families, professionals and communities;**
2. **Family Support interventions are needs led and strive for minimum intervention required;**
3. **Requires a clear focus on wishes, feelings, safety and well-being of children;**
4. **Family Support reflects a strengths-based perspective which is mindful of resilience as a characteristic of many children and families' lives;**
5. **Effective interventions are those which strengthens informal support networks;**

6. **Family Support is accessible and flexible in respect of timing, setting, and changing needs, and can incorporate both child protection and out of home care;**
7. **Facilitates self-referral and multi-access referral paths;**
8. **Involves service users and front line providers in planning, delivery and evaluation on an ongoing basis;**
9. **Promotes social inclusion, addressing issues of ethnicity, disability and rural/ urban communities;**
10. **Measures of success are routinely included to facilitate evaluation based on attention to outcomes for service users, and thereby facilitate quality services based on best practice.**

Chaskin (2006) suggests that Family Support practice principles operate on different levels. A strong value base is suggested (a strengths-based, inclusive perspective focused on prevention) with an overall conceptual guide to service provision advocated (strengthening informal supports and partnership) and promotion of concrete suggestions for practice (needs-led and flexible). The core principles under each of these levels, including prevention and early intervention, partnership, a strengths based approach and the provision of supports based on children and family's needs, are now further elaborated. The importance of communities is also discussed.

3.1.1

PREVENTION AND EARLY INTERVENTION

The role of Family Support in preventative services for children and families in Ireland is advocated in the national policy document, the Agenda for Children's Services (2007). This principle suggests that services use prevention and promotion, as opposed to treatment, as a model of practice and by doing so will achieve better outcomes for children and families (the Agenda, 2007; Sheppard 2009; Allen, 2011). Preventative initiatives deter the occurrence of problems before they become a negative factor in family functioning. As a means of strengthening and supporting family functioning, the Family Support approach asserts that a preventative model should be employed as opposed to a more treatment- or crisis-intervention approach.

Key goals of Family Support are to intervene early where there are difficulties, in order to prevent problems escalating, to strengthen families' capacities to nurture children and function well for all members, to integrate fragmented services and make them accessible to all families, and to encourage and enable families to solve their own problems. Prevention involves intervening early in the genesis of a problem or difficulty experienced, and also early in the life of a child where necessary (Daly, 2004; Families Matter, 2009; Munro, 2010; Barlow *et al.,* 2010; Allen, 2011; Munro, 2011; CES, 2012). As Allen (2011) suggests, one great merit of early intervention is that it can help families under stress to fulfill their mission of giving children a secure and loving space in which to grow. It can keep families together and save many from the trauma of break-up and removal (p.ix). There is a vast body of evidence available on the benefits of intervening early in children's lives (Allen and Smith, 2008; Field, 2010; Allen, 2011; Tickell, 2011). The role of prevention is not only to combat risk factors but also to enhance and promote the positives and opportunities for child development by maximising protective factors and processes (Frost and Parton, 2009; Allen, 2011; CES, 2012). Barlow *et al.,* (2010) emphasise a focus in universal service provision on preventing difficulties arising in the first instance. The CFA Commissioning Strategy refers to the need to provide responsive services across the continuum of need. This will include services focussed on prevention and early intervention as well as those offering more specialised services.

3.1.2

PARTNERSHIP AND PARTICIPATION

From both a policy and practice perspective, partnership with families and between key agencies has become the advocated approach (McKeown, 2001; Dolan, 2006; Families Matter, 2009; Munro, 2011; Task Force Report, 2012). A call for a change in the traditional relationship between service providers and family and community members has been noted for some time (Tisdall *et al.,* 2000; Higgins, 2000, Munro, 2011). As noted by the Agenda for Children's services: "effective protection of children and young people at risk or in crisis as well as the promotion of all children's well-being requires working in partnership with families. This principle is noted as particularly important when dealing with those children and families who are most vulnerable and most difficult to engage" (2007, p.17). Davis (2007) emphasises the need for dialogue between parents, children and service providers to ensure no one professional defines children's problems or the solutions to their life issues. In terms of a Commissioning process, the expectation for the CFA is that partnerships will be developed between children, young people and families through participatory structures.

In order to make positive changes in a child's life, the overall needs and context of the family have to be taken into consideration. Strategies that do not fully engage with parents and children are less likely to be effective (McKeown, 2001). Engaging effectively with parents requires skilled staff, which is described as the lynchpin of good practice (Lonne *et al.,* 2009). As Connolly (2004) notes, a constructive relationship involves an attitude of respect and liking for the parent, an understanding of their point of view, and the ability to establish common ground on which to base an intervention plan that accommodates the needs of the parent as well as the child (p.78). The Parents Support Strategy emphasises the need to treat parents as partners in the design and delivery of support services.

Nonetheless, it is also important to avoid pitfalls in a romanticised view of partnership when protecting children through statutory involvement. The potential in forming strong helping relationships with parents - while at the same time attending carefully and effectively meeting the needs of children requires recognition and understanding (Thorpe et al, 1988). As highlighted by Stevenson (1998), the general theme of partnership with parents is 'wholly admirable' in its desire to work with, rather than against, parents and to reduce the imbalance of power between parents and professionals. However, such ideals also pose problems in particular instances. For example, partnership with parents whose capacity is diminished for one reason or another may not be possible, no matter how well intended practitioners are (p.113).

Promotion of children's well-being at every level of service delivery also requires working in partnership with the appropriate agencies (McKeown, 2001; Pinkerton, 2001; the Agenda, 2007; Task Force Report, 2012). The importance of partnership and interagency co-ordination also exemplifies a move beyond organising services in 'silos,' and has been a regular core recommendation of public child care inquiries (Frost and Parton., 2009). However, inter-agency and inter-professional working in children services represents something of a conundrum because it is simultaneously seen as both the problem and the solution (Rose and Barnes, 2008; Fish *et al.,* 2008). While current policy may require increased communication and collaboration across agencies and professions, this is known to be a complex task where misunderstandings, omissions and duplications easily occur (Munro, 1999; Reder and Duncan, 2003; Fish *et al.,* 2008).
The Report of the Task Force on the CFA recommends that an integrated service delivery model be adopted within the CFA. This integrated model requires a full range of services and systems integration from universal services through to more targeted and specialised services. This integrated system includes linkages with both internal and external services that have children's wellbeing as their focus at all levels of need. Children's Services Committees (CSC's) are recommended as the key interface between core CFA services and other services. The development of CSC's provides a platform for interagency working (2012, p.38 -39).

3.1.3

A STRENGTHS BASED APPROACH TO WORKING WITH CHILDREN AND FAMILIES

A strengths based perspective is also considered a cornerstone of practice in Family Support (Saleeby, 1997; Gilligan, 2000; McKeown, 2001; Gardner, 2003). The Commission on the Family (1998) recommended an approach to practice which is " empowering of individuals and builds on family strengths" (p.16). Family Support has emphasised and focused on the strengths of individual and family members, in marked contrast to models which have attempted to correct weaknesses or cure deficiencies. Smith and Davis (2010) describe how a strengths based Family Support perspective advocates choice, participation, anti-discrimination and timeliness and employs approaches that put people's own solutions at the centre of service provision. As Buckley (2002) observes: "an important feature of Family Support is its facility to focus on strengths rather than problems" (p.9).

Saleeby (1997) argues the advantages of a strengths based approach to helping individuals, groups and communities to meet the challenges faced. In his research on Family Support in Ireland, McKeown (2001) highlighted a strengths based approach as a key factor in the success of the Springboard Family Support initiative. Ghate and Hazel (2002), in their research on 'Parenting in Poor Environments' highlighted the importance of building on the strengths of parents in need of support who have accrued multiple forms of disadvantage.

Advocates and promoters of Family Support have forcefully asserted that Family Support programmes acknowledge family strengths, build upon them, and promote the use of family strengths as a way of supporting family functioning and parenting capacity (Dunst, 1995; Gilligan, 2000). Dunst (1995) synthesised thinking on how to incorporate a strengths based approach in practice. This involved five premises:

- **A recognition of the fact that all families have strengths. These strengths are unique and depend upon culture, background, beliefs, and socioeconomic status;**
- **The failure of a family to display competence must not be viewed as a deficit in the family, but rather as a failure in the system to create opportunities for the competency to be displayed or learned;**
- **Work with families must be approached in a way which focuses on positive functioning rather than perceiving families as "broken" and "needing to be fixed". This approach requires acceptance but also valuing individual difference;**
- **A shift away from the use of treatment and prevention models as primary frameworks is necessary to promotion and enhancement models, consistent with strengthening family functioning;**
- **The goal of intervention must be viewed not as "doing for people," but as strengthening the functioning of families to become less dependent on professionals for help. This involves a shift away from the belief that experts should solve the families' problems and towards empowering families to master the challenges in their own lives (p.22).**

These five considerations collectively suggest an alternative to the deficit- and weakness-based approaches which have traditionally been present in service delivery, towards a proactive and positive approach that is truly supportive of families (Dunst, 1995; Gilligan, 2000).

In the UK, the 'Think Family' Report (2008), which aimed to provide a comprehensive support package to children and parents in 'families at risk,' also advocated that services should start with families' strengths. The Report recommends that practitioners work with families, supporting them to build up their aspirations and capabilities, so they can take responsibility for their own lives and support each other in the present and in the future (p.8). Recognising that such an approach cannot take place in a vacuum, a system-wide approach is suggested, with recognition that particular skills are needed by practitioners to confidently work with families in this way (pp.11 - 13).

3.1.4

SERVICES OFFERED TO FAMILIES BASED ON NEED

The delivery of Family Support services is inextricably linked to the concept of need. The needs of children should determine the extent and nature of services provided to them (Families Matter, 2009; Barlow *et al.,* 2010; Allen, 2011; Munro, 2011).). Thoburn at al. suggest that a key initial task in Family Support service delivery is to generate information on the needs of family members (2000). This approach entails a focus on need as identified by family members, as opposed to the needs identified by practitioners, and recognises the role and strengths of the family in both identifying and meeting their needs (Dolan and Holt, 2002). Pinkerton (2001) makes the point that children and families looking for a service should not be placed in routine categories. While some degree of consistency and categorisation may be necessary, needs viewed in this narrow way are only partially understood and responded to. In an effort to deliver this type of approach, the early intervention area-based initiative in the UK, 'Sure Start,' highlights 'meeting the needs of every family' as a provision in its first guiding principle (Frost and Parton, 2009, p.115). The 'Think Family' approach recommended that family centered packages are "tailored" to varying levels of need (2008, p. 8).

A needs led response involves the ability to be flexible in tailoring the Family Support practices to the particular circumstances of the families and communities in which they are based. As suggested by Harris, Family Support is likely to be more helpful when it mirrors "milk van support" (that is, daily, low key, routine), as opposed to "fire brigade support" (that is, once off, emergency, dramatic), and available over the long haul (1993, p.99).

3.1.5

SOURCES AND TYPES OF FAMILY SUPPORT

Based largely on social support theory, the sources of support for families are categorised as either formal, semi-formal or informal.

Informal supporters offering unpaid support include family, friends and neighbours, and provide the most desired type of support at times of difficulty or in a crisis (Dolan and Holt, 2002; Dolan *et al.,* 2006; Families Matter, 2009). Whittaker and Garbarino (1983) described the support within families as the 'bread and butter' source of help (p.4). In their study on parenting Ghate and Hazel (2002) found that 74 per cent of the sample had their primary source of support living in the same house or in very close proximity. However, where such support is non-existent, weak, or incapable of providing the help required, a person is more likely to turn to formal support sources (Dolan *et al.,* 2006).

Additionally, as Gardner (2003) cautioned, families can also be the main source of stress, prompting a need for external supports. Formal support refers to the services provided by professional agencies with paid employees, including state run and those run by voluntary organisations and offering both universal and targeted interventions. Semi-formal sources of support are described as organised supports received from community or neighbourhood based services, which are normally voluntary and do not have paid staff (Ghate *et al.,* 2002). Semi-formal support services may be thought of as complementary to informal supports.

Highlighted as one of the core principles of Family Support, the building and strengthening of informal support networks, and the provision of supports and resources in a flexible, responsive and individualised manner to meet the changing needs of families, is a prerequisite of practice. Building and strengthening informal support networks is viewed by practitioners and academics alike as being central to Family Support (Gardner,

2003; Sheppard, 2007; 2009). As Gardner highlighted in her research on parents' support needs, the greater the informal support network, the lower the degree of difficulty perceived by parents regarding their vulnerability, stress and ill-health. Conversely, the weaker their informal network, the greater their degree of difficulty (2003, p. 8). Reiterating this point, Sheppard's study on social support and parental coping showed a significant relationship between the adequacy of forms of support and positive outcomes. Those who consider their informal support network to be inadequate are liable to be particularly vulnerable, and their capacity to resolve their problems consequentially diminished (2009, p.1443).

Overall, the four most common types of support provided to children and families as identified in the literature are: concrete support, emotional support, advice support and esteem support (Weiss, 1987; Cutrona, 2000; Dolan *et al.,* 2006).

Concrete support is very visible and relates to practical forms of help, such as giving a lift, minding children or doing grocery shopping. Concrete support is sometimes also referred to as tangible support and typically can be measured in physical acts of helping between people with "an offer to do or provide" (Cutrona, 2000, p.112). As Gilligan (1991) observes: "Sometimes it is all too easy to lose sight of the fact that often what a family needs is immediate and tangible practical help" (p.171).

Advice or information support is referred to as guidance support, and relates to helping someone with a decision or giving him or her information on how best to complete a task or resolve a difficulty. Advice or information on child rearing practices or financial matters are everyday examples of this type of advice. Cutrona (2000) suggests that, grouped together, concrete and advice support can be thought of as "instrumental support" (p.112).

Emotional support is a more sensitive form of support and usually involves close relationships (Munford and Saunders, 2003). Typically, it is about being available for people we feel close to, listening to them if they are upset, and offering them unconditional positive regard.

Esteem support relates to how others rate and inform a person in respect of her or his worth and competency. An example of the provision of esteem support would be where a teacher encourages a child in her or his efforts, and expresses confidence in the child's ability. Together, emotional and esteem support can be conceptualised as "nurturant support" (Cutrona, 2000, p.112).

3.2

COMMUNITY AS CONTEXT FOR FAMILY SUPPORT

Although it is just one element of a Family Support principle, community is a fundamental component in the context of delivering Family Support services. Community contexts provide a set of risk and protective factors that have an influence on the wellbeing of community members (Chaskin, 2008). From a Family Support perspective, McKeown (2000) notes how a community development focus addresses the contextual factors that impinge on, and often exacerbate, the problems of vulnerable families. Building on this viewpoint, Gilligan (2000) points out that Family Support is about mobilising support "in all the contexts in which children live their lives" and "counteracting the corrosive potential of poverty and other harm that can befall children in disadvantaged communities" (p.13).

Community development is about building communities through collective strategies on common issues. As a field of practice, Family Support has, for the most part, been characterised by the development and delivery of a diverse set of services, by a broad range of practitioners and organisations in local communities. Such service provision is intended to be flexible, responsive and interactive (Chaskin, 2006; Families Matter, 2009). A key assumption in this orientation is the importance of community in the lives of families.

In describing the relationship between Family Support and the community, Weiss (1987) noted: "in addition to working with the family the programmes now increasingly recognise the importance of creating and reinforcing links between families and external sources of support, both formal (local social and health services) and informal (opportunities to meet neighbours and utilization of natural helpers in programmes)" (p.139). This reflects the fact that Family Support programmes emphasise the identification of need, locate informal and formal community based resources for meeting those needs, and assist families in using existing capabilities, as well as learning new skills necessary for mobilising community based resources. Family Support programmes employ practices that intentionally lead to programmes being assimilated into the "community life" of the families served by these programmes (Families Matter, 2009).

3.3

A THEORETICAL BASIS FOR FAMILY SUPPORT

Family Support, as an approach, is not based upon one theoretical foundation. Rather, it is underpinned by an amalgam of a number of distinct theories from the social sciences. In reviewing the literature the theories that are deemed to have particular resonance in considering positive family functioning and informal Family Support include: social support, resilience, attachment, social ecology, and social capital.

3.3.1

SOCIAL SUPPORT

Social support is a central feature of life and generally refers to the acts we perform in order give or get help. The role of social support as a proven buffer to stress is well established in the literature (Eckenrode and Hamilton, 2000; Ghate and Hazel, 2002; Gardner, 2003). Dolan *et al.,* (2006) suggest that there is a clear link between social support theory and the practicalities of supporting families. Research has indicated that children who can access practical, emotional, advice and esteem support from others are more likely to be strengthened in their coping capacity (Pinkerton and Dolan, 2007). In order to illustrate the relevance and connection of social support theory to the Family Support field, the sources, types and qualities associated with social support are elaborated on.

In the main, social support is accessed through informal social supports (naturally occurring relationships with family and friends). However, there are times and instances where more formal supports (through service based or professional relationships) are necessary (Thompson, 1995; Gilligan, 2000; McKeown, 2001; Gardner, 2003; Dolan *et al.,* 2006). For a young person striving to overcome adversity, where there is at least one reliable adult responsive to his or her needs in terms of tangible support, he or she will be more likely to be successful. Such a relationship is typified by the adult believing in the young person and is best housed within a strong emotional connection (Cutrona, 2000). Informal support is also preferred as it is natural, non-stigmatising, cheap and available outside of 'nine to five' (Gilligan, 2000; Gardner, 2003) . Thus, the best kind of Family Support may be to facilitate and support the flow of support within the immediate and extended family unit, assuming there is a close relationship that can be nurtured (Cutrona, 2000). A key issue in providing support is the extent to which the level and type of difficulty experienced is related to the need for, and adequacy of, support. As Sheppard highlights: "support, problems and needs are close conceptual companions" (2004, p.944). A core task of an assessing worker involves a focus on the social support network and the extent to which this is enacted and available to family members. Apart from the source and timing of social support on offer, the quality of the actual support received is also important. Support is, in essence, positive in its nature and must be offered in a positive and giving fashion in order to be perceived as helpful, and truly benefit the recipient.

3.3.2

RESILIENCE

For everyone life throws up difficulties and challenges. Some experience these difficulties, cope with and are strengthened by them. Others, as a result of the absence of the necessary problem solving skills or self belief, find it too difficult to manage these situations. Resilience is a person's ability to withstand stress and the ability to be positive, optimistic and stronger as a result of life experiences, whether positive or negative (Rutter, 1985). Resilience refers to a dynamic process of positive adaptation within the context of significant adversity (Luthar *et al.,* 2000). While there are a number of definitions for resilience, Masten's (2001) assertion that resilience represents "good outcomes in spite of serious threats to adaptation or development" (p.228) holds strong among a broad audience of policymakers, practitioners and academics, and has resonance for Family Support.

Resilience is found to be a critical resource in coping with everyday challenges (Ungar, 2005). Rutter noted that "good relationships outside the family can have the protective effect similar to that which apparently stems from within the immediate family" (1984, p.139). Factors identified by Rutter (1985) as associated with resilience include a sense of self esteem and confidence, a belief in one's own self efficacy and an ability to deal with change and adaptation, and a repertoire of problem solving approaches. Theorists have identified factors that help a person to become resilient. They include competent parenting, the availability of a close social support network, a positive educational experience, and a sense of self worth. Good relationships with pro-social adults and an ability to problem solve and make sense of what is happening are critical factors in promoting resilience (Seden, 2002).

3.3.3

ATTACHMENT THEORY

Forming close attachment to a care-giving figure is regarded as perhaps the most important early social relationship (Howe 2005, p. 45). Attachment theory involves the study of human relationships, particularly early formative relationships, and holds that it is imperative for infants to form attachments, asserting that they exhibit behaviours to promote such attachments. The quality of such relationships and attachments informs emotional functioning and personality development throughout childhood, adolescence and on into adult life. Fahlberg (1994) defines attachment as an "affectionate bond between two individuals that endures through space and time and serves to join them emotionally" (p. 14).

Attachment behaviour is activated when children are stressed and fearful and seek the proximity of a familiar adult who becomes an attachment figure. Children who do not have a consistent and positive response from attachment figures from an early age (six months and earlier) are likely to develop problems in their emotional and social development (Howe *et al.,* 1999; Aldgate and Jones, 2006). A lack of secure attachment is correlated with emotional distress, antisocial and aggressive behaviour, and feelings of rejection and incompetence. How children learn to develop such attachments influences their emotional and social development, including their perception of who they can trust and build positive relationships later in life. Attachment theory also adds to the understanding regarding how the developmental wellbeing of children and adults can be recovered within good quality close relationships (Howe *et al.,* 1999). Furthermore, secure attachments create a context in which resilience can be developed (Connolly, 2004).

It is, however, too simplistic to say that it is the parent or primary carer who is fully responsible for children's well-being. Children are influenced by many others in their ecology, including other family members and significant others outside the family. As Green suggests: "attachment describes a crucial part of the parent-child relationship, but it is not the whole" (2003, p.1).

Applying attachment theory to the lifespan provides an understanding of why those who have suffered adverse relationships in the past go on to find relationships difficult in the future, with parents, peers, partners, children, neighbours and figures in authority (Howe *et al.,* 1999, p.293). Although it is not inevitable that children raised in adversity will, in their turn, become parents who raise their children in adversity, there is an increased risk that those who have suffered poor care giving will become poor care givers. The intergenerational transmission of insecure attachment styles, problem behaviours, and social incompetence is strong (Howe, *et al.,* 1999, p.293). However, Family Support can intervene by introducing positivity to the relationship between parent and child, supporting problem solving and the building of social skills in an effort to discontinue such intergenerational patterns. Supportive interventions to improve the quality of care throughout childhood and, critically, in the early years of a child's life, can work towards preventing difficulties in later life and promote healthy relationships. Attachment theory supports an understanding of how the developmental wellbeing of children and adults can be recovered within good quality close relationships through supportive initiatives.

3.3.4

SOCIAL ECOLOGY

The principles of Family Support are firmly embedded in the ecological perspective that recognises that the family is a system where the care, protection and development of children, among other functions, are facilitated. However, families do not exist in isolation, and they are both affected and influenced by their surrounding environment. Essentially, the social ecology theory proposes that there is an interdependent relationship between the individual and the environment (Bronfenbrenner, 1979; Garbarino, 1992; Kemp *et al.,* 1997; Jack, 2000), which must be considered when supporting children and their families.

In Bronfenbrenner's ecological model (1979) the individual is viewed as dynamic and growing, and there is reciprocal interaction between the individual and his or her environment. Critical inter-related factors in a person's environment include: family members (both nuclear and extended), institutional systems such as neighbourhoods, schools and workplaces and the more indirect influence of society at large including norms, beliefs, laws and culture. These distinct domains include the places people inhabit, the people that are there with them and the things they do together on a regular basis. At a young age this involves mainly home and family, but as a child grows and becomes more independent this moves to involve wider relationships with neighbours, school friends and work colleagues.

The ecological perspective is closely linked to the concept of social capital. The more embedded the family is across the levels of the eco-system, the greater will be their social capital. The benefits or 'capital,' which they accrue from involvement with networks, includes support for themselves, activities and opportunities for children, and supervision of children by people outside the family. Families who are not integrated across the levels of the eco-system can be isolated and have trouble functioning.

3.3.5

SOCIAL CAPITAL

Social capital refers to the assets of daily living, including goodwill between people, fellowship, mutuality and social intercourse (Feldman and Assaf, 1999). An original pioneer of social capital, Hanifan (1916), describes social capital as "those tangible assets that count most in the daily lives of people" (cited in Coleman, 1988). Social capital refers to the social connections and networks between people based on principles of shared norms, trust and reciprocity. It is created by people's actions, and is not located in individuals, organisations, the market or the state, although all can be involved in its production (Bullen and Onyx, 2001). According to Coleman (1988), family social capital refers to the relationship between parents and their children, and encompasses the time, effort, resources and energy parents invest in their children. As Putnam summarises: "social capital keeps bad things from happening to good kids" (2000, p.296).

As a concept, social capital is firmly embedded in the ecological and social support network theories (Dolan, 2008). Thompson links social capital to wider community networks, describing it as "the integrated, structured, mutually supportive relations between individuals within a community - necessary for productive activity and growth" (1995, p.116). Coleman (1988) describes this as 'exterior' or 'community' social capital, representing the family's interactions with the surrounding community, residents and local institutions such as schools. Social capital can play a role in promoting the resilience of community members and responding to the threats or opportunities that have collective implications for community well-being.

The concepts of bridging and bonding social capital, in particular, have been used in the context of community based Family Support services. Bonding social capital refers to the close ties and strong localised trust that characterise relationships in many communities, while bridging social capital is characterised by weak ties by people who are not close. The concept of social capital underpins the Family Support approach, particularly in community-based settings where the local supportive networks are created or enhanced in an effort to build up bonding social capital (Jack, 2000).

3.4

A FRAMEWORK FOR FAMILY SUPPORT SERVICE DELIVERY

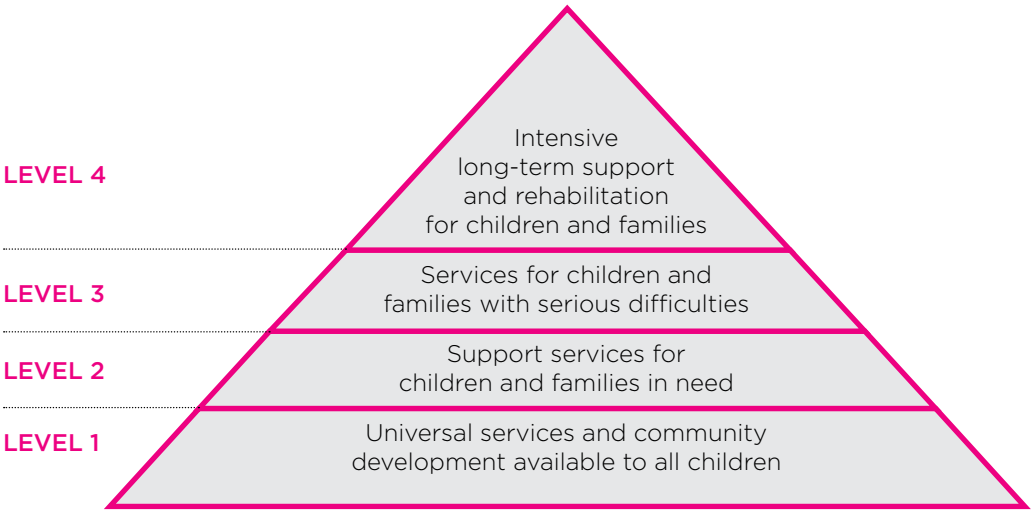
The delivery of welfare services is now generally organised into typologies or frameworks, in an attempt to categorise and differentiate the types and levels of supports provided. Interventions are typically located on a continuum - from universally available preventative services to more targeted protective and specialised services (Colton *et al.,* 2001; Task Force Report, 2012).

In 1986, Hardiker, Exton and Barker were commissioned by the Department of Health and Social Security in the UK to "take one step back and undertake an exploratory study on preventative practice to prevent family breakdown or the need to take children into care" (1991, p.168). In doing so, Hardiker and colleagues developed a model to illustrate how services can be provided at different levels, in response to the stages of problem development.

The four level model conceptualises children and family services as meaning something different according to the different levels of need and associated services and interventions.

At the primary level, there are universal services provided with a promotional role that are available to all children and families in an accessible and localised format. As a child or young person presents with an identified level of need, the services available at the secondary level are targeted to vulnerable families, groups and communities. Much of what is understood as preventative child care services is framed within this level. At the tertiary level, the services are more specialised, and focus on children with a high level of need and risk who are at risk of requiring a care placement. Where, in spite of the input of the preventative services, residential or therapeutic placement is needed, such services are provided for children at the quaternary level of the framework. The aim at this level is to minimise damage to the child, and prevent long separations from their families (1991, pp.46-49). This framework is currently applied to categorise services provided within the Irish context (the Agenda, 2007; Implementation Plan, 2009; Task Force Report, 2012) and is referred to in the Commissioning Strategy with a requirement to provide services across the continuum of care (i.e. across levels 1 -4). As children's needs vary in complexity and intensity, the formal support services provided to meet their needs must adapt in complexity and intensity when necessary.

Figure 1: Levels of support for children and families



In the Irish context, Gilligan (1995a; 2000) suggested a three-category Family Support framework for service delivery, as illustrated in Table 2.1. The first is that of developmental Family Support, which seeks to strengthen the social supports and coping capacities of children and adults in the context of their neighbourhood and community. This type of Family Support is not problem-focused and is available to all who are experiencing the everyday challenge of parenting. Youth programmes, personal development groups, and parent education groups are included in this category. Secondly, compensatory Family Support seeks to compensate family members for the negative or disabling effects of disadvantage or adversity in their current or previous experiences. Examples of such support includes childcare centres, school attendance and completion programmes, targeted youth services, and parent support groups. Protective Family Support is the third category, which seeks to strengthen the coping and resilience of children and adults in relation to identified risks or threats experienced in families. Protective Family Support programmes include: respite fostering, refuges and support groups for those experiencing domestic violence, behaviour management programmes for parents who have difficulty with children's behaviour, home management and budgeting skills, and intensive youth work groups focused on issues such as bullying and self esteem (1995a, p.66; 2000).

Table 3.1: Categories of Family Support

Category of support	Developmental	Compensatory	Protective
Aim of the support	Strengthen the social supports and coping capacities.	Compensate famillly members for the negative or disabling effects of disadvantage or adversity.	Strengthen the coping and resilience of children and adults in relation to identified risks or threats.

Merging Gilligan's categories (2000) and Hardiker's (1991) levels into a new and developed conceptual framework illustrates the potential to meet children and families' needs across the range of levels, with an array of services provided across the three categories, by a range of disciplines working on behalf of children and families (Family Support Strategy, 2011). Again, this framework of services delivery, illustrated in Table 2.2, needs to be fluid, enabling children and their families to avail of services across the levels and at varying stages and intensities (the Agenda for Children's Services, 2007; Devaney, 2011).

Table 3.2 Categories of Family Support across levels of need

Categories of Support	Levels of Needs
Protective	Supports and rehabilitation for children and families with established difficulties and serious risk **Level 4**
Compensatory	Services for children and families targeting early difficulties and significant risk **Level 3**
Developmental	Support for children and families in need **Level 2**
	Universally available service **Level 1**

3.5

CONCLUSION

In sum, the theories of attachment, social support, resilience, social ecology and social capital are suggested as a theoretical basis for Family Support with the main points on each theory reviewed. Family Support is a clearly defined orientation with an accompanying set of practice principles applicable across the four levels of service provision and with a developmental, compensatory or protective focus, as required.

4.0

EXAMPLES OF EVIDENCE BASED PROGRAMMATIC INITIATIVES

4.1

INTRODUCTION

The range of Family Support services being offered both within and outside of Ireland includes pre-school interventions, school based programmes, parenting programmes and more targeted services for families with particular difficulties. Many Family Support services or programmes have strong theoretical bases which clearly outline what aspects of family functioning are to be addressed and how change is to be effected.

Programmes with explicit implementation processes have been most extensively evaluated. Such programmes are somewhat easier to evaluate as they will have more measurable outcomes that are easier to define and compare with other, similar, programmes. However, there are also many more loosely defined programmes that have vague definitions of purpose and therefore are less likely to be suitable for thorough evaluation in terms of either the process of implementing the programme or measuring outcomes for the families involved. These points need to be kept in mind when interpreting results from evaluations of Family Support services, and pertinent caveats are explained where appropriate throughout the following review.

In order to distinguish between Family Support approaches and the evaluations reviewed here, a number of parameters were used to group them. These included: the theoretical basis of the support programme/intervention; the level of risk at which they are aimed; and the age group that is the target of the programme . The amalgam of Family Support theories outlined above and the 'Hardiker' framework were both applied.

4.1.2

EVIDENCE BASED PROGRAMMES & INITIATIVES

The literature on evidence based programmes and initiatives are presented in three separate sections[2]:

1. **The first section includes universally available services that are provided to children and parents and services aimed at those with a low level of need (Hardiker levels one and two). The programmes and services are presented according to age, ranging from those provided to very young children and their parents to programmes for parents of teenagers;**
2. **The second section includes programmes and initiatives provided to children, young people and families with a higher level of need (Hardiker levels two and three);**
3. **The final section outlines programmes provided for specific populations or to respond to specific needs.**

Examples of programmes in all three sections are both national and international. Where programmes are delivered in the Irish context this is specifically highlighted.

2 The data sources and search terms used are outlined in Appendix 2.

4.2

LEVELS ONE AND TWO: UNIVERSAL SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

The services outlined below as universal services include general parenting programmes and early intervention programmes that are universally available but tend to focus on those families thought to be in greater need of such interventions. The term 'early intervention' can refer to two types of intervention: programmes aimed at younger children to stem difficulties before they cause more long-term problems, and interventions aimed at tackling problems in children of any age at an early stage of a particular problem.

For younger children many of the interventions are targeted at parents. Some also include a pre-school or primary school strand, and for older children there are a number of intervention programmes delivered through schools and aimed at preventing problems in adolescents. The initiatives and programmes included in this section are listed below in Table 4.1. The programme, the mode of delivery and the locations in which it is currently delivered are outlined.

Table 4.1: Level one and two programmes

FAMILY SUPPORT INITIATIVES & PROGRAMMES			
Name	**Target group**	**Mode of delivery**	**Location where delivered**
Preparing for Life	Parents of 0 -5 yrs	Centre & home based	Ireland
Community Mothers	Parents of 0 - 2ys	Home based	Ireland
Nurse Family Partnerships	Parents of 0 - 2ys	Home based	USA & UK
HighScope/Perry Pre-School Projects	0-5yrs	Pre-school based	USA & UK
Lifestart	Parents of 0 -5 yrs	Home based	Ireland, N Ireland, Macedonia & Zambia
Sure Start	Parents of 0 -5 yrs	Centre based	UK & Northern Ireland
Roots of Empathy	Senior infants, first & fifth class	School based	Ireland, N Ireland, UK, USA, Canada, New Zealand, Isle of Man
The Marte Meo method	Parents of 0 - 18 yrs	Home based	Ireland, UK, Europe, Asia, USA, Australia
Families and Schools Together	Parents of & 6 -13 yrs	School based	Australia, UK, USA, Netherlands & Germany
Als Pals	3 – 8 yrs	School based	USA and Canada
Triple P*	Parents of 0- 16 yrs	Centre based	Ireland, Australia, USA, UK, Canada etc
The Incredible Years	Parents of & 0 – 12yrs	Centre and School based	Ireland, USA, UK Australia, , Canada etc
Flying Start	Parents of 0 – 3 yrs	Home based	Wales
Strengthening Families (10 -14)	Parents of 10 – 14 yrs	Centre based	Ireland, UK, USA, Spain, Norway etc
Parenting Ur Teen	Parents of adolescents	Centre based	Northern Ireland
Teen Parents Support Initiative	Teenage Parents	Centre & Home based	Ireland

* Although typically provided to families with need categorised as level one or two Triple P is also provided to families with a higher level of need.

Preparing for Life (Ireland)

Preparing for Life (PFL) is an early intervention programme based in North Dublin that aims to improve life outcomes for parents and children by intervening during pregnancy until the child starts school. Preparing for Life is jointly funded by Atlantic Philanthropies and the Office of the Minister for Children and Youth Affairs and is part of the Prevention and Early Intervention Programme for Children (CES, 2012).

This programme is in the process of being fully evaluated using longitudinal RCT approaches along with implementation analysis (UCD Geary Institute, 2011). Currently, findings from the six-month follow-up of the evaluation are available, using randomised allocation of families to either a high support treatment group (115 families) or a low support treatment group (118 families) and a no treatment comparison group (99 families). The programme involves providing access to preschool, developmental toys, public health workshops and provision of a support worker. Those in the high support group also receive home visits and take part in the Triple P parenting programme (see p. 35 for further information on Triple P).

Initial findings from this first stage evaluation report show that when comparing the two treatment groups, those in the high support group showed greater improvements in child immunisation, better eating habits and higher quality parent-child interactions. For mothers in the high treatment group they showed better health, lower levels of parental stress and better quality of life in their home environments. Other measures in the study showed insignificant differences between the two treatment groups, although - as hypothesised - those in the high treatment group appear to be improving at a greater rate than the low support group. Comparisons of the low treatment group to the control group show modest, though not significant, differences in measures of home environment, social support and income levels. There is some suggestion that the benefits of the programme are more pronounced for some groups than for others, a factor that will be investigated more fully as the evaluation progresses. While still at an early stage of the full evaluation, this six-month report shows tentative, positive findings for the programme.

Community Mothers (Ireland)

The Community Mothers intervention has been established in Ireland for a number of decades. Trained volunteers visit new mothers in disadvantaged areas to offer support and advice on issues around health and wellbeing. While few evaluations of the effects of the programme have been carried out, at least one RCT was conducted in 1990 which was later followed up seven years after the intervention (Johnson, *et al.,* 2000). As the focus within the Community Mothers scheme is to improve general health outcomes for children and to foster positive parenting attitudes, outcome measures included levels of immunisation, attitudes toward parenting and whether parents read to their children and oversaw homework. Benefits that emerged from the initial RCT were seen to be maintained at the seven year follow-up which compared two groups of 38 families - one control group and one intervention group. Positive outcomes for the intervention group include higher levels of immunisation, spending time reading to children and checking homework, visiting the library and endorsing more positive statements relating to their children and being a parent. The Community Mothers scheme shows that trained volunteers can effectively deliver interventions to those at low risk or disadvantaged which are maintained over time.

Nurse-Family Partnerships

The Nurse-Family Partnership programme for supporting vulnerable first time mothers was developed in the US by Professor David Olds and has been evaluated through a number of RCTs since its inception there. The programme is targeted at first time mothers who are at some risk of negative life outcomes due to poverty and low levels of education and is implemented from pregnancy to early toddlerhood. In the UK the programme is offered as the Family Nurse Partnership and has been rolled out across the country. However, outcome evaluations for the UK have not been conducted to date. Delivered by public health nurses, the programme aims to improve life outcomes for both parents and children in terms of health, education and socio-emotional development. The programme involves intensive home visits starting in early pregnancy by an individual public health nurse

who uses a strengths based approach to improving health and family functioning.

The research evidence for the effectiveness of this programme is primarily based on three large scale RCTs in the US, and long term follow-up studies are continuing based on these (see www.nursefamilypartnership.org for a review of current research). From these and other, less rigorous studies a number of positive outcomes for children and parents have been found:

- **Better overall health of mothers, including a decrease in prenatal smoking, lower levels of hypertension and fewer closely-spaced subsequent pregnancies;**
- **Fewer injuries in children and reductions in child abuse and neglect compared to control groups and over the long term at follow up;**
- **A reduction in infant mortality due to premature birth, sudden infant death syndrome and injuries;**
- **For children of mothers with psychological difficulties (e.g. anxiety, depression), educational outcomes were better compared to a control group in terms of language development and test scores;**
- **For parents, studies showed an increase in the rate of employment of mothers and greater involvement of fathers in childcare.**

So far the only RCT type studies that have been conducted on this programme have been based on US populations. While the findings show positive outcomes for both children and parents across a range of important life markers, further evaluations of the programme in other countries would show if these outcomes can be seen in other cultural and policy contexts as well as in the US.

HighScope/Perry Pre-School Projects

The HighScope Curriculum is an early pre-school initiative aimed at young children from birth to 5 years old. It was developed in the US in the 1970s and has since been expanded to a number of other countries including Ireland and the UK. The aim of the programme is to develop social, emotional, cognitive and physical development through an evidence based curriculum that supports learning through activity. The programme is open to children from all backgrounds, although reviews of effectiveness tend to focus on the advantages it offers to those from disadvantaged backgrounds.

A unique feature of the curriculum is the 'plan-do-review' aspect whereby children independently plan what they will do, carry out their plans and then review what they have done with adults or other children. Classrooms are structured so that there are individual areas for different types of activities. In addition, there are a number of adult led activities that can be individual or group based. A number of evaluation studies have been carried out on the effectiveness of the programme, and these have been reviewed by the National Registry of Evidence-based Programs and Practices (NREPP), which include international research papers, although the majority of this is from the US (see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=18 for details). Accumulated evidence for the programme shows a number of positive outcomes for children including:

- **By the end of the second preschool year, children in the programme showed significantly better vocabulary scores compared to a non-intervention group, although the effects of these differences were not maintained up to seven years old;**
- **A further study did show long term benefits of the programme which measured educational achievement compared to those who didn't receive the intervention; this study showed small effects for higher levels of reading, vocabulary and arithmetic achievement through school up to age 14;**
- **Programme participants were also more likely to graduate high school compared to non-participants;**
- **Other long term effects showed that participants were both more likely to be employed up to age 40 and had higher earnings than those not involved in the pre-school programme at ages three and four.**

- **Arrest rates for those involved in the preschool programme were also lower for adult crimes in comparison to non participants, although there were no differences for juvenile crimes. This measure was also carried out up to age 40.**

Overall, the programme shows promise for both short term and long term positive outcomes for children who receive the intervention. The most popular evaluation study is that of the Perry Pre-School Longitudinal study which followed participants up to age 40 who were compared to a similar group not involved in the programme. This is one of the few programmes that has been reviewed over a long time frame, and it is useful to see how early interventions such as the HighScope curriculum can have lasting effects on children long into adulthood.

Lifestart (Ireland)

The Lifestart Curriculum is a month-by-month programme of holistic child development, delivered to parents of children aged up to five years, in their own homes. It consists of age-appropriate information supported by art, story, music and movement resources that are tailored to suit each individual child and family. The curriculum is delivered by Family Visitors trained in such areas as child development, confidentiality, language, boundaries, art, story, movement, play and presentation and delivery of information. The primary impact of the Lifestart programme is on parenting outcomes which in turn impacts positively on child development outcomes. Outcomes for parents include increased knowledge, competence and parenting skills and enhanced wellbeing and self-esteem. Lifestart aims to build confidence by reassuring parents about the normal phases of child development and by supporting them throughout the ups and downs of parenting (Mc Clenaghnan, 2012).

In 2005 the Lifestart Foundation drew up a strategic plan for the future development and growth of Lifestart service provision and acquired resources from Atlantic Philanthropies to begin a longitudinal evaluation of the Lifestart programme's impact. A pilot evaluative study was carried out in 2005-2006, and a revised development strategy and methodology for the full scientific testing of Lifestart outcomes was agreed in June 2007. The study, which is being conducted by the Institute of Childcare Research and the Department of Education at Queen's University Belfast, is using a fully experimental methodology based on a 500-family randomised control trial (RCT). The study will also include a qualitative dimension aimed at aiding the interpretation of the RCT results. The recruitment of families to the RCT began in the North Donegal area in May 2008 and has subsequently been rolled out over all Irish project areas. Base-line testing of families began immediately after the initial launch, and many families have already been allocated to projects for programme delivery. Developmental outcomes of the 500 children whose families are participating in the study will be measured on three occasions – at entry, at ages 2 and 5 years, and the results of those to whom the Lifestart programme has been delivered will be compared with those of a control group who have not received the programme (Mc Clenaghnan, 2012). The evaluation is scheduled to be completed in 2015 with interim findings published in 2012 (See http://www.lifestartfoundation.org/ for further information).

Sure Start

Sure Start is a government funded early intervention service originally introduced in the UK and Northern Ireland that targets particular geographical areas that are characterised by high levels of poverty and unemployment. The programme is aimed at parents to be and parents of children up to primary school age. The main aim of the programme is to improve outcomes for children at risk of social exclusion through poverty by providing childcare for all children, improving health and emotional wellbeing of children and supporting parents. Rather than having a particular programme, Sure Start aims to change existing services usually by filling gaps that are missing in these services (National Evaluation Report, 2005).

As a locally based initiative, Sure Start is provided as a community based project adapted to meet local needs and involve communities in effecting change in their own areas. A range of services are on offer including outreach and home visiting, family

support, childcare support, health care and, support for children and families with special needs. A national evaluation of the programme assessed outcomes for over 3,500 families with children under seven years old in the UK who have used the service compared to almost 1,500 families in disadvantaged areas who have not availed of the service (National Evaluation, 2012). Findings show that for 15 outcomes measured four showed significant effects: fewer harsh discipline practices, more stimulating home learning environments, less chaotic home environments (for boys only) and better life satisfaction (for lone parents and workless households only). No significant effects were shown for educational or behavioural outcomes for children.

In terms of educational benefits for children, by age seven all children, whether involved in the programme or not, would have received equivalent primary school education which may have diminished any differences between groups on this measure. As each Sure Start centre will be based on particular needs of the community that it is based in, it is difficult to determine the aspects of the intervention that may help to improve child outcomes alongside the reported effects on parental and home environment outcomes. A larger scale study that could compare educational outcomes for Sure Start service users with children from less disadvantaged areas would help to determine whether the service does improve 'school readiness' for children and helps to equalise educational progress across groups.

Roots of Empathy (Ireland)

Roots of Empathy is an evidence-based classroom program that has shown significant effect in reducing levels of aggression among school children while raising social/emotional competence and increasing empathy. The Roots of Empathy programme involves a local parent and baby (who is two to four months old at the start of the school year) visiting a classroom nine times over the school year. In this innovative approach, the baby is the teacher. Children observe and learn to understand the perspective and emotional life of the baby and are then guided by the specially trained instructor to link this learning to their own lives. The instructor also facilitates 18 additional classroom sessions to complement the babies' visits. The students gain deeper insight into their own and others' emotions and into the impact of their behaviour on others. In Ireland, the programme is currently delivered in a number of primary schools (senior infants, first class and fifth class) in collaboration with either the HSE or Barnardos.

Since 2000, there have been nine independent evaluations of the effectiveness of Roots of Empathy, as well as two reviews of the program as a whole. Overall results showed that compared to comparison groups, Roots of Empathy children demonstrated:

- **Increase in social and emotional knowledge;**
- **Decrease in aggression;**
- **Increase in prosocial behaviour (e.g. sharing, helping and including);**
- **Increase in perceptions among students of the classroom as a caring environment;**
- **Increased understanding of infants and parenting;**
- **Lasting results.**

For more information on Roots of Empathy see; www.rootsofempathy.org and www.rootsofempathy.org/documents/content/ROE_Research_Report_09.pdf

The Marte Meo method (Ireland)

The Marte Meo method was developed as a practical model for promoting new parenting and child rearing skills in daily interaction moments. It was specifically designed for both parents and professional caregivers to support their care giving roles. Through the use and analysis of video-pictures that record normal daily interaction moments in naturalistic settings (the family home), Marte Meo therapists enable parents to see their reality, including their strengths. The therapist offers step by step guidance on specific behaviours, checking if a new behaviour is working and providing opportunities for parents to see positive outcomes of their enhanced parenting skills. The Marte Meo Method looks at moments of interaction in daily situations between parent and child, professional and parent. The central focus of the method is to identify, activate and enhance constructive

communication, interaction and development for the child, family and professional. The method involves an interactive solution-focused programme. The programme can be offered as part of a range of therapies for parents with children with autism, Asperger, or behavioural problems. Specifically, through the Marte Meo method, the HSE provides a therapeutic programme for parents that helps them to build on their own strength as parents. There are occasions when the programme is sanctioned as part of a child protection response by statutory agencies.

A qualitative evaluation of Marte Meo in Ireland was conducted between 2009 and 2011 with a total of eleven parents interviewed in one-on-one interviews. The method has proved particularly useful for parents, including foster and adoptive parents, equipping them with the knowledge and skills to support the emotional, intellectual and social development of their children. It is effective in facilitating attachment between children and their parents, while at the same time equipping parents to be more confident in their parenting skills. Parents reported growing in confidence in applying the Marte Meo learning over the time of the therapy and subsequent to it (Clarke, Corcoran & Duffy, 2011).

Families and Schools Together

There are a number of programmes that operate on an after-school basis with the aim of involving parents or the whole family in engaging in activities together. One such programme is an eight week intervention called Families and Schools Together that has been implemented in a range of countries including Australia, the UK, the Netherlands, Germany and the US (UNDOC, 2009). The programme tries to involve all families registered in primary school (children aged 6 to 13 years old) which allows for new students and traditionally marginalised groups to interact with other families in their communities. The programme involves all members of a family coming to the school after school hours for a meal together and a number of designated activities led by trained facilitators. Older children may also have group activities led by older adolescents. Based on a number of theoretical bases, including social learning and attachment theories, the programme aims to strengthen family bonds and reduce family stress.

As each new programme is required to undertake pre- and post-test evaluation measures, there are currently over 2,000 evaluation reports on which to base effectiveness, in addition to a number of RCT studies.

Overall, evaluations have found:

- **High retention rates, especially for 'hard to reach' marginalised families;**
- **Similar outcomes for high and middle income families;**
- **Reduced stress levels;**
- **Increased parent involvement in school activities;**
- **Positive mental health outcomes for children, reduced aggression and anxiety and improved school performance;**
- **Decreases in children's externalising behaviours, both at home and at school;**
- **Positive outcomes were maintained up to two years after the programme.**

Training is provided for facilitators over a two-day course, and the programme is structured according to a manual of activities. Parents who have taken the programme with their own families are encouraged to undertake training to become facilitators themselves.

Al's Pals Programme

A similar resilience-based programme to promote social and emotional wellbeing in children delivered through schools is the Al's Pals programme (UNDOC, 2009). Aimed at children aged three to eight years old, the programme trains teachers in techniques to enhance expression of emotions, reduce aggression and conflict and to encourage healthy decision making.

Only in use in the US and Canada, the programme is delivered in 10 to 15 minute sessions during class time twice a week over 46 sessions. The sessions allow for children to acquire and practice positive social and emotional skills, and parents are sent information on the skills their children are learning as well as activities they can do at home. Over 90 pre- and post-test evaluations

have been conducted since the start of the programme. The main outcomes found for this intervention are:

- **Children show improvements in social skills, emotional regulation and prosocial behaviour;**
- **Children are up to four times more likely to discuss problems with teachers or another adult;**
- **Up to 95% of children show a decrease or no increase in antisocial behaviour; compared to the control group children**
- **Children show significant decreases in the use of verbal or physical aggression to solve problems.**

Overall, the programme shows positive improvements in children's social and emotional behaviour and may even act as a protective buffer against later delinquent or antisocial behaviour. Al's Pals has been endorsed by the departments of mental health, justice and education in the US.

Parenting Programmes

Parenting programmes were introduced in the US in the 1970s and have grown in popularity in many countries, including Ireland, since then. As highlighted in the Parents Support Strategy, supporting parents is part of the core business of the CFA. These interventions typically take a structured approach and involve a set number of sessions with parents aimed at improving parental confidence, discipline practices and lowering parent stress levels (Moran, Ghate and Van der Merwe, 2004). Usually these programmes take place outside of the home and are delivered to groups of parents as training sessions. Some (usually for those deemed at higher risk of difficulties) will also include home visits and more targeted intervention aspects. The evidence base for parenting programmes contained in this document can be used as a resource for the CFA in commissioning parent support programmes.

Triple P Positive Parenting Programme (Ireland)

One of the most commonly used, and most researched, programmes aimed at parenting skills is the Triple P Positive Parenting Programme developed by Matt Sanders and others at Queensland University. The programme is a multi-level strategy that aims to prevent behavioural problems in children by focusing on establishing effective parenting practices in families and by improving communication between family members. It is based on a social-learning perspective that sees child behaviour as a product of their environments and parenting experiences and takes an ecological approach that incorporates a holistic view of child development (Sanders, Turner and Markie-Dadds, 2002). The target age for the programme ranges from infants to teenagers with specific programme approaches for different age groups. A United Nations (UN) report on evidence based family support programmes reported a wide evidence base for the Triple P programme which included: 4 meta analytic reviews; 57 RCTs; 28 quasi-experimental studies and; 11 pre and post test studies carried out in a diverse range of countries.

The programme is highly structured and offers intensive training for facilitators to use in seminars with some levels including homework based activities and rehearsal and practice sessions within the seminar. There are a number of strands within each Triple P level that include interventions for parents of children up to the teenage years and of differing levels of need. Most evaluation studies of the programme tend to focus on one of these levels or age groups so that each strand of the programme has been assessed for effectiveness individually. Generally, outcomes for the Triple P programme are positive, although these are dependent on the level of intervention (i.e. group or individual), the level of outcomes measured, the methodologies used in evaluations, and the fidelity to the manual in implementation (UNDOC, 2009).

Evaluations of the Triple P programme have been carried out in a number of countries including Canada (McConnell, Breitkreuz and Savage, 2012), Australia, focusing on parents of teenagers (Ralph and Sanders, 2006), China (Leung, 2003) and Switzerland (Bodennman, Cina, Ledermann and Sanders, 2008). An evaluation of the programme in the Longford and Westmeath areas is currently underway in Ireland. The programme has shown success at the various levels that target increasing severity of difficulties and child age cohorts, with both two-parent and single-parent families and to both clinical and non-clinical populations (Ghate *et al.,* 2008).

Overall, there is support that the Triple P programme shows positive child outcomes in the following areas: fewer behavioural problems, increased self-esteem, and fewer emotional and psychosocial problems. Positive outcomes for parents include lower levels of parental stress, depression and anger; increased use of positive parenting methods and decreased coercive parent practices; improved parent-child relationships and communication; reduced marital conflict; fewer cases of child maltreatment, and hospitalisation due to maltreatment; reduced need for child placement, and high levels of satisfaction with the programme.

The Triple P programme reflects an evidence based intervention that can be adapted to different levels of need among parents and has been widely evaluated and shown to have positive effects on both child and parent outcomes.

The Incredible Years Programme (Ireland)

A number of intervention programmes focus on training both parents and teachers in effective ways to deal with childhood behaviour and to promote better overall wellbeing and social and emotional competencies in children. One of these, the Incredible Years programme has been well researched and has undergone a number of RCT and quasi-experimental evaluations over the past 30 years. It has been implemented in a number of countries outside of the US where it originated, including Ireland.

The Incredible Years programme is a multi-faceted programme based on a social cognitive approach to child development where it is argued that negative parenting and teaching practices encourage negative behaviour in children. The programme aims to improve both teacher and parent practices that will help to encourage productive problem solving and better discipline in younger children. The programme is aimed at children aged 0 to 12 years old and incorporates multiple levels of training for parents and teachers of children with varying degrees of risk and problem behaviour.

The programme involves a number of strands of intervention, including teaching young children anger management and cooperative skills using teacher-led sessions and video material. The teacher component of the programme involves discussion and intervention sessions for teachers, school counsellors and psychologists and focuses on class management techniques, promoting pro social skills in children and reducing aggression in children. The parent aspect of the programme has three specific levels and focuses generally on promoting social competence in children, improving communication in families and promoting educational attainment in children.

The UN report on family support services found a total of 18 RCTs relating to the Incredible Years programme and an additional three studies based on pre- and post-intervention measures (UNDOC, 2009). Findings based on parent, child or teacher outcomes have shown differing levels of effects for different types of outcomes measured. In general, there are positive effects for the programme across each target group. The most consistent positive outcomes for children include reductions in aggression both at home and at school, increased school readiness for pre-school children and increases in social and emotional competence. Positive outcomes for parents include an increase in positive parenting skills and a reduction in coercive or harsh parenting practices. Outcomes for teachers in the programme include positive classroom management strategies and some improvements in parent-teacher bonding.

In terms of assessing the impact of the Incredible Years programme for pre-school children in particular, an evaluation of the Dina curriculum to foster social and emotional skills was conducted in Galway which included follow up measures at two time points up to 18 months after initial programme involvement (Miller, 2011). Findings from this evaluation, which included a number of interviews with stakeholders as well as standardised questionnaires to measure problem behaviour and parenting skills and stress, show small effect size differences in parental competencies. This may be somewhat affected by the socio-economic status and educational attainment of parents, which may reflect differences in parental competencies at the start of the programme. There were no statistically significant improvements in parental depression scores at follow up. For children's behaviour, the number of children who fell in the 'normal' range on the Strengths and Difficulties questionnaire increased at follow up from 79% to 90% of those included from both parent and teacher reports, and this appears to have a larger effect for boys than girls.

Although not employing a control group for comparison, this study lends support to the programme in that positive outcomes were shown for children in terms of behavioural problems, with some evidence to show that by time three, children involved in the programme had fewer problem behaviours than found in the general population. As with other studies, the sample size was relatively small in this evaluation (51 children), but does add to the support for the programme showing effects that last post-intervention, and it employs measurements that are widely used in assessing childhood behavioural and parenting problems making it useful as a comparison with other similar studies.

An ongoing evaluation into the overall programme in Ireland has shown similar outcome results using an RCT method where comparisons between intervention and control groups showed that behavioural difficulties in children involved in the programme were significantly improved at a six-month follow-up (McGilloway *et al.,* 2012). A further follow-up study also using the Incredible Years BASIC strand, conducted in Wales showed that positive outcomes, although generally small in terms of effect sizes, were maintained at 18 month follow-up for both child behaviour measures and parent competencies (Bywater *et al.,* 2009). In addition this study also measured the extent of other service use such as child protection agencies and showed a reduced need for these services when compared to a control group indicating a cost-effective advantage of early intervention parenting programmes.

A comparison study of outcomes between the Triple P, Incredible Years and Strengthening Families (outlined below) programmes showed that both Triple P and Incredible Years programmes had similar outcomes on child behaviour and parental competencies with little differences between the two (Lindsay, Strand and Davis, 2011). Both also showed larger effect sizes and greater numbers of statistically significant improvements compared to the Strengthening Families intervention. It should be noted that Strengthening Families is aimed at those families with established, serious risks and difficulties, and this may be the reason for less obvious positive outcome measures, as target families will have different needs.

Flying Start Strategy

Parenting interventions are also undertaken as a home-based programme in some areas. A longitudinal examination of the effects of one such programme in Wales, the Flying Start strategy, was recently published (Byrne, Holland and Jerzembek, 2010). The programme aims to promote positive parent-child interactions and is available for families with children up to three years old. There are four strands of the programme which include:

1. **free part-time childcare;**
2. **extra Health Visitors in addition to those usually available;**
3. **language and play services;**
4. **parenting programmes.**

The Parent Plus programme, on which this evaluation was based, is a time-limited home-based course that is needs based in that each programme is individualised to each family and aims to promote empowerment. This approach allows for particular tips and techniques to be given to parents that are tailored to their own child's individual problem areas (e.g., going on outings, mealtime problems).

The study conducted telephone interviews with parents who had participated in the programme over the previous seven years. Like many of the other evaluations, this one is also limited by a small sample size (21 parents) and is primarily a qualitative study. Findings showed that parents reported highly positive experiences of the programme and general improvement in both their child's behaviour and overall family functioning. Many of the mothers interviewed for this study reported that often the children's father reacted to the programme and techniques negatively. This may highlight the potential need to include both parents (where available) in parenting programmes so they can both have the same understanding of techniques and how they are expected to influence behaviour.

Parents of Teenagers

The majority of universal parenting interventions tend to concentrate on parents of younger children, on the basis that establishing good parenting practice and communication early in life works as a protective factor against later problems. There are many fewer programmes that cater for parents of teenagers. The Triple P programme offers a tailored parenting programme for teenagers. While this strand of the intervention has not been evaluated to any great extent, preliminary studies suggest that the programme does improve parenting skills and communication between parents and their teenage children. To date no RCTs have been conducted to assess the effective of this strand of Triple P intervention programmes. Two programmes that have been evaluated are the Strengthening Families Program for Parents and Youth and Parenting Ur Teen.

Strengthening Families Program for Parents and Youth

The Strengthening Families Programme (SFP) is an evidence-based 14-week family skills training programme that involves parents and teenagers/children. SFP was developed in the USA by Dr Karol Kumpfer and associates at the University of Utah, in 1982. The programme has been adapted to many age ranges including 3-5 years, 6-11 years, 10-14 years, 12-16 years and is available in web format for 10-16 years and DVD for 8-16 years. The shorter version such as the 7-week 10-14 years programme is suitable for universal families, and the longer versions such as the 14 week 6-11 and 12-16 programme are targeted at high risk families.

SFP is designed to reduce multiple risk factors for later alcohol and drug use, mental health problems and criminal behaviour by increasing family strengths, teens/children's social competencies and improving positive parenting skills. It focuses on building family protective factors such as parent-child relationships, communication, cohesion, social and life skills, resisting peer influences, family organisation and attachment, and reducing risk factors such as conflict, excessive punishment, family drug and alcohol abuse, truancy, depression, etc. Further information can be found on www.strengtheningfamiliesprogram.org .

SFP has been culturally adapted to suit many populations and has also been translated into different languages. Similar results have been found for culturally adapted SFP programmes but with the added advantage of making recruitment and retention of families much easier. The Strengthening Families Programme is now operating across 27 countries. SFP (12 -16) has been delivered in Ireland since 2007. A National SFP Council of Ireland has been established to facilitate an inter-regional joined-up approach to the development of SFP in Ireland. The members are made up of multi-site SFP Coordinators and Trainers who have coordinated the implementation of SFP in their areas.

In a study of the effectiveness of a culturally adapted SFP 12-16 years for high risk Irish families involving over 200 families, all 21 measured outcomes had statistically significant positive results. Results showed significant improvements in all of the outcomes measured including 100% or five of five family outcomes, 100% or five of five parenting outcomes, and 100% or eight of eight youth outcomes. Larger effect sizes were found for the Irish families than for the USA families. This study cited SFP 12–16 as effective in reducing behavioural health problems in Irish adolescents, improving family relationships and reducing substance abuse.

Significant changes in the parents and in the family environment and family resilience and in the children's outcomes such as concentration and covert aggression were demonstrated. There were also statistically significant improvements in the areas measured for overt aggression (fighting, bullying, etc), covert aggression (lying, stealing, etc), depression, social skills, hyperactivity, concentration and criminal behaviour. These risk factors were identified in the study as the most important in reducing later substance use and abuse (Kumpfer, K.L., Xie, J. & O'Driscoll, R. (2012).

The Strengthening Families Programme is disseminated worldwide by the United Nations Office of Drugs and Crime (UNODC) as an effective evidence based family intervention. The UNODC refers to the current level of evidence on the Strengthening Families Programme as the following (2010: 18):

- **Eight independent randomized control trials;**
- **Ten randomized control trials;**
- **Over 100 quasi-experimental studies.**

Randomized control trials found that the programme consistently yielded the following results on the basis of a five-year follow-up measure (UNODC, 2010:20):

- **The Parent Training component improves parenting skills, parenting efficacy, parental confidence, monitoring and supervision and parent-child involvement and decreases negative child behaviour, overt and covert aggression and conduct disorders.**
- **The Children's Skills Training component improves children's grades and social competencies (e.g., communication, problem-solving, peer resistance and anger and behavioural control).**
- **The Family Skills Training component improves family attachment/bonding, harmony, communication, organization, family strengths and resilience.**
- **The full Strengthening Families Program (comprising all three components) reduces alcohol and drug use or the likelihood of initiation of alcohol or drug use by parents and older children, improves protective factors and reduces risk factors predictive of later problem behaviours.**

Odyssey, Parenting Your Teen

Odyssey, Parenting Your Teen is a Northern Irish group-based programme developed by Parenting Northern Ireland delivered over eight two-hour sessions. Underpinned by Family Systems Theory, the programme promotes authoritative parenting throughout. In each session, trained facilitators introduce a range of relevant topics, followed by group discussions of homework tasks and problem solving scenarios. Sessions cover issues such as parenting styles, teen development, self esteem, rules and consequences, conflict and problem solving.

The Odyssey, Parenting Your Teen programme was subjected to independent evaluation by the Institute of Child Care Research at Queen's University, Belfast. Odyssey, Parenting Your Teen was evaluated using an experimental design in which study participants were allocated either to the Odyssey, Parenting Your Teen Programme or a wait list control group. Parents in the wait-list control received the programme approximately two months later. Randomisation was used to create two broadly equivalent groups of parents (comparable in known variables such as demographics, family size, religion and in unknown factors), thereby enabling changes to be attributed to the impact of the programme, rather than to any systematic differences between the two groups, or other explanations such as the passage of time.

The study findings suggest that Odyssey, Parenting Your Teen can improve outcomes for parents, their teenage children and the family as a whole. The programme:

- **enhanced parental well-being;**
- **improved the parent/teenager relationship and decreased levels of stress;**
- **increased perceived parental competence and reduced feelings of guilt;**
- **made a positive difference on some important aspects of teenagers'; social functioning, such as decreased moodiness.**

In particular, the programme had a positive effect on parents' mental health. It reduced parental stress, feelings of social alienation and the feelings of guilt and incompetence that can so often beset parents. In terms of conflict, the programme lead to lower levels of overall distress and reduced conflict about school, meals and eating. Compared with parents in the control group, parents who participated in the programme reported greater improvements in communication, problem solving, and family cohesion. They also reported less stressful relationships with their teens.

Parents who participated in the programme were less likely to:

- **interpret their teen's behaviour as malicious;**
- **think that their teen's bad behaviour would end in disaster or ruin;**
- **feel their teenager should behave flawlessly at all times (MacDonald *et al.,* 2012).**

Programmes for Teenage Parents

Teen Parents Support Initiative (Ireland)

The Teen Parents Support Initiative was established for the purpose of providing a range of additional support services for single teenage parents, through pregnancy and until their child reaches two years of age. The main purpose of the programme was to identify and develop models of good practice in working with, and supporting, young parents, particularly those deemed to be at risk. It was envisaged that, through the establishment of the programme, the knowledge base and understanding of key stakeholders would be enhanced, leading to more efficient and effective services for young parents. The programme is currently in operation in nine Counties in Ireland. The Centre for Social and Educational Research, Dublin Institute of Technology carried out an evaluation on the initiative's four initial projects which was published in 2002. The results of the evaluation were very positive, with participants highlighting the help and support received from the programme staff. Key strengths of the Initiative as identified by participants and professionals were:

- **It was non-stigmatising, strengths focused, flexible and creative in its responses to young parents needs;**
- **The positive personal qualities and characteristics of project staff;**
- **Its commitment to supporting young parents regardless of the type of need expressed;**
- **Its commitment to the development of multi-agency working arrangements to ensure an integrated and effective response to young parents support needs (Riordan, 2002).**

A Cochrane Review of parenting programmes aimed at teenage parents was carried out in 2011 (Barlow *et al.,* 2011). Of eight RCT studies focusing on parenting programmes specifically aimed at teenage parents the review showed that all interventions improved parent-child interactions, parent responsiveness both post intervention and at follow up. Of particular note, the studies in this review involved only mothers, and further research is needed to assess programmes aimed at teenage fathers to see if the programmes are of benefit to them as well as to mothers.

4.3

LEVELS THREE AND FOUR: TARGETED SERVICES FOR CHILDREN, YOUNG PEOPLE & FAMILIES AT RISK

This section outlines services aimed at those with a higher level of need (categorised as Hardiker levels three and four). A number of initiatives are aimed at the parents of children and adolescents, others are aimed at children and adolescents themselves while the third type of initiative is aimed all families in particular catchment areas. Each of these will be outlined based on their target participants and method of evaluation. The initiatives and programmes, their target population, mode of delivery and the location in which they are delivered is outlined below in Table 4.2.

Table 4.2: Level two and three programmes

FAMILY SUPPORT INITIATIVES & PROGRAMMES			
Name	**Target group**	**Mode of delivery**	**Location**
Head Start	Parents of & 3 -5 yrs	Centre & school based	USA
Stop Now & Plan	Parents of & 6 – 11 yrs	School based	Canada
Hagadal Parent Baby Clinic	Parents of 0-8 mths	Centre based	Sweden
Parents Plus Early Years & Children's programme	Parents of 0-6 yrs & 6-11 yrs	Centre based	Ireland
Parenting Wisely	Parents of 6 – 18 yrs	Web based	Ireland, France, Australia, UK, Canada etc
Parents Plus Adolescent Programme	Parents of 11- 16 yrs	Centre based	Ireland
Strengthening Families	Parents of adolescents	Centre based	USA & UK
Springboard	Parents of & 0 – 18 yrs	Community based	Ireland
Neighbourhood Youth Projects	10 -18 yrs	Community based	Ireland
Big Brothers Big Sisters	6- 18 yrs	Community based	Ireland, USA, etc
Youth Advocate Programme	Parents of & 8 – 18 yrs	Community based	Ireland, USA
Community Development projects	Parents of & 0 – 18yrs	Community based	Ireland
Family Welfare Conferencing	Parents of 0 -18	Home and Centre based	Ireland, New Zealand

Head Start

The Head Start programme is a USA government funded pre-school programme for disadvantaged children who are thought to be most at risk of falling behind in school. The programme is open to all children aged three to five years old living in designated areas. An RCT evaluation of the programme using a nationally representative sample of centres has recently been concluded (US Department of Health and Human Services, 2011). The overall evaluation included standardised outcomes for 5,000 children either in the programme from age three or four and a control group who may have had different preschool experiences or stayed at home until school entry.

Findings from the evaluation showed that teachers in the programme were more likely to have qualifications for working with pre-school children than those in other centres. At school follow-up any improvements in cognitive or emotional development that children in the intervention showed had dissipated by the end of first year at school. For children who had been in the programme since age three, their parents were more likely to read to their children and less likely to use physical punishment.

Overall, the study suggests that improvements that may be gained during the programme intervention tend not to endure once children enter primary school. The possible reasons for this are not explored in the evaluation, but it may be that extra intervention for children at risk of falling behind in school is still needed in the first few years of school and not just at the preschool level.

Stop Now and Plan (SNAP)

For slightly older children with established conduct or behavioural problems the Stop Now and Plan (SNAP) programme is a multi-faceted, evidence based school delivery programme that was first developed in Canada over 25 years ago (UNDOC, 2009). The programme is aimed at children aged 6 to 11 who are at risk of juvenile offending, by teaching problem solving techniques and emotional regulation. Both child-and parent-focused sessions are offered, and there are a range of treatment components that can be chosen depending on the individual need of each child. Programmes cater to either girls or boys, recognising that each gender likely needs differently-focused interventions. Sessions take place after school over 12 weeks. Across ten RCT studies and a further nine quasi experimental or pre- and post-test design studies outcomes for the intervention include:

- **Positive improvements are shown in externalising and internalising behaviours and in social competencies;**
- **The programme has a larger impact on boys than on girls;**
- **Parent and child relationships improve;.**
- **70% of children involved report no criminal record by age 18;**
- **Slower rates of improvement occur for those with more severe difficulties at the start of intervention;**
- **Intensity of the programme affects outcomes;**
- **Poorer outcomes for girls are somewhat explained by early sexual development and evidence of abuse or neglect.**

Parenting programmes

Similar to universal parenting programmes, programmes aimed at parents who are experiencing difficulties such as clinically significant conduct or behavioural problems in their children are often based on teaching parents effective discipline and communication skills. Overall, these interventions show similar positive effects on both children's behaviour and parenting practices, as do universal parenting programmes (Furlong, *et al.,* 2012). Parenting programmes can also be offered for families where the main psychosocial difficulties occur in the parent, for example substance abuse, mental health problems or social problems. As noted earlier, the Parents Support strategy emphasises the responsibility of the CFA in relation to supporting parents as part of its core business.

Hagadal Parent Baby Clinic

A longitudinal evaluation of one such intervention, at the Hagadal Parent Baby Clinic, followed up with families eight years after initial intervention in Sweden. The centre-based programme starts soon after birth; referrals are usually from ante-natal or maternity services, and runs for five hours a day, three days a week over a course of six weeks (Wadsby, 2012). The intervention is run by a number of professionals including social workers, paediatric nurses and psychologists and may include home visits. The main focus of the intervention is to establish positive bonds and communication between parent and child.

The evaluation involved follow up with 46 parents (all mothers) who had had the intervention eight years previously, 45 parents described as at psychosocial risk eight years previously but who had not undergone any intervention and a third group of 56 non-risk parents. Findings showed that children in both of the risk groups had more behavioural problems than the non-risk group. Generally the children in the treated risk group had better outcomes at age eight in terms of school achievement and attachment to parents than the untreated group but fared less well than the non-risk group overall. While only marginal improvements were shown for this treatment group at follow up, they did appear to be in a better position than children of mothers experiencing psychosocial risk who were untreated. A deeper level evaluation of the intervention procedures and expected outcomes would help to explain why outcomes are not more pronounced; also a post intervention measure would reveal whether changes had disimproved over time.

Parents Plus (Ireland)

The Parents Plus Programmes are evidence-based parenting courses designed in Ireland. There are a number of programmes: Early years (aged 1-6), Children (aged 6–11), Adolescents (aged 11-16) and a programme for parents who have separated. The three age-determined programmes have been evaluated and are outlined.

In a large scale multi-site controlled outcome study (n = 97) of children aged one to six, it was found that for families attending the Early Years programme there was a:

- **Decrease in Total Difficulties, and Conduct problems, and an increase in prosocial behaviour as measured by Strengths and Difficulties Questionnaire;**
- **Decrease in Parental Stress as measured by Parent Stress Scale (PSS);**
- **Reduction in Commands and increase in Positive Attends in the parent-child interaction as measured by independent before- and after-video observation;**
- **Significant reduction of parent-defined problems, and gains in parent defined goals.**

Positive gains were maintained at five month follow-up. Compared to 'treatment as usual,' parents completing the Early Years programme reported more significant reductions in behavioural problems, and there was no significant difference in benefit for children with developmental delay and children primarily with behaviour problems, suggesting that the Early Years programme is equally beneficial to both groups.

A community study of the Early Years programme delivered in school settings showed that a significant number of the forty parents who attended the groups reported high levels behavioural and emotional problems pre-group (23% in the clinical range) suggesting the high need for these supports. Most encouraging, though, was the high impact of the groups (only 3% remaining in clinical range post-group) lending support for parenting groups in the community (see KIlroy et al, 2008).

In evaluating the Children's programme (6-11) programme, a sequential block design was used to assign 74 parents of children referred to the service to the children's programme (n= 42) or the Treatment as Usual (TAU) Comparison Group (n= 32). Assessment took place before and immediately following the eight-week intervention for both groups and

at five-month follow-up for the parents in the Children's programme. Compared to the TAU Group post-programme, parents in the Children's programme displayed significant reductions in total difficulties and conduct problems as measured by the Strengths and Difficulties Questionnaire, decreased parental stress, increased parental confidence and significant improvements in parent-defined problems and goals. These positive changes were maintained at five month follow-up, in addition to further significant improvements in peer problems and prosocial behaviour. The analysis also suggests that the programme is more effective for parents of children with behavioural problems only, than for those with associated developmental difficulties. The children's programme is undergoing an RCT in primary schools throughout Ireland with initial results expected in 2012.

A Cochrane Review looked at home-based parenting interventions for preschool children from disadvantaged backgrounds (Miller, Maguire and Macdonald, 2011). They reviewed seven studies with over 700 participants who took part in a development programme and were evaluated using RCT methods. Unfortunately a lack of information and sufficient data, coupled with low quality research methods, mean that conclusive findings cannot be drawn as to the effectiveness of such programmes.

Parenting Wisely (Ireland)

A different approach is taken with the Parenting Wisely programme, which is delivered to parents through an interactive CD-ROM for parents of children aged 6 to 18 years old. The programme is aimed at low income families who have children with moderate behavioural problems (UNDOC, 2009). It has been used in Australia, Canada, France, Ireland and the UK. The interactive course includes video demonstrations, quizzes, rehearsal and feedback. Of four RCT studies to evaluate this programme, findings have shown that parents report statistically significant improvements in parenting knowledge and applying adaptive parenting practices to hypothetical scenarios. Children also showed a clinically significant improvement in behaviour. Delivering a programme in this way appears to be relatively unusual, but may offer an alternative to parents who have difficulty attending programmes outside of the home due to childcare or transport issues.

However, there are other evaluations that fail to show these positive effects for behaviourally based parenting programme. For example, in the UK an intervention for parents of children with behavioural problems was compared to a no treatment condition at post intervention and at a three-year follow up (Anderson, Vostanis and O'Reilly, 2005). This evaluation found no significant effects on family relationship outcomes or emotional or education improvements in children. The modest improvements in behaviour shown at the end of treatment were not present at follow-up, and some had deteriorated by this time - often due to a variety of external factors. It is not clear why this intervention should fail to show the positive outcomes that appear to come from other parenting programmes, but it should serve as a reminder that each programme may need to be independently evaluated for effectiveness, and it cannot be assumed that what works in other countries will necessarily work here.

A similar finding emerged from a US study that compared concrete interventions (e.g. financial support, childcare) to parenting programmes for at risk families (Chaffin, Bonner and Hill, 2001). Additionally, centre based programmes were found to be more effective than home visit approaches. Outcomes in this study were based on child maltreatment events within over 1,600 families, which was the stated target of these interventions. The authors note that the disappointing results may be due to the generic nature of the intervention programmes, which may need to be more specifically tailored to families with particular risks of child maltreatment or neglect. Future research on interventions with this group is needed in order to establish whether this is the case.

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Parents Plus Adolescent Programme (Ireland)

The adolescent programme has been recently evaluated using a RCT within secondary schools in Kerry and Cork in Ireland. An RCT design was used to assign 109 parents of adolescents to a treatment group (n=70) and a waiting list control group (n=39). Assessment took place before and immediately following the eight-week intervention for both groups and at five-month follow-up for the parents who attended the programme. Compared to the waiting list group post-programme, the attending group displayed significant reductions in total difficulties and conduct problems as measured by the Strengths and Difficulties Questionnaire, decreased parental stress as measured by the Parenting Stress Index, increased parental satisfaction as measured by the Kansas Parenting Scale, as well as significant improvements in parent-defined problems and goals (Nitsch, 2011).

Following a sequential block design, the adolescent programme has been evaluated as an intervention in a Adolescent Mental Health Setting. Results show that parents completing the programme (n=38) rated their adolescents as 'significantly improved' in terms of total difficulties, peer difficulties, and conduct difficulties as measured on the SDQ when compared to the routine clinical care control group (n=17). Parents in the programme also rated their relationship with their adolescent as 'significantly improved,' and showed greater progress in achieving their goals (Fitzpatrick *et al.,* 2007)

Strengthening Families (Ireland)

Programmes that focus specifically on alcohol reduction and prevention in adolescents were reviewed by a separate Cochrane Review study (Gates, McCambridge, Smith and Foxcroft, 2006). Of 24 (primarily US based) studies the Strengthening Families programme was found to be most effective. However, many of the studies reported inadequate measures of alcohol , and a large proportion of the programmes reviewed had high levels of attrition. Participant attrition throughout the programme or at follow-up causes problems in establishing the effectiveness of such programmes. Also, the authors point out that the usual focus of these interventions in the US is abstinence from alcohol whereas in other countries the aim may be to teach more responsible use of alcohol. Having different intentions these programmes may find dissimilar outcomes in different countries or cultures.

Other less well established programmes that focus on supporting parents have also been reviewed in different contexts. For example, a study on general early parenting in Scotland examined impacts of local, centre based, intervention services (Kirk, 2003). The centres, based in areas of 'multiple deprivation,' offer a number of services including nursery/ daycare for pre-school children and advice and support for families. This evaluation used both quantitative and qualitative methods to assess outcomes. No control group was used, but qualitative interviews helped to expand and explain some of the quantitative findings. Overall, the services' main impact appeared to be on levels of informal social support for mothers (almost 100% of the primary caregivers in this study were mothers) in the form of friendship networks and social networks with other parents. As the main finding from this study it highlights an often neglected aspect of family support services: that of facilitating less formal social support networks for parents who may otherwise feel isolated, particularly in areas of economic and social deprivation. This feature should be considered in evaluating parental outcomes in such interventions.

COMMUNITY BASED FAMILY SUPPORT PROGRAMMES

Springboard (Ireland)

The Springboard family support service operates throughout Ireland and was first piloted in 1998. The Springboard initiative is open to all families but targets those in particular need where intervention can last up to a year or more. Each service provides a range of programmes and intervention approaches which can include any number of the following:

- **Individual work to assess particular needs and provide appropriate responsive intervention;**
- **Group work that can include parenting programmes or specific groups for children;**
- **Family work including parent or child and group sessions;**
- **Drop in facilities for advice or information sharing.**

It is also one of the few initiatives that specifically targets fathers for intervention, a group that appears to be consistently under-serviced across family support interventions. A number of evaluations on the Springboard services have been carried out around the country, and these tend to focus on the outcomes for the most vulnerable families rather than on the universal services impact (McKeown, 2001; Barnardos, 2006; Forkan, 2008). Some of the most common difficulties faced by families who use the service include domestic violence, emotional abuse, high levels of school absence, neglect and economic disadvantage. Evaluations show highly positive perceptions of the service from parents and children in terms of the relationships that are established between facilitators and participants and in increased parenting confidence.

Neighbourhood Youth Projects (Ireland)

Neighbourhood Youth Projects are community-based family support services aimed at young people aged 10 to 18 years old. Managed by Foroige and the HSE, the projects offer a range of activities and interventions for young people deemed to be 'at risk,' due to family, social or educational difficulties. The projects are a needs-led, preventative approach to helping young people to deal with problems they encounter due to the difficulties and challenges they face. A number of evaluations have been carried out on these projects in different areas around the country.

One such study in the West of Ireland used a series of standardised measures to assess outcomes in young people's levels of support and mental health (Dolan, 2005). Findings suggest that for the relatively large proportion of young people who initially reported poor mental health there was a positive change over the 21-month follow-up. The study also showed that the project helped young people maintain or improve existing sources of support such as family and friends, as well as professionals. The majority of evaluation studies into the Neighbourhood Youth Projects focus on assessing levels of user and practitioner satisfaction rather than explicitly measuring outcomes of the intervention. Overall, these studies find high levels of satisfaction with the service and suggest that outcomes for young people are positive. It is difficult to isolate the effective interventions in this type of project, as it encompasses a wide range of options for centres and young people, which may be implemented differently depending on the needs of young people in that area.

Big Brothers Big Sisters (Ireland)

The Big Brothers Big Sisters (BBBS) programme was introduced in the US over 100 years ago and has since expanded to almost 40 countries around the world. The premise of the programme is to provide adult mentoring to young people aged between 6 and 18 years old who have some risk factors, such as coming from a lone parent family or having a history of abuse or neglect or problems at school. The programme aims to provide supportive relationships for young people and to help them realise their potential (Promising Practices Network, 2009). Young people and their volunteer mentors commit to meeting for three to five hours per week for a period of at least one year.

In Ireland the programme is delivered by the youth work organisation Foroige in partnership with the HSE and has been evaluated using an RCT on an national level by NUI, Galway.

The study found:

- **Young people with a mentor were more hopeful and had a greater sense of efficacy in relation to the future than those without a mentor;**
- **Young people with a mentor felt better supported overall than those without a mentor;**
- **Parents of mentored youth rated their pro-social behaviour more positively than did parents of non-mentored youth;**
- **There were positive but non-significant trends in relation to social acceptance, school liking, plans for school and college completion and drug and alcohol use in the core RCT study. There were also non-significant findings in relation to misconduct and scholastic efficacy;**
- **There was an average effect size (Cohen's d) of .09 after two years across all the youth measures, which compares favourably to the Tierney et al (1995) RCT study of BBBS in the United States of America.**

Further analyses showed:

- **Promising findings in relation to education for young people matched with a mentor;**
- **Promising findings in relation to perceived sibling support for young people matched with a mentor;**
- **Matches that meet regularly and last for a minimum of 12 months have stronger outcomes;**
- **The programme is particularly effective for young people from one-parent families (Dolan *et al.,* 2011).**

Youth Advocate Programme (Ireland)

The Youth Advocate Programme (YAP) was introduced in the US in the 1970s to facilitate young people's reintegration into the community after incarceration. YAP in Ireland is aimed at children aged 8 to 18 years old who are at significant risk of being placed in care or incarceration. YAP is a strength based, intensive, family based intervention that aims to keep children in their communities and out of care or custody. There are a number of levels of intervention that involve the young person and their family. The core of the programme is a mentoring service provided for up to six months, which is uniquely available 24 hours a day to the young person.

In Ireland, YAP has been evaluated twice since its introduction in 2002, once in the Western Health Board area (O'Brien and Canavan, 2004) and once on a national scale (YAP Ireland, 2011). The young people referred to the programme have a range of difficulties including lack of engagement with education, family breakdown, anti-social behaviour/ conduct problems, criminal charges for a variety of offences, homelessness and social and emotional problems. The programme is tailored to meet the individual needs of each young person, and needs are addressed through a range of activities in order to offer support with particular areas of difficulties.

Based on both qualitative and quantitative findings from these two evaluations the following findings show the positive outcomes for young people and their families involved in the programme and any potential barriers to implementing interventions:

- **Greatest improvements in engaging young people in education and employment;**
- **Improvements in family and peer relationships;**
- **High levels of improvement in behaviour and consequent reductions in offending and involvement in criminal justice services;**
- **Relationships between the young person and advocate are rated as highly positive by both parties, and young people report that these had been effective in offering advice and helping them to change their behaviour;**
- **Parents were highly supportive of the programme, and many showed improvements in parenting practices and general family functioning;**
- **There are some reservations about the level of training received by advocates, and ongoing training is not available;**
- **A poor match between young person and advocate can reduce the effectiveness of the programme;**
- **Some young people reported that they felt intimidated by the initial 'wraparound' meeting;**
- **The six-month time limit on the intervention may be too short to effect long term changes for the young person;**
- **No follow-up meetings are offered in the programme.**

The programme is generally highly rated by the young people, families and service workers who have used it. It may be a way to reduce long-term costs to other state services by providing an intervention to help young people remain in their communities and reducing the amount of interaction with the criminal justice system, while also improving young people's chances of engaging in education and employment.

Community Development Initiatives (Ireland)

Community Development Initiatives cover a broad range of interventions aimed at providing support for families who are at particular disadvantages due to poverty and social exclusion. A review of the body of evaluation research into Community Development Initiatives was carried out in 2006 by the Combat Poverty Agency (Motherway, 2006). General conclusions as to the impact of the initiative can be made from drawing together this body of research:

- **Improvements in general self confidence and self-esteem in service users;**
- **Greater access to and use of educational and training opportunities;**
- **Collaboration with groups and schools leading to better understanding of young people's difficulties;**
- **Provision of information relating to rights, entitlements and employment prospects.**
- **Access to employment;**
- **Better health outcomes due to educational programmes;**
- **Building of formal and informal networks within the community;**
- **Provides support and facilities to community groups.**

Family Support - Community Development Projects (Ireland)

Community Development Projects (CDPs) offer a range of family support services depending on particular local needs. An evaluation of these projects in the West of Ireland was conducted in 2008 (Brady, 2008). The evaluation of CDP services in the West of Ireland included information on 25 families involved from different community areas. Outcomes for families were measured through standardised assessment tools including measures of well-being, parent-child relationships and child behaviour inventories. Qualitative interviews with families were also included to offer personal responses to the service. Findings from this evaluation showed positive trends in terms of parent emotional well-being, child behaviour and family communication, depending on the target of the intervention. As projects adopted different types of approaches depending on the assessed needs of each family, it is difficult to see outcomes as relative to all interventions, so caution is advised in interpreting results in these instances. Qualitative interviews showed that parents reported increases in their confidence as parents and better communication with their children. When compared with quantitative measures, interview data is supportive of the same positive effects of the intervention.

Family Welfare Conferencing (Ireland)

Family Welfare Conferencing originated in New Zealand in the 1980s and aims to place the family at the centre of decision making in issues of child welfare. Evaluations to date on the Irish implementation of Family Welfare Conferences have mostly been on the pilot stage of the intervention. These evaluations, often including interviews and reports from children and their families involved, have found generally positive perceptions of the service (e.g. Brady, 2006; Brady, 2009; Cullen, 2003; Kemp, 2005). Measurable positive outcomes include:

- **Better school attendance;**
- **Children being returned home from care;**
- **Better use of professional services by families as a whole;**
- **Improved communication within families;**
- **Less risky behaviour from children.**

It should be noted that for some families there are no discernible positive outcomes for either children or their families. Reasons for this appear to be due to a lack of engagement with the intervention or with implementing decisions made by children or their families. Overall, conferences that are held to help children return to their families after being in care appear to be more effective than those for children who are engaging in risky behaviour. One particular drawback identified in these evaluations is the lack of follow-up after completion of the conference. It may be that some families need further encouragement to continue to implement decisions made within the conference, and that they may not be able to resolve family conflicts in a short space of time.

4.4

PROGRAMMES FOR SPECIFIC GROUPS

As certain difficulties and risk factors are often unique, there are a number of family support services available that cater directly to those difficulties. Some of these include ethnic minority children and families that have separated or broken down. As can be inferred from some of the findings from evaluations of programmes outlined above, targeted interventions may be required for certain groups where more general or universal programmes fail to show positive outcomes for children or families. Examples of some of these programmes and initiatives are included in this section. Table 4.3 outlines the programmes reviewed.

Table 4.3: Programmes for Specific Groups

PROGRAMMES FOR SPECIFIC GROUPS					
Specific Group	**Programmes**				
Ethnic Minority families	The Belong Programme	Globe: All Ireland Programme for Immigrant Parents	Family Centre's	Home visiting	Family Group Conferencing
Separated Families	Time 4 Us				
Parents who misuse substances	New Choices	Community Reinforcement Approach	Drugaid, Jigsaw, Families Matter, Bridgend		
Children & adolescents with Conduct Disorders/ involved in anti-social behaviour	Parenting Programmes, Family Therapy, Multidimensional Treatment Foster Care, Multi Systemic Therapy				
Intensive family Intervention	Homebuilders	Multi Systemic Therapy	Functional Family Therapy	Building Bridges	

Ethnic Minority Families

Children from ethnic minority families may face a number of additional challenges and difficulties compared to majority children, such as acculturation difficulties, language barriers, racism or bullying from other children, and lower educational attainment. In Ireland, the term of ethnic minority refers to both those who are not white and/or Irish and those of the Traveller community.

The BELONG Programme

Launched in Northern Ireland in 2009, the BELONG programme is aimed at fostering a sense of belonging in children of ethnic minorities 7 to 12 years old and has four main outcome objectives: to increase cultural confidence, to increase participation in youth clubs and organisations, to increase educational achievement of Traveller children, and to increase resilience. A preliminary evaluation of the implementation of the programme has been produced which shows the wide range of targeted activities and programmes on offer that aim to achieve these objectives (Forkan, Canavan and O'Sullivan, 2011), and a full evaluation of outcomes is currently in process. Project activities include educational strands, public awareness aspects and group activities. The implementation evaluation shows that there is a need for a service that offers programmes to ethnic minority children and also highlights the need to engage in policy formation and influence in order to achieve the main objectives of such a project.

Globe: All Ireland Programme for Immigrant Parents (Ireland)

This project involved the development of a set of three resources to (a) support immigrant/ black and minority ethnic (BME) parents in their parenting role, and (b) support the professionals who work with them. The set or resources comprised:

- **A Toolkit developed for practitioners working with immigrant/BME parents, both in a one-to-one and group setting;**
- **An Information Pack for parents and practitioners containing information on a range of issues;**
- **A DVD;**
- **A Capacity and Awareness Raising Training (CART) programme aimed at raising the cultural awareness of attending practitioners and promoting the use of the resources in practice.**

The project was evaluated by NUI, Galway and found that the resources supplement and add value to professional practice with BME/ immigrant parents specifically in relation to parenting and diversity. It also has a more general application for practitioners who provide parent support. At an overall level the evaluation concluded, the Globe: All Ireland Programme for Immigrant Parents has been a worthwhile endeavour that meets the needs of practitioners working to support BME/ Immigrant parents (Coen and Canavan, 2012).

In the UK a number of Family Fupport services have been implemented that specifically work with minority families. Findings from studies that looked at three types of such family support service were reviewed by Chand and Thoburn. This included family centres, home visiting services and family group conferences (Chand and Thoburn, 2005). In terms of family centres, the main benefits reported included providing a safe place for children to play (especially for families living in high crime areas), allowing parents to have a break from childcare, and improving social networks among other parents of similar ethnic background. Home based services were reported to be most effective when service workers were 'matched' to ethnic minority families particularly in terms of language and cultural knowledge. Family group conferences are used to address particular child welfare concerns and involve bringing the whole family together to discuss options. The issue of ethnic or cultural matching is raised in the review of these services. Overall, methodological problems in evaluations of services targeted at ethnic minority groups need to be addressed before strong conclusions can be drawn as to what factors of these interventions are most useful and whether or not they are effective in producing positive outcomes for families.

Separated Families

While the majority of family support services that target groups of parents and children considered to be at higher risk of problems and difficulties will usually include lone parent families, few services are directly targeted at this group or at families that have separated. One such service available in Ireland is Time4Us.

Time 4 Us (Ireland)

Time 4 Us is a centre based service that provides both physical space and support to non-resident parents of children in separated families. Opened in 2007, the aims of the service are to provide a safe place for parents to play with their children and to improve relationships between parents and children. An evaluation of the project, based on questionnaires and centre data sources, showed that overall the relationships between non-resident parents and their children improved and relationships between resident and non-resident parents also improved. There were also reports that children in these families were happier since they started using the service (Coen and Kearns, 2008). As well as reducing conflict within families that are likely to experience a high degree of negative interaction, the centre also facilitated a greater amount of access between non-resident parents and their children. The centre appears to be offering a relatively innovative service that can offer support and practical solutions to at least some of the particular difficulties faced by families that no longer live together and should be seen as a useful means of aiding children in developing positive relationships with both of their parents.

Families with significant risks or difficulties

Inevitably, there are families who experience serious risks or difficulties in their lives due to either the severity of mental health problems, neglect or mistreatment of children, or domestic abuse or involvement in crime. While it is generally agreed that the earlier the intervention for such families the better the potential outcomes, when such difficulties persist for a long period of time they can contribute to problems in a variety of other aspects of the family's life. It is not possible, however, to offer services to all families at an early stage. For this reason there are a number of family support services that are available for families experiencing particular extreme difficulties and risks.

Substance Misusing Parents

Interventions that are aimed at substance misusing parents have been reviewed as to their effectiveness in changing parenting practices and improving the relationship between parents and their children.

New Choices

A preliminary evaluation of a centre based intervention, 'New Choices' in Canada, was reported in 2005. New Choices was targeted at women who were substance abusers (Niccols and Sword, 2005). The service acted as a 'one-stop shop' for these women and their young (under 5 years old) children. Programmes on offer include social support, education on health and nutrition and parenting courses. Thirteen mothers and their children were assessed at three and six-month follow-up intervals. Findings showed that there was a reduction in illegal drug use by mothers in the service, but also a corresponding increase in over-the-counter drugs, though none were statistically significant. After six months of intervention maternal nutrition was seen to increase as were reports of social support. Large, though not statistically significant, improvements were seen for maternal depression and improvements in parental attitudes at six-month follow-up. All of the positive impacts increased in effect size from the three-month to six-month follow-up ratings, indicating that a longer term intervention can produce larger changes in many areas. As a pilot study, the sample size in this report is small at just 13 participants and is based on parent report rather than objective measurements. However, findings do show moderate to large improvements in areas that participants deem to be important in improving their relationships with their children.

Community Reinforcement Approach (Ireland)

The Community Reinforcement Approach (CRA) is a comprehensive behavioural program for treating substance-abuse problems. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. CRA employs familial, social, recreational and vocational behavioural reinforcement contingencies to support the individual in the recovery process. The goal of CRA is to assist the individual in developing a lifestyle and environment where the reduction of or abstinence from use of alcohol or drugs is rewarded, and substance abuse or dependence is discouraged.

The philosophy of CRA is to rearrange an individual's life so that non-using behaviour becomes more rewarding than using behaviour. The use of alcohol and other drugs can be highly rewarding. Therefore, CRA uses several treatment strategies to achieve its goal of arranging rewards in a client's life. These strategies include increasing/exploring a client's motivation, carrying out a functional analysis of the client's alcohol or other substance use, supporting a trial period of abstinence, increasing positive reinforcers, and developing or enhancing basic social skills.

The CRA has been empirically supported (Meyers & Miller, 2001) with three recent meta-analytic reviews citing it as one of the most cost-effective alcohol treatment programs currently available (Finney & Monahan, 1996; Holder, Longbaugh, Miller, & Rubonis, 1991; Miller *et al.,* 1995).

A number of other parenting interventions that are available for substance misusing parents were evaluated in Wales in 2010 (Wright *et al.,* 2010). The services reviewed in the evaluation report included:

- **Drugaid: focusing on substance use reduction - only addresses parenting if the client requests it;**
- **Jigsaw: provides a range of interventions including group work, home visits and telephone follow-ups, but does not focus exclusively on current substance misusers;**
- **Families Matter: offers a range of interventions including CBT, one to one and some group work, initially accepting complex case work, later refined the target group to exclude 'chaotic families';**
- **Bridgend: a holistic programme to improve family functioning with family focused therapy and child-centred interventions.**

The purpose of this evaluation of the various intervention services was to inform effective model development for service delivery to substance misusing parents and their families.

The main points that emerged relating to the most effective means of creating positive change were:

- **Parenting programmes need to be targeted specifically at this group, as generic programmes are generally ineffective;**
- **Time-limited interventions are not appropriate for this group. Interventions need to be needs-led, and this includes offering support for as long as difficulties exist;**
- **Direct work is needed with children of substance misusing parents. Focusing solely on parental interventions does not necessarily address problems being experienced by their children;**
- **The level of substance misuse in the parent needs to guide the types and intensity of interventions on offer to a family, as those with more or less chaotic substance misuse will require different types of intervention. This report highlights the need to tailor interventions to different groups depending on their particular problems and difficulties, and also gives support to other studies that find that generic parenting interventions are not always suitable for certain groups of parents.**

Anti-social behavior and Crime

Parenting and family interventions for children and adolescents who have clinically diagnosed conduct disorder or who have been arrested for anti-social offences were reviewed by a Cochrane Review group to determine the most effective intervention types for this group (Woolfenden, Williams and Peat, 2001). Eight RCT studies were reviewed that included a total of 749 children and their families in either treatment or control groups. Interventions ranged from parenting programmes, family therapy and multi-systemic therapy involving two or more family members. Each of the interventions are intensive and time limited with the aim of reducing conduct problems in children and improving family functioning and reducing arrest or incarceration rates. Of the eight studies, positive results were shown across these outcomes, suggesting that targeted interventions are effective in reducing re-arrest rates at up to three-year follow-ups. However, caution is advised in interpreting these results, as there is much heterogeneity in the reported studies. Further research is needed to discover which elements of these interventions are most effective and what family characteristics are related to either more positive or more negative outcomes. It should also be noted that juvenile law-breaking is a complex issue that may have many influencing factors outside of the family home, and these need to be considered in formulating interventions.

Multidimensional Treatment Foster Care (Ireland)

Multidimensional Treatment Foster Care (MTFC) was developed in the early 1980's in the United States. It was designed as an alternative to institutional, residential, and group care placements for young people with severe and chronic criminal behaviour. Subsequently, the MTFC model has been adapted and used with children and adolescents with severe emotional and behavioural difficulties. It is underpinned by Social Learning Theory, which describes the mechanisms by which individuals learn to behave in social contexts. In family settings, daily interactions between family members shape and influence both positive and negative patterns of behaviour that children develop and carry with them into their interactions with others outside of the family (e.g., peers, teachers, etc).

Young people involved in an MTFC programme are placed to live with foster carers who have been trained in implementing the programme, for a period of six to nine months. During this time, wrap-around support is provided to the young person in every aspect of their lives, as well as to their birth family and foster carers.

Three key elements of treatment are targeted during placement and aftercare:

1. **To assist the young person develop appropriate social skills so that they can achieve success at home, in school and in their community;**
2. **To help the young person to decrease/ eliminate difficult behaviour;**
3. **To promote the young person's return to live with their parent(s), relative(s) or other long term committed carer(s).**

The aims of MTFC are to create opportunities so that young people are able to successfully live in families rather than in group or institutional settings, and to simultaneously prepare their parents, relatives, or other aftercare resources to provide them with effective parenting so that the positive changes made while the young people were on an MTFC programme can be sustained into the future.

Eight randomized trials and numerous other studies have provided evidence of the feasibility and effectiveness of MTFC. Later studies examined immediate and long-term outcomes in several areas including:

- **Youth criminal behavior and incarceration rates;**
- **Youth violent offending**
- **Youth behavioral and mental health problems;**
- **Disruption of placements and running away;**
- **Placement recidivism;**
- **Attachment to caregivers;**
- **Gender differences;**
- **Foster parent retention and satisfaction.**

MTFC has been shown to be an effective and viable method of preventing the placement of youth in institutional or residential settings. Studies have found that placement in MTFC can prevent escalation of delinquency and other problem behaviours such as youth violence.

Intensive Family Preservation Programmes

Intensive family interventions are provided to families who have a complex set of difficulties requiring ongoing and specialist support to address their issues. Since the 1970s intensive family preservation programmes have been used widely in the USA for families in crisis experiencing imminent risk for out-of-home placement of a child (Lindsey *et al.,* 2002). The primary aim of these programmes is preventing out-of-home placement. In order to do so, the programmes focus on ending the crisis, improving family functioning and promoting the use of social support.

Although intensive family preservation programmes carry different names, most programmes are built on the Homebuilders model that was developed in Washington in 1974. Important characteristics of the Homebuilders model are a quick start of the intervention (within 24 hours after referral), small caseloads of social workers and short duration (four to six weeks). The intervention is intensive and flexible and offers therapeutic services - for example, training new parenting skills - and concrete services, such as organizing financial support (Berry, 1977).

Family Preservation programmes including Homebuilders have been widely evaluated, and the results are mixed (see Channa *et al.,* 2012). After the introduction of these interventions, many positive results were presented. Evaluation studies reported successful prevention of out-of-home placement, from 71% up to 93% prevention rates (Pecora *et al.,* 1987; Berry, 1992). However, the positive results were mainly found in studies that did not use control groups, and therefore no conclusions on effectiveness could be drawn (Lindsey *et al.,* 2002).

In order to establish the effectiveness of intensive family preservation programs, several narrative reviews (Fraser *et al.,* 1997; Lindsey *et al.,* 2002, Tully, 2008) and two meta-analyses (Dagenais *et al.,* 2004 and Miller, 2006) were completed. All showed mixed results with respect to out-of-home placement. Some promising results concerning improvement of family functioning were presented, however, particularly in uncontrolled studies. Miller, 2006, conducted a selective meta-analysis of intensive family preservation programs delivered in Washington State and concluded that only programs that adhere to the characteristics of the Homebuilders model were effective in preventing out-of-home placement and improving child and family functioning.

A meta-analysis of intensive family preservation programmes targeted to families where children are at risk of being placed in care was conducted in the US (Dagenais *et al.,* 2004). When looking at studies that include only treatment groups there appears to be strong evidence that the intervention is successful in keeping children at home. However, when a control is used there are little to no differences in rates of institutional care for children, suggesting that most children in intervention or not would likely be placed in care anyway, which should encourage caution in interpreting findings from studies where a control group is not used. A similar discrepancy was found when measuring outcomes for children in the interventions, when a control was used and outcomes compared between groups, effect sizes were lower than if just pre and post test measures were used.

A total of 27 programmes were included in the meta-analysis, and overall findings suggest that while there appears to be no real effect on child placement for the intervention, programmes that focused on delinquency or specific behaviour problems in children tend to achieve better results. Most of the interventions included in the analysis also showed that family functioning improved in service users. However it is not clear if this will act as a long term protective factor against children being maltreated.

Multisystemic Therapy (Ireland)

Multisystemic therapy is an intensive home based therapy intervention for young people with social, emotional, and behavioural problems and in particular for young people who have committed serious offences, and their families. This short term (four to six months) therapy is aimed at children and adolescents aged from 10 to 17 years old. The main aim of the intervention is to reduce substance misuse and offending in young people and is based on an ecological perspective that takes account of individual, family, neighbourhood and wider social factors that can influence antisocial and delinquent behaviour.

Masters level therapists engage families in identifying and changing individual, family and environmental factors that contribute to problem behaviour. The therapy has been used primarily in the US where it was developed, but also in Ireland, Sweden, Denmark and the UK (UNDOC, 2009). Techniques are used dependent on the individual needs and goals of each family and are drawn from evidence based practices that help to promote strengths in family members. Nine therapy principles guide the intervention (these can be found at: www.mstservices.com/text/treatment.html#nine) and underlie the treatment approach. In a review of 16 RCTs the therapy has shown that participants have a reduced level of recidivism, lower levels of substance use and a decrease in both offending behaviour and violent behaviour. However, other systematic reviews have found that there are no significant differences between MST and other usual services (Littell, Campbell, Green and Toews, 2005).

As most of the evaluation studies of this intervention have been conducted in the US, it is not clear if any positive outcomes would be seen in other countries where the therapy is used.

Functional Family Therapy

Functional Family Therapy (FFT) is an evidence based systemic family prevention and intervention therapeutic programme. It is a programme that has been proven in a number of research studies to work for families and young people. It has been used successfully to treat young people and their families coping with relationship issues, emotional and behavioural problems at home, at school, and in the community. Studies show that FFT helps reduce violence and family conflict. FFT works by recognising the importance of family unity, working to improve family relationships, and enhancing family members' support for one another. While the programme is designed for young people aged 11 – 18, their younger siblings also benefit from the therapy. FFT is a short-term therapy of approximately 16 – 22 sessions, with up to 26 – 30 sessions for more complex issues.

Aos *et al.,* (2006) located and meta-analyzed seven rigorous evaluations of this programme in the United States of America and found that the average FFT program with quality control can be expected to reduce a juvenile's recidivism rates by 15.9%. Their analysis indicates that, without the programme, a youth has a 70% chance of recidivating after a 13-year follow-up. Aos *et al.,* suggest that if the youth participates in FFT, the recidivism rate drops to 59 per cent - an expected 15.9% per cent reduction.

Building Bridges

In the UK Building Bridges was initially rolled out in London to offer services to families with a parent who suffers from severe mental health issues. The project has since been expanded to cater to other families with a wide range of complex and interacting difficulties. An independent review of the service using quantitative and qualitative data collection methods was conducted in 2011 (MacLeod, 2011). Using evidence based practices, the project offers a range of intervention services that focus on practical issues as well as emotional and behavioural problems and relationship difficulties. A total of 1,347 families were included in the evaluation with no control group used.

Outcomes from 848 service users, where pre- and post-intervention data was available, showed that there was a statistically significant improvement in family relationships. Data for children involved in the intervention showed high levels of depression at pre-test; there were improvements in these scores by post-test follow-up, as well as some increases in self esteem. None of the children's outcomes had been maintained by a six-month follow-up after intervention, and a number of children showed decreases by this stage. This may reflect a need to focus more on children's needs as separate from those of the family in order to effect more enduring changes. Overall, interview data reflects similar findings to other evaluations in that positive reports are given regarding perceptions of the intervention, the relationship between service users and workers and of increased feelings of competence among parents.

4.5

SUMMARY AND CONCLUSION

Due to the variety of family support services available in Ireland and in other countries it can be difficult to compare interventions with each other. When many evaluations use different outcome objectives, measures and methods of calculating effectiveness it is also difficult to compare levels of effectiveness between services. However, there are a number of common themes that emerge from reviewing the range of family support services about the factors that are most likely to promote positive outcomes and factors that can reduce the effectiveness of programmes or interventions.

Factors that promote positive outcomes.

- **Relationships between service users and providers is usually perceived as positive by participants, mainly due to the sense of trust that develops between individuals.**
- **While early intervention is usually best to tackle difficulties before they become too severe, those with more entrenched difficulties can still benefit from family support services.**
- **Most successful programmes are both strengths-based and needs-led and tailored to the individual needs of families.**
- **Programmes that are highly structured and manual-based need to maintain a high level of fidelity to the implementation of the programme.**
- **Comprehensive training for all facilitators, including volunteers, is needed to ensure adequate levels of knowledge.**
- **Services for ethnic minorities appear to work best when there is a match in language and/or culture between participants and service providers.**
- **Programmes that are based on a theoretical model of change are most likely to show effective outcomes.**
- **For those with more complex problems longer term interventions appear to add to positive outcomes.**
- **For families with child behavioural problems up to and including Level 3 needs, parenting programmes are generally an effective intervention.**
- **A number of side benefits can also be accrued from centre based services, such as increasing friend networks and facilitating social support.**
- **Most interventions show similar levels of effectiveness for both individual and group style programmes.**

Factors that reduce effectiveness.

- **Many families require a multi-agency response to meet their needs.**
- **For families who are at higher levels of risk and have more complex problems, generic parenting programmes appear to have little effect.**
- **Single focus interventions are unlikely to affect other difficulties being experienced by families, so all potential areas of difficulty need to be addressed in interventions.**
- **While many family support services aim to be mainly self-referral services, there can be a perceived stigma attached to attending, which is difficult to overcome in some families.**
- **Services which are aimed at mothers and children and do not include fathers in their interventions. This may impact on outcomes related to family functioning.**
- **Location and timing of programmes can sometimes be inaccessible or restrictive for some families.**
- **Some time-limited interventions may not be effective for families with multiple difficulties.**

5.0

IMPLEMENTATION

The adoption of services, programmes and practices, even when underpinned by evidence, is no guarantee that they will result in positive changes in the lives of children and families. It is well established that evidence-based programmes and practices will often fail to produce intended outcomes because of the challenge of successful implementation. Achieving high quality implementation will be key for successful CFA Family Support efforts. Implementation is a core feature of the commissioning process as detailed in the Commissioning Strategy, and this document is designed to support this. Part of the commissioning process involves the analysis of local need and service provision, responding to identified gaps and supporting the implementation of proposed new services through monitoring and evaluation. While only emerging in recent years, there is a developing, quite robust, literature in the area of implementation science.

In order to address implementation issues in the policy field of child protection and welfare, two factors must be considered. First is the nature of the system itself, and the task to which it is addressed. Writing specifically about Child Welfare Systems in the United States, Aarons and Palinkhas suggest that '... implementation may be impacted by system, structural, process, and person factors' (2007, p.412). One of the most significant points relates to the role of parents as mediators of provision – and their amenability/capacity for engagement, while more generally, the high degree of variability in the nature of the populations served presents significant challenges for systematic implementation. Second, but less well elaborated in the literature, is the dearth of the evidence on what are effective child protection systems. Thus, while there are examples of effective programmes, there are fewer examples of what are the most effective systems at preventing child abuse and neglect, and effective responses in mitigating their short and long-term negative effects for children where abuse and neglect occur. Where examples of effective systems exist, the political, social, cultural and administrative contexts in which they operate may make direct system replication an unrealistic goal.

In spite of these evidence challenges, there is much to inform successful implementation of support programmes and initiatives by the CFA from the field of implementation science. Current leaders in implementation science are Fixen and colleagues at the National Implementation Research Network in the United States. They propose a conceptual model of implementation - developed over many years - involving six phases: Exploration, Installation, Initial Implementation, Full Implementation, Innovation and Sustainability. They propose a set of core implementation components

necessary for successful implementation and set this in a context of multilevel influences (see Figures 1- 3 in Appendix 1). More recently, Aarons and colleagues, much of whose focus is children's welfare and mental health, have developed a similar model, which is more explicitly addressed to the contextual features. Thus, they consider implementation in relation to four phases: Exploration, Adoption/Decision Preparation, Active Implementation, and Sustainment, and two contextual levels: the Outer and Inner Context. This framework, while addressed to the core of implementation within organisations at worker level, is usefully directed to the other levels that affect implementation (see Figures 4 – 5 in Appendix 1).

Meyers *et al.,* synthesised twenty-five implementation frameworks and suggested that there are similar steps in the implementation process regardless of the type of innovation, target population, and desired outcomes. They have developed a Quality Implementation Framework that provides a conceptual overview of the critical steps composing the process of quality implementation (2012). In an Irish context, the Centre for Effective Services has produced An Introductory Guide to Implementation which aims to introduce readers to the key terms, concepts and frameworks associated with implementation (2012, p.1) . These frameworks and reference materials present a solid foundation in framing and planning for the implementation of new Family Support practices and programmes within the CFA.

5.1

IMPLEMENTATION AND FIDELITY TO PROGRAMME DESIGN

The concept of fidelity refers to how well a programme is implemented in accordance with its original design. There are a number of descriptions or definitions of fidelity. Mowbray *et al.,* define fidelity as "the extent to which delivery of an intervention adheres to the protocol or program model originally developed" (2003). The definition put forth by CSAP (2001) is the degree of fit between the developer-defined elements of a prevention programme and its actual implementation in a given organisation or community setting. There is research evidence that implementation and fidelity to programme design are clearly related to program outcomes (Rhine et al, 2006; Broderick and Carroll, 2008; Webster-Stratton, 2011). Having high program delivery fidelity has been shown to predict significant improvements in parents' and children's behaviours across a number of different evidence based practices (Broderick and Carroll, 2008; Eames *et al.,* 2009).

A review of the literature shows five primary components examined when considering programme fidelity (Dane and Schneider, 1998; Dusenbury *et al.,* 2003)

1. **Adherence (or integrity, fidelity) refers to whether the programme service or intervention is being delivered as it was designed or written, i.e., with all core components being delivered to the appropriate population; staff trained appropriately; using the right protocols, techniques, and materials; and in the locations or contexts prescribed.**
2. **Exposure (or dosage) may include any of the following: the number of sessions implemented, length of each session, or the frequency with which programme techniques were implemented.**
3. **Quality of Program Delivery is the manner in which a teacher, volunteer, or staff member delivers a programme (e.g., skill in using the techniques or methods prescribed by the program, enthusiasm, preparedness, attitude).**
4. **Participant Responsiveness is the extent to which participants are engaged by and involved in the activities and content of the programme.**
5. **Program Differentiation identifies the unique features of different components or programmes that are reliably differentiated from one another.**

The research literature highlights the debates that exist about programme fidelity and its implications for prevention research. Fidelity of implementation is important not

only to programme evaluators, but also to programme developers (Weiss, 1998). Programme developers assess the fidelity to which a programme was delivered to determine the quality of a programme and consider improvements. Programme evaluators assess the fidelity in which a programme is implemented to help explain why innovations succeed or fail (Dusenbury *et al.,* 2003). Researchers may try to determine the critical components of the programme to determine which features of the programme are essential and require the highest level of fidelity, and which may be adapted or deleted without compromising the effectiveness of the intervention (Mowbray *et al.,* 2003). The need for programmes to be effective in a real-world setting and adapt to their context is argued; however, modification of programme components to fit the particular needs of a site poses a specific challenge (Dane & Schneider, 1998; Fixson *et al.,* 2005).

Adapting programmes

Programmes are often adapted from their original design when they are implemented by a new organisation, in a new community, or by a new staff member. This issue is of particular relevance in the Irish context where many of the programmes used in children and families services are designed and developed in another jurisdiction. Changes might be made to a programme to better meet the needs of the community where it is being implemented, to reflect the lifestyle and culture of those receiving the programme, to fit within an organisation's budget or calendar, or to accommodate the preferences of the local staff members facilitating it. While adaptations for some of these reasons may be justified, changes to the content, duration, or delivery style of the program can diminish the programme's effects (O'Connor, Small and Cooney, 2007).

O'Connor *et al.,* note that one very common reason for adapting a programme is a perceived cultural mismatch between a program and its targeted audience (2007). Although research shows that, for example, juvenile delinquency programmes tend to be equally effective for youth from many cultural backgrounds, cultural mismatch continues to be a concern (Wilson *et al.,* 2003). A large study of the effectiveness of the Substance Abuse and Mental Health Services Administration Model Programs in various settings in the USA offered some support for adaptations designed to address cultural mismatch: the researchers found that fidelity to the original programme design was generally important to programme effectiveness, but less so when there was a cultural mismatch. In other words, in situations where the "culture" of the programme was different from the culture of the target audience, adaptations were less damaging to the programme's effectiveness (Emshoff *et al.,* 2003).

However, another study found that culturally adapted versions of a violence prevention programme had higher retention rates but weaker outcomes when compared to the non-adapted programme. The authors suggest that, although the adaptations made the programme more attractive to participants and improved retention rates, the adaptations also may have eliminated crucial elements of the original intervention, making it less effective (Kumpfer *et al.,* 2002).

Other intentional changes to evidence-based programmes may have similar effects, making a programme more attractive to potential participants or sponsoring agencies, but potentially reducing or eliminating the positive effects of the programme. Possible adaptations include shortening the length of the programme or reducing the number of staff involved in delivering a programme or using volunteers who do not have adequate experience or training. However, reducing the "dosage" of a programme, changing the staff-to-participant ratio, or staffing the programme with less qualified personnel is likely to diminish the programme's effectiveness (O'Connor *et al.,* 2007). Sufficient dosage and the opportunity to form positive relationships with well-trained staff have been identified as important principles of effective prevention programmes. Eliminating parts of a programme's content and shortening the duration or intensity of a programme are

viewed as riskiest forms of adaptation (O'Connor *et al.,* 2007). However, adding material or sessions to an existing programme while otherwise maintaining fidelity does not generally seem to have a detrimental effect.

Another type of programme adaptation comes in the form of unintentional changes that are made as the programme is implemented over time. This is sometimes referred to as "programme drift." These changes may happen when a facilitator adjusts the programme to fit his or her facilitation style, eliminates content, or adds in elements from other programmes. As the number of these changes grows, it becomes less and less likely that the implemented programme will have the promised effects. For this reason, it is not uncommon for evidence-based programmes to require regular "re-certification" of facilitators and provide tools to measure programme fidelity (Elliot and Mihalic, 2004). O' Connor et al (2007) usefully outline what they consider to be acceptable and unacceptable adaptations to programmes (see Table 5.1).

Table 5.1: Types of Programme adaptations

PROGRAMME ADAPTATIONS	
Acceptable adaptations:	**Unacceptable adaptations**
• **Changing language – Translating and/ or modifying vocabulary** • **Replacing images to show youth and families that look like the target audience** • **Replacing cultural references** • **Modifying some aspects of activities such as physical contact** • **Adding relevant, evidence-based content to make the programme more appealing to participants**	• **Reducing the number or length of sessions or how long participants are involved** • **Lowering the level of participant engagement** • **Eliminating key messages or skills learned** • **Removing topics** • **Changing the theoretical approach** • **Using staff or volunteers who are not adequately trained or qualified** • **Using fewer staff members than recommended**

Enhancing programme fidelity

Attention to a number of specific areas has been shown to enhance programme fidelity. In an analysis on the extent to which programme fidelity was verified and promoted in evaluations of prevention programmes, Dane and Schneider (1998) outlined a number of key areas that enhanced fidelity. These include:

- **the provision of training manuals;**
- **the training of facilitators;**
- **the supervision of those tasked with implementation.**

Training manuals with clear descriptions of the activities to be implemented are highlighted as a key component in promoting programme fidelity along with training and ongoing supervision of those tasked with implementing the programme (Ibid; Webster-Stratton, 2004; Fixson *et al.,* 2005). Training and supervision increases preparedness and comfort levels and provides information on the programme's utility and effectiveness (Webster Stratton, 2004; Fixson *et al.,* 2005; Millar, 2011). Adequate training and supervision may decrease resistance to the proposed intervention, which, in turn, may increase implementation. Fixson *et al.,* describes how attention to the core components of "implementation drivers" (training, supervision, supports) creates "high-fidelity practitioner behaviour" (2005, p.28). An American study on those delivering a home-safety programme for children caring for themselves after school ('latchkey children') found they followed programme procedures more closely when they received consistent supervision from project directors (Peterson *et al.,* 1988). The authors speculated that regular contact with project supervisors may have increased their feelings of accountability. Supervision meetings may also provide opportunities for experienced staff members and service providers to decide collaboratively how to resolve problems encountered during implementation (Fixson *et al.,* 2005). As outlined in the Commissioning Strategy, following implementation of a new programme or service the challenge then lies in maintaining standards and ensuring relevance through monitoring and evaluation.

6.0

CONCLUSION

This report has provided a comprehensive overview on 'What works in Family Support?' The issues involved in establishing an evidence base in social service settings were discussed with specific reference to the types and levels of evidence that constitute an evidence base. Exemplars of evidence based practices responding to a range of needs across a range of ages and stages were provided and the challenges involved in implementing programmes with fidelity considered. The report also provided a thorough description of Family Support as an orientation in working with children and families.

In order to be of use, this report must benefit managers and practitioners within their role in the CFA to respond to the needs of children, young people and their families at a local level. To this end it is worth developing awareness at national and local management level of some of the limitations and constraints of a simple 'what works?' approach. First, as identified in this report, no single programme will meet all needs; what will be required is a detailed understanding of local need and the careful and nuanced matching of intervention to need. Investment in programmes with strong 'market-recognition' may not always suit local need. For example, the scale of investment required for programme establishment and operation might only be warranted if contiguous local areas participate in funding and provision. Similarly, any investment in programmes must take account of the existing context – there are few, if any, 'green-field' sites. Decisions on investment need to reflect evidence that alterations to existing service landscapes will bring better outcomes for children and families than what is in place.

Related to this is, is the question of the value of local knowledge and innovation. The CFA will want energized, motivated staff to drive forward its services and those it commissions. To date, a key organizational strength of the CFA (the HSE and, formerly, the Health Boards), has been the level of innovation and project development locally – something strongly reflected in the process of development of the new National Service Delivery Model. If it is only those programmes whose efficacy is demonstrated by Randomised Control Trials or meta-analyses that are acceptable as evidence for what works, the possibility of organizational innovation and ongoing renewal will be stymied. What will be needed is space within provision to innovate and incrementally build evidence. This point connects to the wider issue that over the medium to long term, knowledge and practice are dynamic entities. In three to five years' time, evidence informed practices may emerge that represent better service options for the CFA. 'What works?' in this sense is always changing. The implication for investment is that sensible horizons should be considered that allow for programmes to embed and deliver, but around which reasonable questions about continued relevance need to be posed.

One dimension of the emergent evidence on good practices is that it may begin to orient towards established common factors of effective interventions. As research and evaluation on the range of programmes addressed to different types of needs becomes more comprehensive, the scientific task will be to find out what are the common components that can be implemented. This in turn speaks to the need for the CFA to address its expectations of the core, common, good practices of its staff and its commissioned services. What is it that the CFA expects from everybody's practice and the services being provided? The principles of the Agenda for Children's Services offer a set of ideas on which this could be based – these are currently the basis of detailed practice research being undertaken in Northern Ireland.

This document is intended as a resource to CFA managers and practitioners and is intended for use alongside the Commissioning Strategy and the Parents Support Strategy in particular. The wider developments within the CFA and the proposed National Service Delivery Model will also inform the design and delivery of commissioned services in the future. This document reflects the evidence base for Family Support programmes and services at a particular point in time. In order to continue to be of value to CFA employees, the intention is that this document be updated at regular intervals with additional evidence based programmes and services added.

7.0

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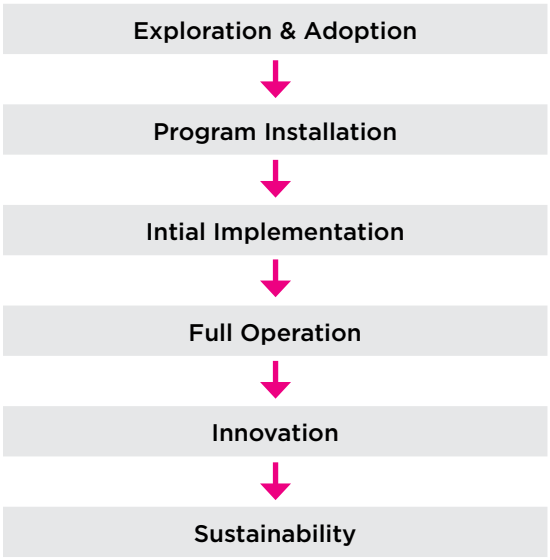
1

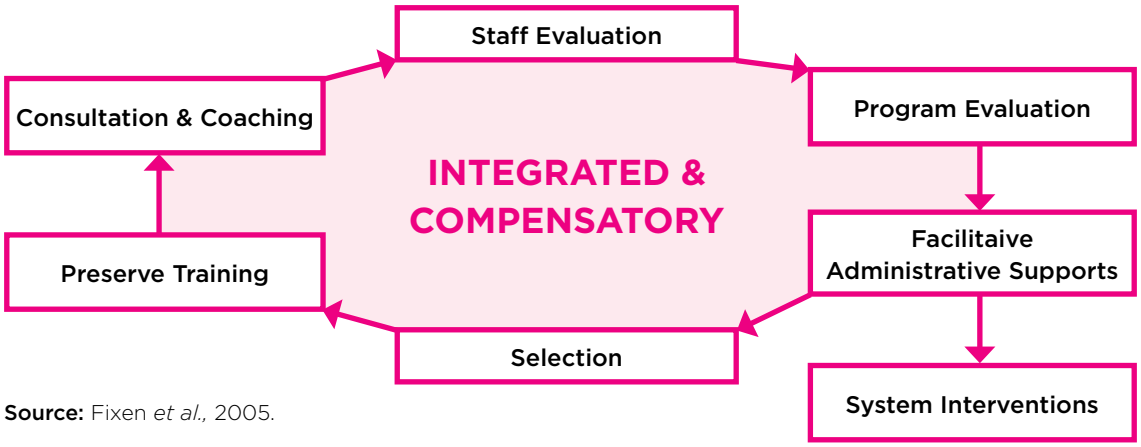
APPENDIX

Figure A1–1: **Stages of Implementation Process**



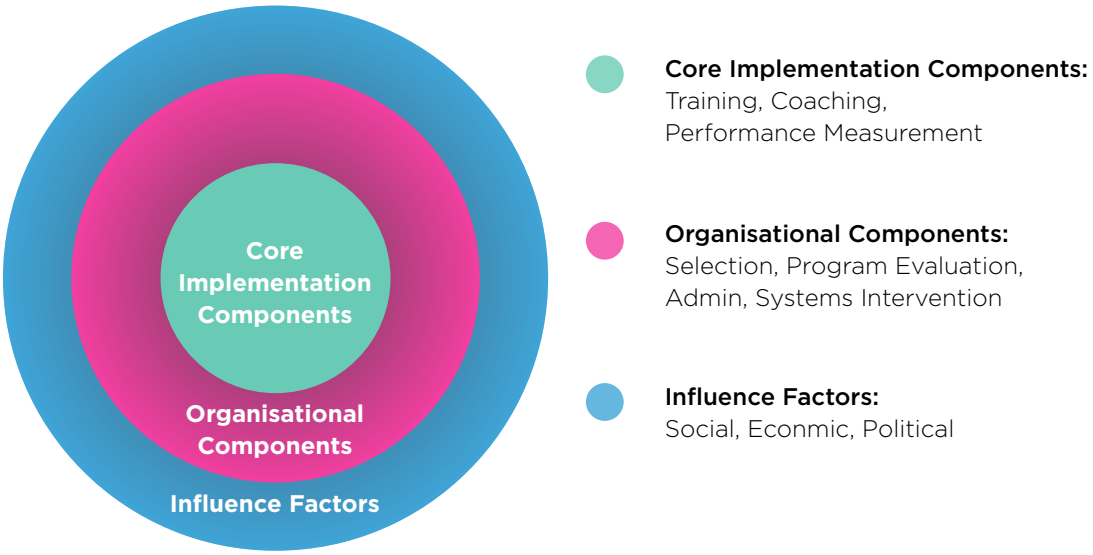
Source: Fixen *et al.*, 2005.

Figure A1-2: **Core Implementation Components**
That can be used to successfully implement evidence-based practices and programs



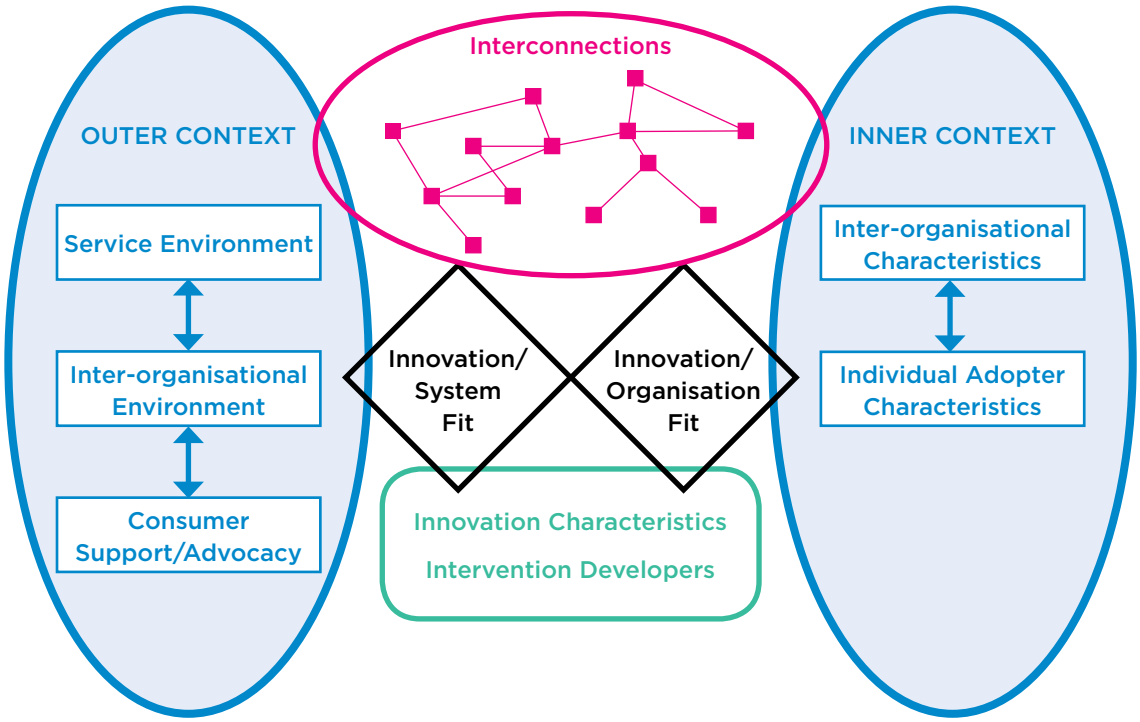
Source: Fixen *et al.*, 2005.

Figure A1–3: **Multilevel Influences on Successful Implementation**



Source: Fixen *et al.,* 2005.

Figure A1–4: **Conceptual model of global factors affecting implementation**



Source: Aarons *et al.,* 2011.

Figure A1–5: **Conceptual model of phases and factors affecting implementation**

Source: Aarons *et al.*, 2011.

2

APPENDIX: Data sources and search terms

The following search engines were used to gather research and evaluation studies as outlined:

ERIC, International Bibliography of Social Sciences, The Cochrane Library, Medline, PsychInfo, Sociological Abstracts, Social Sciences Citation Index, SCIE (Social Care Institute for Excellence).

In addition, an internet search using Google was also used to extract government-published literature, and the reference lists from selected journal articles were used to follow up on further evaluation studies. Each database was searched using keywords and various combinations of these keywords including: early intervention; family intervention; parenting programmes; social support; family problems; family difficulties; parent support; emotional development; social development. This approach yielded several hundred papers that were scanned for relevance and appropriateness to the review, and only those that included an evaluation of a family support service were finally included.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Document reference number	Family Support document No: 1	**Document drafted by**	Dr Carmel Devaney, Dr John Canavan and Mr Fergal Landy (UNESCO CFRC, NUIG) and Dr Aisling Gillen (CFA), National Specialist Family Support
Revision number	1	**Document approved by**	Mr Paul Harrison, Head of Policy & Strategy (CFA)
Approval date	1-07-2013	**Responsibility for implementation**	Area Managers, Regional Directors, all staff of CFA and partner organisations
Revision date	1-01-2014	**Responsibility for evaluation and audit**	Area Managers, Regional Directors, National Specialist
		Pages	80