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Evaluation of the Early Intervention Support Service in Northern Ireland

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THE CENTRE FOR
EVIDENCE AND
SOCIAL INNOVATION

AN EVALUATION OF THE EARLY INTERVENTION SUPPORT SERVICE IN NORTHERN IRELAND

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EXECUTIVE SUMMARY

INTRODUCTION

The Early Intervention Support Service (EISS) in Northern Ireland was developed under Workstream 2 of the Department of Health-led Inter-Departmental Early Intervention Transformation Programme (EITP) and is concerned with supporting families who require additional support outside of the statutory system. From late 2015 to the time of writing the report there are five services currently operating with one in each of the Health and Social Care (HSC) Trust areas and they deliver a range of therapeutic and practical support to families, mainly within their home.

Informed by a National Children's Bureau (NI) review of evidence-based approaches for family support for families with emerging vulnerabilities, the Public Health Agency (PHA) designed, commissioned and implemented a family support model (EISS) on behalf of EITP. This has enabled the model to be tested and has contributed to the transformation theme of EITP by establishing a coherent regional service within a previously diverse and disparate family support offer across the region. EISS was designed to include a Family Support Team including a service manager, 2.5 therapeutic workers, 1 full-time practical support worker and administrative support. Families requiring additional support with practical, family or child related issues would be referred to EISS and be assigned a support worker to work with the family using a range of evidence-based interventions to prevent or reduce the escalation of these issues in a timely manner.

Contact was to be made within ten days of receiving a referral and a family would wait no longer than four weeks before receiving an initial visit from a support worker. Therapeutic workers and practical support staff in each EISS would be trained in, and use, a variety of evidence-based therapeutic interventions including the Solihull Approach, Solution-Focused Brief Intervention Therapy and Motivational Interviewing. The Outcomes Star™ was the assessment tool to be used to assess, plan and evaluate the intervention within the services themselves. In addition, 5% of families could avail of Family Group Conferencing; Incredible Years and Strengthening Families parenting programmes were also available for families whom the support worker thought these programmes may benefit.

THE EVIDENCE BASE FOR EISS

The evidence base for the individual interventions used within EISS is well-established. However, our review of the literature highlights that EISS is unique in its toolkit family support approach, and that there is no equivalent evidence base for interventions targeting a broad population equivalent to Tier 2 of the Hardiker Model across such a wide range of needs and issues. In the studies reviewed, we highlight key mechanisms of successful interventions, including intervention fidelity, tight-screening and definition of target population, and key worker-family relationships.

Objectives

The objectives of this evaluation were:

- To assess the effectiveness of the Early Intervention Support Service in improving family functioning; parenting stress and self-confidence; and in improving the quality of the child/parent relationship;
- To assess how reliable and valid the Outcomes Star™ is as a measure of key outcomes among parents and their children;
- To assess how well EISS, and its component elements, fit to the local geographical and stakeholder context;
- To assess the experience of parents taking part in EISS;
- To assess what elements of EISS are most valued, and regarded as most beneficial, by the service providers and the parents participating in the programme, and;
- To identify aspects of the EISS that may need to be modified to enhance the effectiveness and fit of EISS before a scaled roll-out across Northern Ireland is attempted.

Specific research questions to be addressed within this report are:

- How effective is the EISS in improving outcomes for children and their families?
- What is the experience of delivering and taking part in EISS?
- What aspects of the EISS programme may need modification before a scaled roll-out is attempted?

METHODOLOGY

The evaluation comprised a non-randomised wait-list control group design assessing changes in outcomes as a result of accessing the service, a process evaluation, and a psychometric and process analysis of the Outcomes Stars as both assessment and measurement tools.

A non-randomised wait-list control group design was decided upon because a randomised control trial (RCT) was not possible, and a matched control group methodology was resisted by services. Four key outcome measures were identified and agreed for use. They were selected on the basis that they are relatively short and they are well-validated: The Family Functioning Scale (FFS); The Strengths and Difficulties Questionnaire (SDQ); Tool to Measure Parental Self-Efficacy (TOPSE); and the Parenting Stress Index Short Form (PSI/SF).

Participation from all five EISS's was sought. Unfortunately, the research team did not receive the required permissions set out for the evaluation from the Belfast Trust so were unable to collect data from parents at this location. The sample includes 109 parents at pre-test, with a total of 80 parents completing pre- and post-test measures across the four EISS. Due to a combination of factors (i.e. the design of EISS, the recruitment procedure, parental drop-out issues and other extenuating factors), the sample size is lower than desired which the analysis will take into account.

Scales were computed from the raw data for 22 outcomes. The main analysis of the data used a series of regression models to compare the mean scores for the intervention and control groups for each of the outcome measures at post-test, controlling for pre-test differences. The analysis of the impact of the intervention is exploratory in approach due to the non-RCT design and relatively small sample size of the evaluation.

The purpose of the process evaluation was to identify what did and did not work in the conception, set-up and delivery of the service. Robust ethical protocols were followed in relation to the recruitment of, consent to and storage of this qualitative data. Therefore, interviews were conducted with 55 people comprising: 10 people involved in managing EISS; 15 people delivering the service to parents; 12 parents receiving the service; and 18 local stakeholders who had used and/or referred to EISS. The interviews were recorded electronically and transcribed before being deleted and the participants were assigned pseudonyms so they could not be identified. The anonymised interviews were stored on a secure SharePoint site and analysed in NVivo 11 using a thematic coding framework.

FINDINGS

Process evaluation

The process evaluation was designed to explore how EISS was conceived, set-up and implemented and then to explore views of implementation, from a practitioner and manager perspective, a family perspective and views of the service from local stakeholders.

The general consensus from the process evaluation was that EISS met unmet need, was well placed in the targeted areas and was well received by families. This was due in part to the welcoming and non-judgemental attitude of staff and the quick referral process. The wide target population meant there were few limits on who could be referred. Staff reported a low dropout rate and praised the benefits of a home visiting family-led model in helping parents to engage more with the service. Parents receiving the service felt listened to and that they were able to be open and honest without fear of reprisal. They reported that their children engaged well with the family support worker and reported they could see positive changes as a result of receiving the service. Even where these changes were small, it had made them feel more confident in their parenting style and improved their well-being.

There were some areas that could be improved. Targets and caseload numbers were reported by all to be unattainable and unsustainable if the service was rolled out further. Complex cases were a regular issue, i.e. families were referred with extremely complex needs, or emerging problems with multiple family members. Staff reported a very fast pace of work life which led to pressures on a work-life balance. A lack of alternative services, particularly in rural areas, led to additional pressures on EISS. Sometimes families were referred as there was nowhere else to go. This was the case for one service who received a large number of referrals for children with ASD/ADHD, clinical areas which EISS staff were not trained in.

Main effects analysis

Only two of the 22 outcomes were associated with statistically significant effects of the intervention compared to control ($p < .05$): TOPSE Empathy and TOPSE Play. In addition, we found no evidence to suggest that the intervention has differential effects in relation to the gender or age of the child, the Trust area they are located in or the duration of the problems by the time they were referred. The current evaluation does not provide any formal evidence of the effectiveness of the intervention. Having said this, there are some possible indications that the intervention may be having a small but notable impact in the directions that one would expect. However, given the limitations of the current research design, even

these potential indications need to be treated cautiously as they may be unreliable. A note of caution has to apply: although the results demonstrate a small positive effect, they do not provide robust evidence that the intervention is effective. Such indications need to be confirmed through further research using a more robust evaluative design and a larger sample size.

Outcomes Star Analysis

Anecdotal feedback from practitioners and families was very positive about the utility of the Outcomes Star™ as an assessment and goal-planning tool. In addition, improvements in most Star domains were recorded by key workers. More specifically, key workers perceived there to be improvements in several areas when using the Family Star Plus. They perceived improvements for 71.4% of families in the ‘well-being’ outcome, 78.5% in ‘meeting emotional needs’ and improvements for 81% of families in addressing ‘boundaries and behaviour’. The outcome areas of ‘physical health’ and ‘progress to work’ did not show an increase for most families – 55.9% and 57.1% respectively reported staying the same. Likewise, for the My Star, key workers perceived there to be improvements in most areas; 85.9% of children reported improvements in their ‘feelings and behaviour’, and 74% reported improvements in their ‘confidence and self-esteem’. As with the Family Star Plus, some areas stayed the same. 56.9% reported their ‘physical health’ as staying the same and 61% reported the same for ‘where you live’.

However, the Stars were never intended to be used as objective measurement tools and the developers of the Outcomes Star™ (Triangle) do not recommend treating the ratings as numerical values. It is therefore inappropriate to perform statistical analyses of the ratings in relation to calculating means and levels of change over time as the ratings given are subjective and specific to each child and thus are not comparable across children. Rather, the appropriate way to report the findings, in line with the original guidance provided by Triangle, is simply to report the proportions of children deemed to have improved over time. Strong conclusions cannot be inferred from these improvements in the absence of a control group.

Whilst the Outcomes Star™ should not, therefore, be used as an objective measurement tool, especially when seeking to measure the effects of an intervention, there appears to be an increasing tendency to do this. While it was not possible for the My Star data, the psychometric properties of the Family Star Plus, if used as a 10-item scale, were explored. Whilst the Family Star Plus would appear to have sufficient internal reliability, there are questions concerning its construct validity. There is also reason to believe that the concurrent validity may well be limited given that whilst the Outcomes Star™ data tend to show improvements, these findings are not reflected when using the various battery of objective measures that have been used in this study. This, in turn, provides further suggestive evidence of the subjective nature

of the Outcomes Star™ and their increased risk of bias. Further research here is also required to assess the Family Star Plus's concurrent validity.

DISCUSSION

The evaluation design and sample size limit the strength of conclusions that can be drawn from the main effects analysis in this evaluation. However, a number of key mechanisms may explain the lack of significant improvements found in the data, which have been found in the process evaluation and with reference to the wider literature. These include the flexible use of interventions in contrast to the importance of fidelity stressed in the wider literature, the broad target population in contrast to tightly defined and screened populations targeted in the wider literature, and the lack of wider resources and services in each area for EISS to link in with and step down to. Given the design of the 12-week intervention, services reported difficulty meeting demand (if a referral could not be met within four weeks the family were declined), and the pressures of unrealistic targets placed a large amount of pressure on all staff. Due to the broad target population, each case could potentially be challenging in terms of additional issues or the time required to respond to the families' issues. Staff therefore required a wide set of skills.

The service also did many things well, we found it targeted an area of unmet need, was in high demand and practitioner and family experiences were extremely positive. The non-stigmatising nature of the service encouraged engagement, as did the approach and skills of the key workers. The nature of EISS being family-led service seemed to work for most families as they did not feel judged or criticised by the support workers. Having a home-based service worked extremely well for families in rural areas and in terms of practical issues of childcare and transport. A challenge for such services to is maintain this flexibility and family-led approach while ensuring intervention fidelity is high, in order to create sustained improvements in outcomes for families. This is a particular challenge within a model where a range of different community providers are delivering the service.

RECOMMENDATIONS

a) EISS target population

The current model addresses a broad population and we have described a number of potential issues with this including its impact on outcomes and on staff. Staff reported facing a wide range of family situations, with issues they were not familiar with, inappropriate referrals, increasingly complex cases and having to

provide support for several members of the same family. Future iterations of the model could take these challenges into account and could consider whether the broad population, covering 0-18 year olds across a wide range of social, emotional and behavioural issues at Tier 2 level of need, is a feasible target in light of the challenges discussed in this evaluation. It is noted however that EISS was designed to address a broad area of unmet need and as such fills a gap across Northern Ireland; if the target population is narrowed, this will change the objective and ethos of EISS.

b) Context and resources

EISS meets an important need and is well-viewed, but its success requires a whole system approach where other appropriate resources are available locally for staff to refer families too. In the context of financial restraints this is a difficult issue to address but one that should be acknowledged within further iterations of the EISS model.

c) Referrals

The model should consider using tighter screening processes to ensure that a well-defined Tier 2 population is being considered, both in terms of level of need and length of difficulties.

Increasing the clarity of who and what EISS is for may help reduce the burden of inappropriate referrals and the impact that this has on each service's workload, as well as help manage the expectations of families being referred and the stakeholders who refer them.

d) Implementation

There is a large literature focusing on intervention fidelity and the benefits of achieving maximum fidelity on a specific program. If EISS was designed to be delivered to achieve maximum outcomes on individual components, fidelity to the programme would be important, as evidenced in the literature. However, EISS was never intended to be a manualised programme. It was designed using an overall approach and used Outcomes Star™ to identify appropriate supports. There are some tentative, non-statistically significant encouraging signs from this evaluation, however these cannot be generalised.

It is recommended that future iterations of EISS consider whether higher fidelity in service provision can be achieved across delivery of interventions, timescales and use of the Outcomes Star, while retaining the ethos of the service and with an acknowledgement that this can be difficult to achieve in community, multi-agency contexts.

e) Future research

A longer follow up for measuring changes in those receiving the intervention, such as at three, six, 12, or 18 months, would provide important insights into the impact of the service. Outcomes may be found to be significantly improved compared to control with longer term follow up and future use of services could be assessed to show whether or not EISS prevented escalation of need. In turn, an analysis of cost-benefit could be conducted using data on future higher tier service use.

A full RCT methodology with a larger study sample is recommended as the most robust approach to evaluation the impact of EISS, with a control group receiving treatment as normal and follow-up after the same time period as the intervention group. A larger sample size would allow a thorough break-down of sub groups to assess for whom the intervention does and does not work.

1. INTRODUCTION

The Early Intervention Support Service (EISS) was established as part of the Early Intervention Transformation Programme (EITP). EITP is a Northern Ireland Executive/Atlantic Philanthropies Delivering Social Change Signature Programme jointly funded by the Delivering Social Change fund, Department of Education, Department of Health, Department of Justice, Department for the Economy, Department for Communities and The Atlantic Philanthropies. The aim of EITP is to improve outcomes for children and young people in Northern Ireland through establishing a range of early intervention approaches.

There are three Workstreams in EITP. EISS was developed under Workstream 2, which aims to support and empower families with emerging vulnerabilities or needs, that is, families within Tier 2 of the Hardiker Model, by intervening early with evidence-informed services before difficulties become intractable, and before there is a need for statutory involvement. Each EISS was aligned closely with Family Support Hubs (FSH) and existing services in the pilot area and aimed to provide a range of therapeutic and practical support to families.

The Family Support Hubs consist of a collaborative network of community, voluntary and statutory providers within a specific area who convene on a monthly basis to manage referrals, from a variety of sources, for family support. They work together to ensure the family's best needs are met. It was anticipated that EISS would be aligned alongside the FSH and accept referrals from a range of sources including self-referrals and referrals from the FSH. Duplication of existing services was to be avoided. In addition, EISS was envisaged as being able to provide support to families who were 'stepping-down' from Gateway, who are the first point of contact for referrals to a social work service. The design and implementation of EISS was purposefully intended to test a family support model across the region with a view of reviewing learning to inform future redesign and potential future implementation.

1.1 The EISS pilot study

The Early Intervention Support Service (EISS) in Northern Ireland was developed under Workstream 2 of the Department of Health-led Inter-Departmental EITP and is concerned with supporting families who require additional support outside of the statutory system. From late 2015 to the time of writing the report there are five services currently operating with one in each of the Health and Social Care (HSC) Trust areas and they deliver a range of therapeutic and practical support to families, mainly within their home

Informed by a National Children's Bureau (NI) review of evidence-based approaches for family support for families with emerging vulnerabilities, the Public Health Agency (PHA) designed, commissioned and implemented a family support model (EISS) on behalf of EITP. This has enabled the model to be tested and has contributed to the transformation theme of EITP by establishing a coherent regional service within a previously diverse and disparate family support offer across the region. EISS was designed to include a Family Support Team including a service manager, 2.5 therapeutic workers, 1 full-time practical support worker and administrative support. Families requiring additional support with practical, family or child

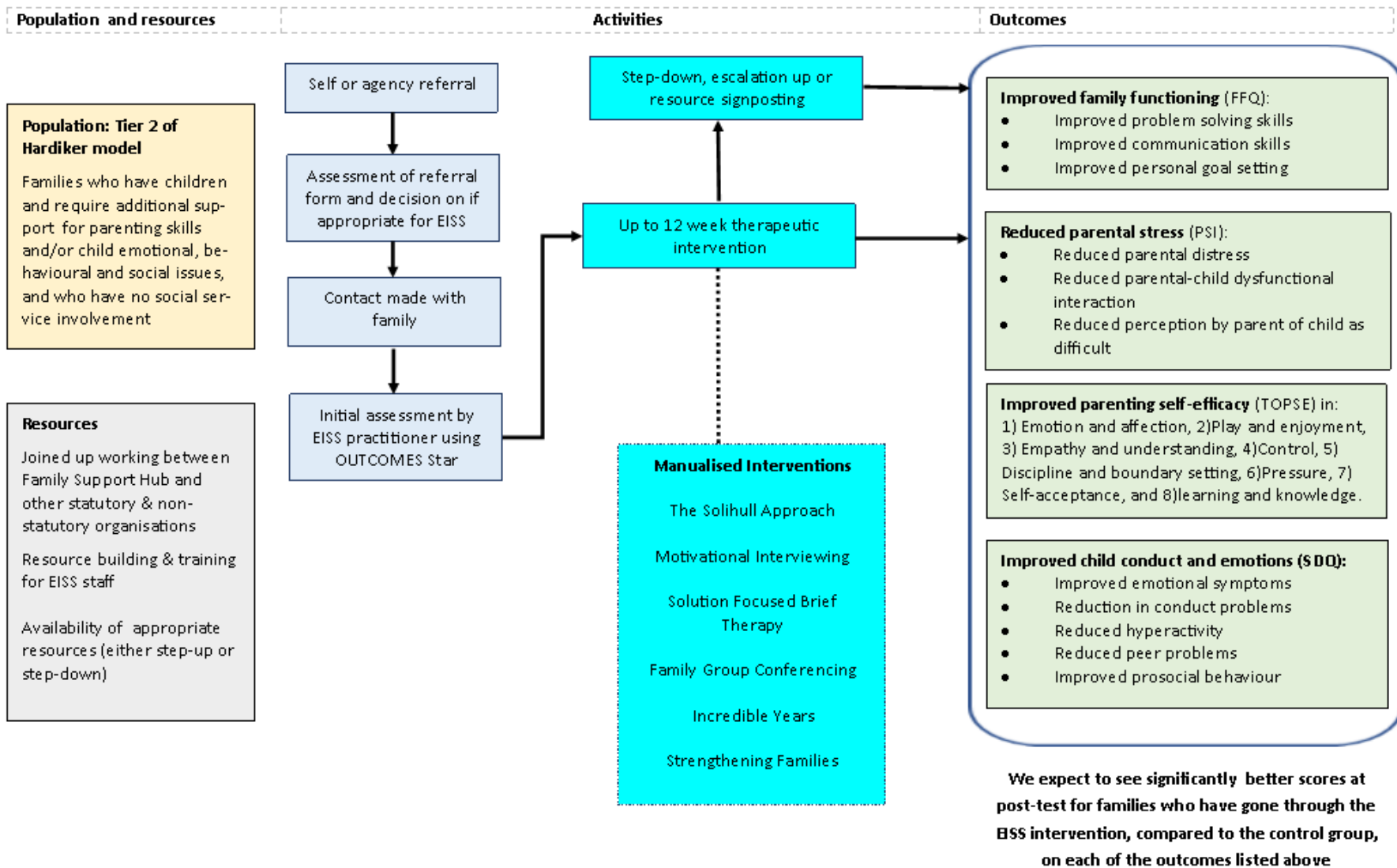
related issues would be referred to EISS and be assigned a support worker to work with the family using a range of evidence-based interventions to prevent or reduce the escalation of these issues in a timely manner.

Contact was to be made within ten days of receiving a referral and a family would wait no longer than four weeks before receiving an initial visit from a support worker. Therapeutic workers and practical support staff in each EISS would be trained in, and use, a variety of evidence-based therapeutic interventions including the Solihull Approach, Solution-Focused Brief Intervention Therapy and Motivational Interviewing. The Outcomes Star™ was the assessment tool to be used to assess, plan and evaluate the intervention within the services themselves. In addition, 5% of families could avail of Family Group Conferencing; Incredible Years and Strengthening Families parenting programmes were also available for families whom the support worker thought these programmes may benefit.

1.2 The Logic Model

A logic model was developed by the evaluation team at Queen's University Belfast and describes the outcomes being measured by the evaluation, as well as the setting out the inputs and activities required to achieve these expected outcomes.

EISS Evaluation Logic Model



* Based on ten outcomes star scales: physical health, wellbeing, emotional needs, child safety, social networks, education & learning, boundaries and behaviour, family routine, home and money, progress to work

1.3 The current evaluation

This report presents the findings of an evaluation of the Early Intervention Support Service in Northern Ireland. The overall aim of this evaluation is to provide an evidence base to inform future investment in and continued roll-out of the Early Intervention Support Service in Northern Ireland.

The objectives of this evaluation were:

- To assess the effectiveness of the Early Intervention Support Service in improving family functioning; parenting stress and self-confidence; and in improving the quality of the child/parent relationship;
- To assess how reliable and valid the Outcomes Star™ is as a measure of key outcomes among parents and their children;
- To assess how well EISS, and its component elements, fit to the local geographical and stakeholder context;
- To assess the experience of parents taking part in EISS;
- To assess what elements of EISS are most valued, and regarded as most beneficial, by the service providers and the parents participating in the programme, and;
- To identify aspects of the EISS that may need to be modified to enhance the effectiveness and fit of EISS before a scaled roll-out across Northern Ireland is attempted.

Specific research questions to be addressed within this report are:

- How effective is the EISS in improving outcomes for children and their families?
- What is the experience of delivering and taking part in EISS?
- What aspects of the EISS programme may need modification before a scaled roll-out is attempted?

This report begins with an overview of the key literature that defines early intervention in the context of family support, the evidence base for early intervention approaches targeting similar populations to EISS, as well as providing an overview of the local policy and contextual issues. It then describes the methods used for the current evaluation, which included:

- Pre-and post-test measures with families who were in contact with EISS;
- A qualitative process evaluation involving interviews with managers and family support workers in each EISS service, key stakeholders and families who were in contact with EISS, and;
- Descriptive and psychometric analysis of the outcomes star.

The report then discusses the findings from each of these elements of the evaluation and concludes with some recommendations for the future investment and roll-out of the Early Intervention Support Service in Northern Ireland.

2. LITERATURE REVIEW

2.1 Introduction

This section provides an overview of the key literature examining early intervention approaches providing support to families experiencing additional needs. Specifically, this section addresses the following questions:

1. What is early intervention?
2. What are the wider contextual issues in Northern Ireland?
3. What is the evidence of effectiveness for early intervention approaches targeting similar approaches to EISS?
4. What lessons can be learned from the research evidence already available?
5. What are the mechanisms and processes underpinning an effective early intervention approach?

2.2 What is early intervention?

The concept of intervening as early as possible to address problems when they arise is now an internationally recognised focus in work to address mental health and developmental issues in families, children and young people. The Early Intervention Foundation notes that intervening early has the likelihood to reduce *'poor long-term outcomes for children, young people and families'* (Fitzsimons and Teager, 2018:5). Within the family support context in Northern Ireland, the Children and Young People's Strategy Partnership (CYPSP) define early intervention using the definition offered by the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO):

'Intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population at risk of developing problems. Early intervention may occur at any stage in a child's life'. (C4EO, 2010).

The Family Support Model, first developed by Pauline Hardiker and colleagues (Hardiker *et al*, 1991), is central to the delivery of tiered services and interventions at different levels of need within Northern Ireland. Tier (or level) 2 of this model specifically addresses families in early stages of difficulties, for whom intervention is aimed at avoiding escalation of need by the provision of access to appropriate lower-intensity services, as early as possible. Outside of the Northern Ireland context, however, the Hardiker approach is not commonly applied to address need or direct early intervention.

Early intervention is now a central concept worldwide across a wide range of family support research and service developments, including work on infants and toddlers, approaches in education and early years learning, the treatment of conduct disorders, and mental health in adolescence. Across these contexts, early intervention approaches have a common focus on identifying, intervening as early as possible and effectively addressing problems or risk factors. There is an extensive and convincing evidence base outlining how the first few years of childhood are at a central phase of neurological development which has a considerable impact on adult health and well-being (Marmot, 2008). In

addition, the presence of risks in early life and in particular social inequalities such as poverty, tend to translate into inequalities in development and outcomes for children and young people (Maggi *et al*, 2010).

The work of Craig and Sharon Ramey in the nineties has been influential on the conceptual development of early intervention approaches to children and their families. They define early intervention in broad terms as all activities designed to promote healthy child development (Ramey & Ramey, 1998), encompassing preventative interventions, approaches to improve childhood learning and addressing needs and difficulties as they develop. There is however no consensus on how early intervention should be operationally defined, particularly in terms of which populations are targeted, as well what cut-off points for developing need are used (Ramey & Ramey, 1998; Valentine & Katz, 2015). These variations inevitably make it difficult to compare the effectiveness of different approaches, and the evidence base around what is the most effective stage to intervene and address different types of difficulty is still emerging.

Within the context of early intervention family support literature, the evidence can be broadly split into three categories: early interventions available to universal populations, those targeted at-risk populations, and those providing early treatment. Universal early intervention approaches are open to all families and tend to define 'early intervention' as providing services to parents who have recently had children - or intervening when children are as young as possible. The Incredible Years Parents and Babies Program, for example, is commonly offered universally and on the basis that infancy is a vital period for development, when adverse experiences or gaps in parental skills can have the most impact (Pontoppidan *et al*, 2017).

The evidence base on risk-based early intervention is more substantial, as interventions are often targeted at populations deemed to have the highest risk of developing additional needs. A common focus of early interventions is on geographical areas identified as being economically and socially deprived (e.g. Webster-Stratton *et al*, 2008; Draper *et al*, 2009; Draper *et al*, 2017). Such early interventions are not treating a diagnosed additional need or difficulty but addressing risk and aiming to prevent poor outcomes occurring, through mechanisms such as improving parental skills, well-being and child behaviour.

The third category of early intervention approach we differentiate here is that which is most closely aligned to the EISS approach and includes those interventions which provide support on the basis of an additional need having been identified. Additional need is also commonly identified through the use of evidenced-based tools and measures which identify children or parents as crossing a threshold score (e.g. Jones *et al*, 2007, Sourander *et al*, 2016).

2.3 The Northern Ireland Context

In 2016 NISRA documented that 460,093 children and young people under the age of 18 lived in Northern Ireland. This indicates that nearly a quarter (24.7%) of the Northern Irish population are children (NISRA, 2017). Families and children who experience multiple deprivation are at higher risk of developmental problems including conduct disorders (Kayrouz *et al*, 2017). A recent comparative analysis of multiple deprivation measures within the United Kingdom (Abel *et al*, 2016) found that Northern Ireland is the most deprived area of the United Kingdom, with 37% of the population living

in an area that is within the 20% most deprived across the UK. Similarly, a briefing paper for the Northern Ireland Assembly comparing in-work poverty across the UK and Ireland found that rates were highest within Northern Ireland (Murphy, 2015).

Intervening early for children and young people can lead to a reduction in costs to the public sector (Fitzsimons and Teager, 2018). Health outcomes for children in Northern Ireland have been described as amongst the worst in Western Europe (RCPCH, 2014), including the UK's highest infant mortality rate and suicide (Wolfe *et al*, 2014), while 28% of children are overweight or obese (RCPCH, 2017). The most recent social services statistics for Northern Ireland indicate that in March 2017, 22,737 children were known to social services as a child in need, while 2,132 were on the child protection register and 2,983 were being looked after in care (Waugh & Rodgers, 2017). In 2016-2017, 6,077 families were referred through Family Support Hubs in Northern Ireland, providing support for 7,655 children and 4,499 parents for emotional behavioural difficulties, parenting programs and related needs. This was an increase of 1,555 families, 2,361 children and 897 parents compared to the previous year (CYPSP, 2017). The Early Intervention Foundation estimates that the cost of late intervention to the public sector in Northern Ireland is £238 per person, or £1,166 per child (Fitzsimons and Teager, 2018).

2.3.1 Northern Ireland Policy

Given the extent of need within Northern Ireland and the cost of delivering more intensive services, the rationale for early intervention approaches to reduce escalation of issues is clear. This rationale underpins a series of key strategies in Northern Ireland.

'Our Children, Our Pledge', the strategy for children and young people in Northern Ireland from 2006 to 2016 (OFMDFM, 2016), sets out a framework to improve the health, achievement, safety, well-being, societal contribution and rights of all children and young people in the country. Since then, a number of policy drives within the last ten years have built upon the 'Our Children Our Pledge' policy to move towards preventative and early intervention approaches in family support. These include:

- Families Matter (DHSSPSNI, 2009);
- Healthy Child, Healthy future (DHSSPSNI, 2010);
- Learning to Learn: a Framework for Early Years Education and Learning (DENI, 2012)
- Transforming Your Care: Vision to Action (HSCB, 2013), and;
- Making Life Better (DHSSPSNI, 2014).

Within these strategies there has been an emphasis on delivering support using more collaborative approaches across services and sectors. The Children's Services Co-operation Act (2015) requires co-operation among children's authorities in Northern Ireland to contribute to the well-being of children and young people, which has been in part a response to criticism of services in Northern Ireland for tending to operate in an isolated manner, with a lack of joined-up working to identify and meet needs at an early stage for children, young people and families (Devaney *et al*, 2010).

A review of the evidence for inter-agency working in improving the effectiveness of early interventions by Boydell (2015), found evidence that better joined-up working may improve the process of providing these services and some of the intermediary outcomes for the families involved, but that evidence for long-term improvement primary outcomes is lacking. Nonetheless, the review concluded that the best outcomes are likely to be found where implementation of inter-agency collaboration is of the highest quality.

To address the lack of inter-agency collaboration within Northern Irish services, the Early Intervention Transformation Programme (EITP) is based around a collaborative preventative model which uses partnership-working to work towards three central goals: equipping parents with the skills needed to give their children the best start in life; supporting families outside of the statutory system when problems first emerge; and positively addressing the impact of adversity on children by intervening both earlier, and more effectively, to reduce the risk of poor outcomes later in life.

2.4 What works in Early Intervention?

To further understand approaches to and the impact of early intervention, a thematic rather than systematic search was undertaken (see appendix 7 for description of the search strategy and search terms). Table 9 (see appendix 8) comprises 15 quantitative peer-reviewed papers published from 2007-2017. These assess the impact of family support early intervention approaches on populations equivalent to Tier 2 of the Hardiker model, measuring outcomes across emotional, social and conduct issues in children, and/or parental skills and needs. This next section will review some of the key aspects of evidence of early intervention impact. This section is supplemented with further literature from documents in the public domain as the included papers did not contain this evidence.

2.4.1 The population

In general, early interventions are targeted at need and risk at as early a stage as possible, and while there is no firm evidence on what populations and age-groups benefit most (in part due to differences in definitions as described above), an evidence review by the Early Intervention Foundation (Amussen *et al*, 2016) found that those targeting populations where there was an early signal of risk in child development had the strongest evidence of effectiveness, compared to those which were universal or which targeted on the basis of demographics. However, they stress that this does not mean the latter two population groups cannot benefit to the same degree, but rather that the evidence base is at an early stage. The type of population and their age will also be impacted by the specific issue an early intervention is addressing, and there has not to date been a synthesis of the evidence base on what population groups are most benefited by each type of risk or condition.

2.4.2 The type of intervention

Walsh and Doherty (2016: 10) highlight that family support is used as “*an umbrella term encompassing an array of interventions which vary greatly in terms of delivery, impact and outcomes*”. There is a diverse and complex provision of service delivery in Northern Ireland. Tier 2 interventions are

delivered to users who are receiving targeted resources as they have additional needs (IPC, 2012). There are a range of Tier 2 interventions which are implemented in different ways, by people with different levels of training and skillsets and delivered by a variety of community, voluntary and statutory services and agencies (Montgomery *et al*, 2016). This variation makes it hard to compare interventions.

There is also a general lack of consensus on what type of intervention works best; there is no one size fits all (Sneddon, 2014). The Early Intervention Foundation found evidence for the effectiveness of 17 distinct programmes that could be effective if the programmes were supported by careful commissioning (Amussen *et al*, 2016). A key factor in the effectiveness of an intervention appears to relate to individual circumstances i.e. how things are for an individual at that particular time and whether they are ready to accept change. There are also various process-related factors which may help to increase the effectiveness of early intervention, despite wide variation in implementation, and the literature provides some key areas to bear in mind (adapted in part from NCB, 2014; Montgomery *et al*, 2016; Walsh and Doherty, 2016):

a) Programme accessibility

Engagement can be improved by ensuring that a service is accessible in terms of location, ability to signpost on to relevant services, by providing childcare or delivering the intervention at a reasonable time to ensure parents can attend. The duration of the intervention and frequency of sessions are also important factors to consider.

b) Fidelity to the intervention

Where interventions are manualised, or have strict guidelines for structure and content, they should be delivered consistently in line with such guidance. It may be that there is room for negotiation or flexibility within a service, or that service users are encouraged to co-produce and be involved with the content of the intervention.

c) Awareness of individual needs

Individual needs and context should be taken into consideration in delivery, including the age of children, as well as practical factors such as the location of service delivery and a families' ability to attend. Cultural and language barriers may be present and reading ability of both the child and other family members may also mean that the format of delivery needs to be adapted.

d) The key worker approach

The literature suggests that key worker skills in delivering an intervention and engaging with parents are one of the key elements in determining the effectiveness of an intervention (Sneddon, 2014). The key worker should be able to engage effectively with the service user, provide therapeutic and practical support and be prepared to challenge and change the users approach while working in partnership (DCLG, 2012). In short, the key worker should work with the service user to help them "*function effectively without intense support and engage in positive behaviour*" (CWDC, 2011: 145).

In a review of evidence, the National Children’s Bureau (NCB, 2014) found that key workers who had excellent inter-personal skills, were fully trained, could build rapport quickly and worked in partnership with service users in an empathetic way would greatly improve their chances of effectiveness in terms of ‘getting’ and ‘keeping’ service users (NCB, 2014: 7). Additional key worker qualities included positive interaction techniques, openness, maintaining a child-focused approach, being flexible and having the ability to adapt rapidly to facilitate the needs of service users, while challenging them at the same time (NCB, 2014).

2.5 Evidence of effectiveness

This section will examine evidence for effectiveness within the 15 included papers found by searching for early intervention approaches targeting similar populations (see appendix 7 for full search strategy), outlining the measurable changes that have been observed to support the effectiveness of early intervention. As previously mentioned, a thematic rather than systematic search strategy was employed and the interventions referenced below make up the included table of papers (see appendix 8). An important point to note here is that the majority of included papers examined the impact of one intervention approach rather than a toolkit of approaches as used by EISS; an evidence base for early interventions using a toolkit of approaches targeted towards a similar Tier 2 population does not exist in the literature. Because the evidence base for the individual interventions used by EISS is already well-established, this review focused on the population of families who have children with emerging additional needs.

a) Child conduct and behaviour

Family support interventions targeting child conduct and behavioural problems consistently found medium to strong positive impacts compared to controls. For example, the evidence for Incredible Years is particularly strong; it was found to significantly reduce child conduct and hyperactivity as measured by the Strengths and Difficulties Questionnaire (SDQ) compared to a control group (Seabra-Santos *et al*, 2016) at 12 and 18 months follow up. The same study found that externalising behaviours, measured by the Preschool and Kindergarten Behaviour Scales (PKBS-2) were significantly reduced in the intervention group at 12 and 18 months.

Child conduct disorder was also found to improve significantly as a result of the Incredible Years Basic Programme, with improvements at 6 months compared to control maintained at 12-month follow up (McGilloway *et al*, 2014); this study also reported improved scores in the SDQ, Conners Abbreviated Parent Rating Scale (CPRS) and the Social Competence Scale, maintained at 12 months. A Netherlands study of Incredible Years focusing on socio-economically disadvantaged and ethnic minority families, found Incredible Years significantly reduced Eyberg Child Behaviour Inventory (ECBI) Intensity and Problem behaviour scores as well as SDQ conduct problems (Leijten *et al*, 2017). The longest follow-up period reported was 24 months (Posthumus *et al*, 2012); after this period, sustained effects were found as in the Incredible Years intervention group when compared to controls, in ECBI and Child Behaviour Checklist (CBCL) measures.

Other interventions found similarly positive results. Parent Management Training was found (Braet *et al*, 2009) to reduce the frequency of child aggressive and externalising problematic behaviours post intervention and at one-year follow up compared to control, as reported by parents using the CBLC. The Infant Behaviour Program was also found to significantly reduce infant aggression and defiance and improve compliance in to maternal commands 12-15-month-old infants at three and six month follow up (Bagner *et al*, 2016), as measured by the Infant-Toddler Social and Emotional Assessment (ITSEA).

Variants of Triple P were also found to improve child behaviour. The pathways Triple P-Positive parenting program was found to improve child externalising behaviour as measured by the Child Behaviour Checklist, which were maintained at three-month follow up (Wiggins *et al*, 2009). Another study measured the impact of an enhanced version of the self-directed teen triple P program on behavioural difficulties as measured by the SDQ in adolescents (Stallman & Ralph, 2007). Total difficulties, impact and burden subscales of the SDQ all showed significant post intervention effects, with adolescents showing significantly fewer difficulties than the standard and waitlist conditions; these were maintained at three-month follow up.

Social behaviour was the focus of two papers. One study examined the impact of the Cool Little Kids and Social Skills Facilitated Play programs on child inhibition and presentation of anxiety as behavioural needs and risks (Lau *et al*, 2017). They found that compared to waiting list, the intervention group of children aged 36-65 months had significantly reduced anxiety diagnosis, childhood inhibition and anxiety symptoms as reported by both clinicians and mothers, and these differences were sustained at 12-month follow up. An evaluation of the Incredible Years parenting training program (Seabra-Santos *et al*, 2016) also found that the intervention group of children aged 3-6 years had improved social skills at follow up, as measured by the Preschool and Kindergarten Behaviour Scales (PKBS-II).

b) Parental skills and self-efficacy

Parents' sense of their skills and competence was found to improve as a result of taking part in the reviewed family support interventions, to varying degrees. Incredible Years Parenting Training was found to significantly improve parenting sense of competence (Seabro-Santos *et al*, 2016) as measured by the Parenting sense of competence scale (PSOC). Parents receiving the training had significantly increased perceptions of self-efficacy compared to the control group, with a medium effect size.

Parent practices were measured in the Dutch evaluation of Incredible Years (Leijten *et al*, 2017) using the Parent Practices Interview (PPI) which includes a number of sub-scales. Parents in the intervention group reported reduced use of harsh and inconsistent discipline, and more use of praise and incentives, than the control group, however use of appropriate discipline, reduced physical punishment or use of clear expectations did not significantly change.

An enhanced version of Self-directed teen-triple P was found to improve parenting practices as measured by the Parenting Scale–Adolescent version compared to the standard intervention and waiting list conditions, an improvement that was sustained at three month follow up (Stallman & Ralph, 2007). Triple P-Positive Parenting was also found to significantly improve parenting styles,

reducing dysfunctional parenting practices as measured by the Parenting Scale, with improvements maintained when followed up at three months (Wiggins *et al*, 2007).

The comparative evaluation of three interventions (Lindsay *et al*, 2011), found that Triple P, Incredible Years and Strengthening Families Strengthening Communities all improved parenting styles as measured by the Parenting Scale-Adolescent, as well as self-efficacy measured by the Parenting Sense of Competence Scale. However, Strengthening Families was the least effective programme on all measures while the other two interventions were comparable.

c) Parental stress

The interventions had a mixed impact on parental stress outcomes. The Parental Stress Index (PSI) was reported in eight of the studies reviewed. Six of the studies found significant reductions in parental stress: Child FIRST significantly reduced PSI scores relative to controls at six month follow up, but not at 12 months (Lowell *et al*, 2011). Parent Management Training significantly reduced parental stress compared to control, which was maintained at one year follow up (Braet *et al*, 2009), while significant reductions in parental stress because of Incredible Years training were found after 6 months (Hutchings *et al*, 2007) and maintained at 18 months (Bywater *et al*, 2009). Another evaluation of Incredible Years found intervention effects on the PSI to be maintained at 12 months (McGilloway *et al*, 2014). PSI scores also reduced in the Incredible Years intervention group evaluated in the Netherlands after 3 months (Leijten *et al*, 2017). Finally, the Japanese Early Promotion Program (Komoto *et al*, 2015) was found to reduce parental stress significantly following intervention.

Two studies did not find that interventions significantly improved PSI scores. The Dutch evaluation of Incredible Years (Leijten *et al*, 2017) did not significantly improve scores compared to control group. The Infant Behaviour Program (Bagner *et al*, 2016), was also not found to have any significant intervention effect on the PSI. The authors suggest that the stress experienced by mothers in the study sample could have been due to chronic life stressors rather than their child's conduct, and thus unresponsive to behavioural intervention.

The evaluation of the internet version of the Strengthening Families intervention (Sourander *et al*, 2016) measured parenting stress using the 21-item depression, anxiety and stress scale, but found that parental stress, as well as depression and anxiety, was not significantly improved by the intervention compared to the control group, at six or 12 month follow up. This measure was also used in the evaluation of self-directed Teen Triple P (Stallman & Ralph, 2007), who also failed to find a significant effect of the intervention on stress, anxiety or depression in parents.

d) Parent-child relationships

Parent-child relationships were a primary outcome of the Triple P-Positive Parenting Program assessed by Wiggins and colleagues (2007). They found that the intervention significantly improved parental perspectives of the relationship as measured by the Parenting Relationship Questionnaire, with sub-scales on parenting confidence, attachment and involvement all showing intervention effects, with benefits maintained at three month follow up. The Japanese Early Promotion Program (Komoto *et al*, 2015) focused specifically on improving mother-infant interactions and found that sub

scales of the Nursing Child Assessment Teaching Scale (JNCATS), measuring mother's sensitivity to cues, response to child stress, social emotional growth fostering and mother's contingency, improved as a result of the intervention. However, the study did not find significant intervention effects using an observed coding measurement, the CARE-Index, for dyadic synchrony. The infant behaviour program (Bagner *et al*, 2016) was found to significantly improve observed infant compliance, as measured by the Dyadic Parent-Child Interaction Coding System, compared to control group at six-month follow up.

e) Cost-analyses and service use

Economic measurements were extremely limited, but positive impacts were found in the two reviewed studies that included some form of cost analysis. Incredible Years was found to substantially reduce service use at 6 months, which was maintained at 12 months. Total costs per child fell by 40% per child over all, with primary care, hospital services, special education and social services all decreasing by 12 months compared to baseline (McGilloway *et al*, 2014). The Child FIRST evaluation reported significantly reduced use of child protection service using data that followed up participants over three years. Intervention effects were not found at 6, 12 or 24 months but were found by 36 months post baseline (Lowell *et al*, 2011).

2.6 Limitations of the evidence

The primary limitation of the evidence from the literature in informing EISS is down to the lack of evaluations of similar models – toolkit approaches targeted at Tier 2 equivalent populations – using control group designs. The majority of research evidence on early intervention approaches for this population focus on one specific intervention and tend to also target a much narrower set of outcomes, a reduction in behavioural and conduct difficulties was most common with parental stress and/or ability also addressed.

There are a number of other weaknesses in the evidence base presented here, in particular a lack of long-term follow up when measuring outcomes. The majority of studies used a three, six, 12 or 18-month follow-up as summarised in Table 9 (see appendix 8). The lack of evidence for long-term sustained improvement in outcomes compared to a control group limits the strength of conclusions we can draw as to the impact that early intervention approaches can have on reducing escalation of need. While the indications from short-term outcomes are positive in the studies reviewed, much of the basis for early intervention is predicated upon the long-term impact it can have on child and family outcomes and thus longer-term follow up testing is required to evidence this.

Outcome measures were primarily self-reported, with a minority supplementing self-report with observed measures. These latter studies provide the strongest evidence of outcomes, supplementing parents' reports of changes in outcomes as a result of receiving interventions with expert opinion.

Another common weakness of the studies reviewed was that the majority were not conducted in real world settings but as part of trials delivered in university or clinical settings by expert staff, which may limit the generalisability of the findings to more real-world, community settings, in which a range of providers are tasked with recruiting, delivering and monitoring outcomes for targeted populations

and which face implementation challenges not found in more controlled research settings. An exception to this was the evaluation of Incredible Years delivered in 11 Sure Start services; this programme was delivered by a range of providers similar to EISS, including social workers, Barnardo's project workers, health visitors and family support workers.

Other studies noted weaknesses in terms of sample size and study samples not representing the broader population both of which may limit the generalisability of results to the general population. The vast majority of studies did not report cost-effectiveness of interventions or other forms of economic analysis which would provide an understanding of the feasibility of delivering the interventions in real-world settings, particularly in comparison to other family support interventions. As mentioned above, early interventions are often argued to be a cost-effective form of delivery in reducing the use of services and severity of need over time, thus it is important that these measures are included in interventions.

Finally, fathers are also key agents in improving family outcomes and yet, as noted in Table 9 (see appendix 8), many of the studies deliberately focused on, or only recruited mothers as recipients of parental training. This could be a consequence of challenges in recruiting fathers to such interventions but there may also be a number of improvements to how recruitment is conducted which could increase the participation of fathers in training programs.

2.7 What makes an effective intervention?

There is a reasonably strong evidence base for the impact of the specific interventions used by EISS, including those such as Incredible Years on outcomes similar to those that EISS targets – child behavioural and emotional problems, parental-child relationships, parental stress, skills and confidence. However, the evidence base for toolkit models which target a population similar to Tier 2 on the Hardiker model is lacking, and studies addressing emerging needs tend to have been conducted under tight clinical or research settings rather than within the community as with EISS. Nonetheless, there are a number of key mechanisms within the evidence base which can inform the implementation of a model such as EISS:

a) The population

Central to the majority of the studies reviewed was a set of tight inclusion criteria of parents and children to ensure consistency in the population being targeted and in the level of need being treated. Such criteria ensured that a tightly defined and comparable level of need was included within the intervention group. This is common within controlled trial evaluations of interventions and it is likely that this process is less feasible when evaluating family support intervention being delivered in the general community, however the use of as tight a screening process as possible allows for a carefully defined population and need to be treated, strengthening the conclusions that can be drawn from the outcome measurement and increasing the likelihood of intervention success, because treatment and training can be refined for this specific population.

b) Intervention Fidelity

Fidelity to manualisation was emphasised in many of the approaches reviewed, including the Incredible Years programme. Steps were taken to ensure consistency in delivery through use of standardised training, peer review, manuals, mentoring and supervision so that the evidenced-based aspects of the intervention were delivered comprehensively and consistently. Treatment fidelity within the Incredible Years programme has been shown elsewhere to predict positive outcomes in parenting skills (Eames *et al*, 2009). Fidelity to intervention is another process which is likely to be more challenging in real-world, community settings, where delivery is spread across several organisations and contexts, but in such situations, it is arguably even more important to ensure consistency in the delivery of the intervention, so that if variations in outcomes for families are found, the impact of variations in service delivery can be discounted (or at least measured).

c) Parental Engagement

The engagement of parents as active agents in family support has often been emphasised as a key ingredient of successful interventions and was a central mechanism of many of the interventions reviewed in this section. Successful engagement depends on a variety of factors as outlined above and can take a variety of forms, for example not cancelling appointments, being open and honest with the key worker, accepting help and making a point of trying to do things differently and being proactive in seeking out further support if necessary. Qualitative analyses of the processes that help engage parents in interventions suggest that the relationship between the parent and the professional who is delivering the intervention are integral to improving engagement, particularly in home-visiting interventions (Domian *et al*, 2010; Saias *et al*, 2016).

d) Key Worker qualities

It has been established that a good relationship between key worker and parent/child is essential to effective implementation of the intervention. While this element of the intervention was often not assessed in the papers which evaluated models similar to EISS, in the wider literature some consensus exists on the central importance of this relationship, as described above. Other equally important key worker qualities include using positive interaction techniques when working with families i.e. having a non-judgemental outlook and listening to parents. It is generally acknowledged that there is no 'one size fits all' intervention or approach in family support. Each situation is context and family specific, thus maintaining a whole-family approach can help to ensure the best outcomes for families (NCB, 2014). In addition, working in partnership with families, being flexible and adaptable can help to promote positive relationships and ultimately improve the likelihood of an effective intervention.

e) Practical issues

Practical issues can often hinder an intervention and it is important a service take stock of any potential practical issues that may impact on delivery (NCB, 2014). The location of the service is important to consider; it may be too far away for a family to get to due to lack of access to transport.

The timing of the intervention i.e. 7PM – 9PM may not suit someone who has to travel two hours each way to attend the session. Other issues include childcare difficulties and providing a crèche or a home visit may be of utmost importance to these families, whilst also improving attendance rates.

2.8 Conclusion

The evidence base is lacking for models such as EISS which use a toolkit of interventions to deliver family support interventions in the community, targeting a range of social, behavioural and emotional needs as they arise for a population equivalent to Tier 2 of the Hardiker model. We have reviewed the evidence for a set of interventions targeting similar populations with family support approaches and found that medium to strong indications of positive impact, but note that these interventions tend to use one approach (such as Incredible Years), and target a narrower set of problem areas. The studies in our review emphasised strong fidelity procedures and had carefully targeted populations. EISS, by contrast, is delivered in the community by a range of providers, which may make intervention fidelity more difficult to achieve. EISS is also targeted at a broader population in terms of age range and issues experienced. The wider qualitative evidence points to the importance of the key worker in delivering interventions of this type, as well as the importance of approaches which are family-focused, non-judgemental and which address practical issues to engagement.

3. METHODS

3.1 Research Design

The most robust design to evaluate the effectiveness of interventions is a randomised controlled trial (RCT). The use of a control group is critical in enabling comparison of progress made by those receiving an intervention to those who have continued as normal. Without a control group, it is not possible to determine whether any progress found amongst those receiving the intervention would have occurred in any case. Moreover, the random allocation of participants to the intervention and control groups is also critical to the design as it ensures that the two groups being compared are matched and that any intervening factors are evenly distributed across both groups. Unfortunately, it was not possible to use an RCT design for this current intervention. The service had already been established prior to the research team being commissioned and the conditions to select a randomised control group were not possible given the referral process and operating guidelines of EISS.

In the absence of an RCT, a next-best approach to evaluating the effectiveness of this current intervention was to use a matched control group of families. The matched control group would be similar families to the families accessing EISS and would be recruited from similar programmes i.e. Tier 2 families referred to Family Support Hubs, Sure Start centres and other community-based and voluntary services. There was considerable resistance to this proposal from these services who were reluctant to be compared to EISS.

Finally, a non-randomised wait-list control group design was decided upon in March 2017. Each EISS used a four-week waiting-list to manage the number of referrals and caseloads of the support workers. The evaluation would use this wait-list as the control group and the sample would be recruited at staggered time points for the duration of data collection. Within the timeframe, it was expected to recruit approximately 250 control and intervention families, or 50 per service.

3.2 Aims and Objectives

The main aim of the evaluation was to address whether the EISS was effective in improving parenting skills and, through this, outcomes for children and families. There were a number of subsidiary objectives:

1. A discussion of how well EISS and its components fit to the local geographical and stakeholder context;
2. A reflection on the indicative experience of parents taking part in EISS or, in other words, their journey travelled;
3. A consideration of how reliable and valid the Outcomes Star™ was a measure of key outcomes among parents and their children.

The process evaluation aimed to add further depth to the evaluation and sought to:

1. Further explore the experiences of parents taking part in EISS;
2. Uncover the experience of delivering EISS;
3. Explore which elements of EISS are most valued, and regarded as most beneficial, by the service providers, and the parents participating in the programme and;

4. Identify which aspects of EISS need to be modified to enhance its effectiveness and fit (and how) before a scaled roll-out across Northern Ireland is attempted.

3.3 Outcomes and Measures

From the start of the evaluation it was agreed the Outcomes Star™ would not be used as an assessment measure by the research team. It was an inherent part of EISS rather than independent of the intervention, a measure that needed close collaboration between participants and key worker and which had little evidence to confirm its reliability and validity.

Instead, four key outcome measures were identified and agreed for use (see appendix 1). These were selected in relation to each of the core outcomes of EISS i.e. improving parenting skills and confidence, reducing challenging behaviour, improving emotional well-being and promoting family cohesion. They were selected on the basis that they are relatively short and they are well-validated:

a) The Family Functioning Scale (Roncone, 2007)

This questionnaire included statement describing situations that can happen in families. There were three scales: Problem solving, communication and personal goals. A higher score indicates better skills in these areas. The questions to the family functioning scale are found in Part A of Appendix 1.

b) The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001)

The SDQ is a brief behavioural screening tool which asks about 25 positive and negative child attributes. There are five scales: emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems and prosocial behaviour. The first four categories are added together to generate a total difficulties score out of 40 with a higher response indicating more difficulties. The pro social behaviour is reverse scored and again a higher score indicates more pro social behaviour. The questions to the SDQ are found in Part B of Appendix 1.

c) Tool to Measure Parental Self-Efficacy (TOPSE) (Kendall and Bloomfield, 2005)

TOPSE is used to measure changes in parenting confidence, or self-efficacy. There are eight domains: emotion and affection; play and enjoyment; empathy and understanding; control; discipline and setting boundaries; pressures; self-acceptance and learning and knowledge. Each area is scored from 0-10 and change in score over time would suggest a change in the parent's perception of their parenting ability in that particular area. The questions to TOPSE are found in Part C of Appendix 1.

d) Parenting Stress Index (PSI) Short Form (36 questions) (Abidin and Burke, 1978)

The PSI Short Form was chosen to measure change in parent's reactions to stressful events in their lives. The instrument has three subscales: parental distress, parent-child dysfunctional interaction and difficult child, which yields a 'Total Stress' score. A high score may indicate that any stress or dysfunction of the parent-child relationship may be associated with dimensions of the parents functioning. The questions to the PSI are found in Part D of Appendix 1.

3.4 Recruitment

Participation from all five EISS's was sought. Unfortunately, the research team did not receive the required permissions set out for the evaluation from the Belfast Trust so were unable to collect data from parents at this location.

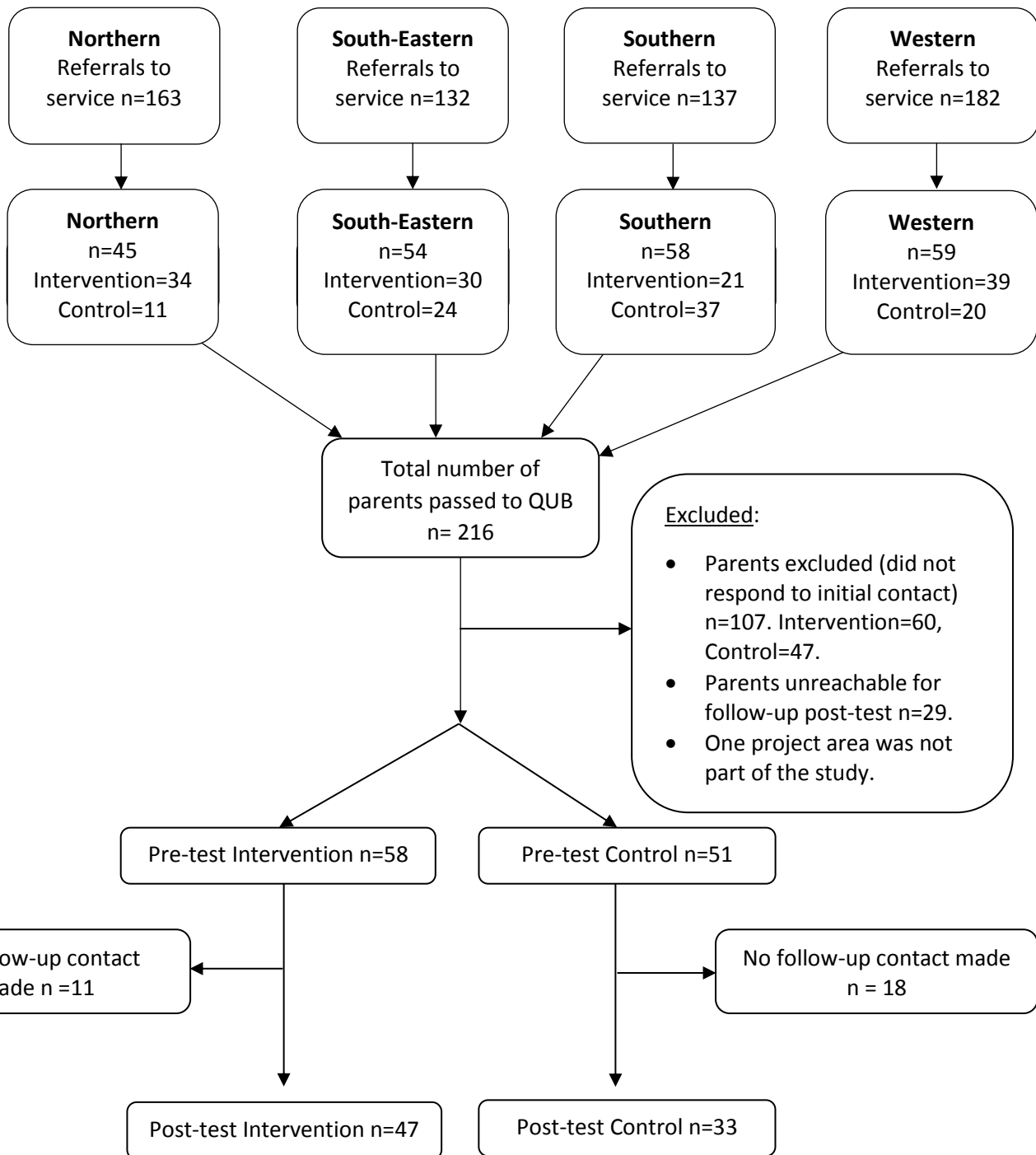
Participants were identified in the initial instance by the EISS to which they were referred. The EISS managers, who were already skilled in managing the waiting list, decided which parent would be in the intervention and control groups. This was achieved by constantly monitoring the referrals and providing contact details when a family was referred to the service (assigned to the control group) or in a few weeks' time (assigned to the intervention group). If a parent was assigned to the intervention group they were spoken to directly by their family support worker at their first visit and asked if they would like to participate. Parents who were assigned to the control group were asked by the EISS manager if they would like to take part during the initial telephone call to inform them of the four-week waiting-list to receive the service. Details of parents who agreed to be involved in the study were forwarded to the research team. Verbal consent was sought in all cases before the names were forwarded to the research team. If the parent was willing to sign a consent form this was also forwarded.

3.5 The sample

The sample includes 109 parents at pre-test, with a total of 80 parents completing pre- and post-test measures across the four EISS. Due to a combination of factors (i.e. the design of EISS, the recruitment procedure, parental drop-out issues and other extenuating factors), the sample size is lower than desired which the analysis will take into account.

The subsequent flow chart describes the flow of participants in the evaluation: from referrals to each EISS, how many participants consented to take part and were forwarded to the research team to be assigned to intervention and control, to the final number that completed pre- and post-test measures.

Figure 1: Flow Diagram of the allocation of participants from April – December 2017



3.6 Data Collection

An online survey was designed and located on a server (LIME), hosted at Queen's University Belfast, and accessed via the internet. Desktop computers and an iPad were used to collect data, or a paper questionnaire where internet access was not available. A unique code was allocated to each case before data collation so that no personal names would be entered alongside the data. Any data collected was uploaded immediately to the LIME server at Queen's University Belfast and deleted from the user's internet history. If a paper questionnaire was used the researcher manually entered the data to the LIME server, before shredding the questionnaire. All data was located in the same place. Data collection took place at times suitable to the participants, in their own homes or over the telephone. The time and location was the participant's decision and only the research team had access to the anonymised data.

3.7 Statistical Analysis

Scales were computed from the raw data for 22 outcomes. The main analysis of the data used a series of regression models to compare the mean scores for the intervention and control groups for each of the outcome measures at post-test, controlling for pre-test differences. The pre-test differences controlled for in the models were: pre-test scores on the outcome variable, age, gender, length of time between testing and trust area. Standardised scores for all pre-test scores, child gender, child age, trust area and time between testing were created before being added as independent variables, along with a dummy variable representing group membership (coded '0' for control and '1' for intervention group), to a regression model. The dependent variable in each case was the unstandardised post-test score.

The models were used to estimate the mean score for the control and intervention groups respectively. More specifically, the coefficient for the constant in the model provided an estimate for the post-test mean score for the control group and the sum of the coefficients for the constant and the dummy variable for group membership provided an estimate for the post-test mean score for the intervention group. Post-test standard deviations for both groups were estimated directly from the data for each measure at post-test respectively. Effect sizes, and their corresponding 95% confidence intervals, were then calculated using these estimates. Hedges' *g* was chosen as the effect size measure.

Beyond the main regression models, exploratory analysis was also conducted to determine whether there were differential effects in pre-and post-test scores for:

- Child gender;
- Child age;
- The Trust area or;
- The duration of difficulties (experienced for over or under a year).

In each case, the statistical models described above were extended by adding interaction terms for the relevant variable multiplied by group membership. Evidence of a potential interaction effect was determined by the statistical significance of the interaction term added to the model. Because of the small sample size overall, estimates of effect sizes for particular subgroups would be highly unreliable and thus have not been calculated for this report. Rather, where there is evidence of potential

differential effects for particular subgroups of children, the report just notes the overall nature of such differences.

3.8 Important Note of Caution

The analysis of the impact of the intervention is exploratory in approach. Because of the inability to use an RCT design and also because of the relatively small numbers of children and young people, the findings reported below should be interpreted with a significant degree of caution. This is particularly the case given the large number of outcome variables that have been analysed and the additional subgroup analyses associated with each of these. Given this, in relation to any statistically significant effects found, it would be misleading to claim that these provide robust evidence of the effectiveness of the intervention. Rather, and given the limitations of this present design, it is important not to place any significant emphasis on individual findings but to assess the overall picture and to regard this as only being indicative in nature.

3.9 Qualitative Process Evaluation

The purpose of the process evaluation was to identify what did and didn't work in the conception, set-up and delivery of the service. Robust ethical protocols were followed in relation to the recruitment of, consent to and storage of this qualitative data.

Therefore, interviews were conducted with 55 people comprising:

- 10 people involved in managing EISS;
- 15 people delivering the service to parents
- 12 parents receiving the service; and
- 18 local stakeholders who had used and/or referred to EISS

The interviews were recorded electronically and transcribed before being deleted and the participants were assigned pseudonyms so they could not be identified. The anonymised interviews were stored on a secure SharePoint site and analysed in NVivo 11 using a thematic coding framework.

4. PROCESS EVALUATION

The purpose of the process evaluation was to understand how the intervention was conceived, implemented and delivered. In particular it relates to the previous research objectives stated earlier:

- To assess what elements of EISS are most valued, and regarded as most beneficial, by the service providers and the parents participating in the programme, and;
- To identify aspects of the EISS that may need to be modified to enhance the effectiveness and fit of EISS before a scaled roll-out across Northern Ireland is attempted.

This chapter will report on the key findings from the perspective of those delivering and managing the service, to the parents receiving the service and the stakeholders involved in referring to the service. It will focus on the key components of EISS, what works well, how it is delivered, if there are any barriers to implementation and recommendations for taking it forward in the future. Robust ethical protocols were followed in relation to the recruitment of, consent to and storage of this qualitative data.

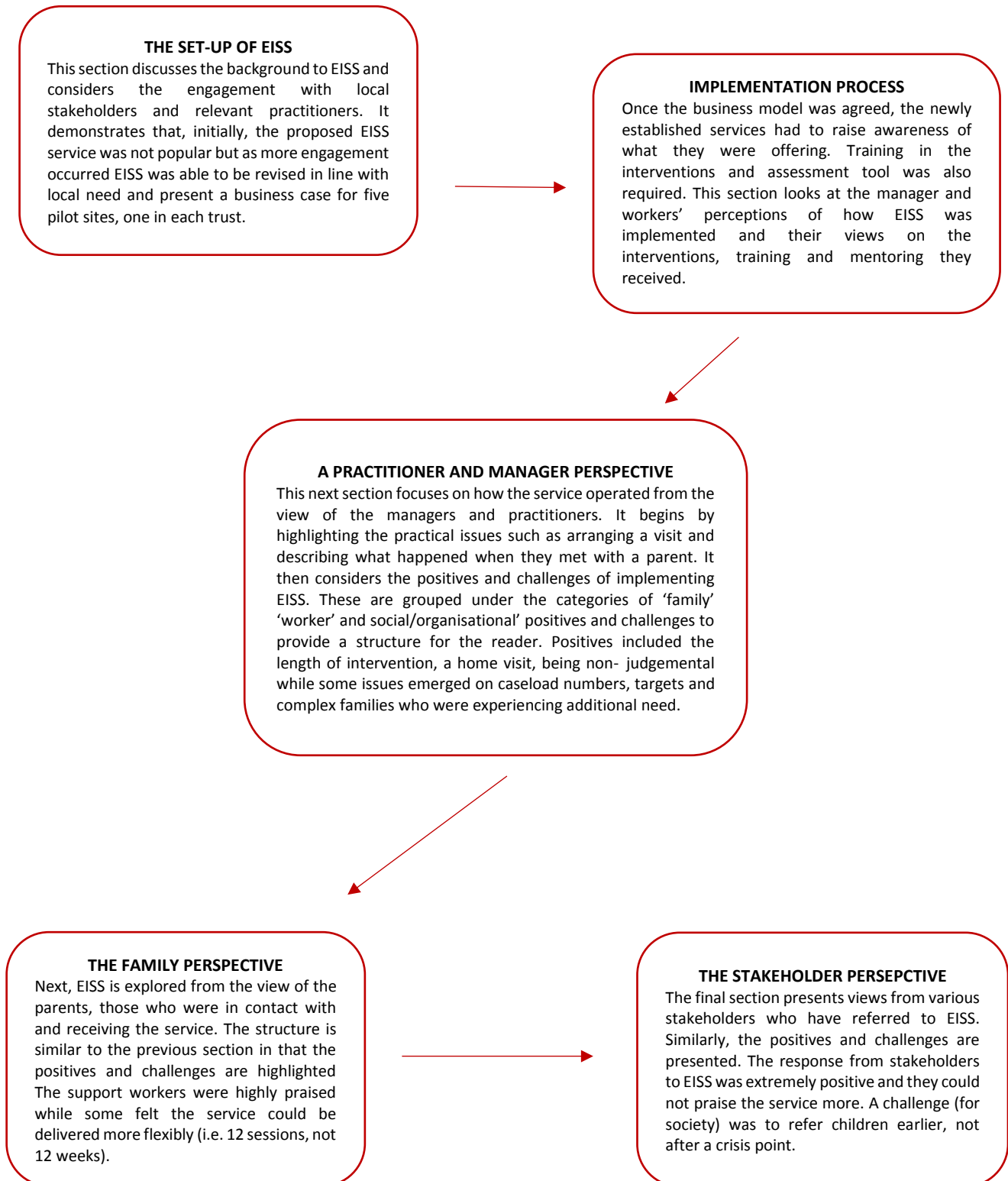
Therefore, interviews were conducted with 55 people comprising:

- 10 people involved in managing EISS;
- 15 people delivering the service to parents
- 12 parents receiving the service; and
- 18 local stakeholders who had used and/or referred to EISS. These consisted of School Principals, Family Support Hub coordinators, Educational Welfare Officers, Gateway teams, Health Visitors and Family Group Conferencing/Incredible Years coordinators.

The interviews were recorded electronically and transcribed before the digital recording was deleted and the participants were assigned pseudonyms so they could not be identified. The anonymised interviews were stored on a secure SharePoint site and analysed in NVivo 11 using a thematic coding framework.

The flow chart on the next page provides a summary of the elements each section the process evaluation contains.

EISS Process Evaluation Summary Chart



4.1 The set-up of EISS

This section looks at the background to setting up EISS as a new service; how local stakeholders were engaged; views from stakeholders about the proposed model and revisions to the EISS model.

4.1.1 Background

EISS was set up as a new service under the Early Intervention Transformation Programme across five pilot sites to help support families when problems first emerge, or before statutory services are required. The overall aim was to develop a short-term intervention, one that could “[be] a coherent, consistent early intervention service across the region”, and focused on improving outcomes for children, young people and families. Prior to the formation of the service it was known there were several existing family support services, with variations in what they offered to families and unevenly distributed across the region:

“Whenever we looked at the landscape of what was out there, there was a number of – quite a number of different family support type services but they’re all slightly different and so there was no coherent service and consistency in services. They all had different – slightly different make up of practitioners and then also, a lot of the time, they had – they just took specific children or specific age groups, age ranges so what we wanted to do was to set up a service that covered the 0 to 18 age range”.

4.1.2 Stakeholder engagement

There was extensive consultation with relevant stakeholders to determine what was currently available, the gaps in provision, and to establish where (and what) the unmet need was. It was anticipated from the start that EISS would be established in partnership with other services:

“Well, from the outset, we wanted it to be a co-design with local services, to be co-designed, it needed to support what was out there locally so it had to fit with local needs and one of the purposes of the early intervention service was that there shouldn’t be duplication of services, it shouldn’t displace services. So, we had to work very, very closely then with the key stakeholders in each of the localities”.

Experts were consulted, both on the ground and at a policy level, to help map out current service provision. In addition, the National Children’s Bureau (NCB) were commissioned to conduct reviews of evidence to identify appropriate evidence based family support interventions that could underpin the EISS model and to provide evidence for a suitable family assessment measure. The evidence review did not identify a single family support model on what worked best for families with emerging vulnerability. There was no evidence for optimal caseload numbers, the skillset of a support worker, how long they should work with a family, or what interventions were most appropriate to use.

Initial engagement took place with the Children and Young People's Strategic Partnership, the Outcomes groups, Family Support Hubs and the Locality Planning groups. There were 10 consultation workshops held to collect feedback from the statutory, community and voluntary sectors and service users on what the service could look like. These were attended by a range of key stakeholders including health visitors, midwives, school nurses, learning disability nurses, teachers, education welfare officers, social workers, community children's nurses, Sure Starts, family support hub coordinators, family support providers and child and adolescent mental health services. A parental consultation undertaken by Parenting NI was also undertaken to consider how support could be improved for families who were struggling to cope with emerging difficulties. In addition, it was proposed that it would be a benefit for Family Support Hubs to align closely to EISS:

"I suppose from the outset we've worked very closely with the family support hubs... [respondent] was instrumental in a lot of that early engagement with the stakeholders and workshops and the services align very, very closely to the family support hubs...And we're aware or they're aware that we're not there to displace services, we're there to as additionality".

Several EISS managers and practitioners were involved in the initial planning of the service and felt their views were well represented in the final design of EISS:

"I do feel like we've been heavily involved from – how it's changed from the start and when it was up and running and getting all the training done and what the families would be and how you'd get the referrals and things like that.

The Outcomes groups in each Trust area were responsible for deciding what areas each service would cover. Local need and gaps in provision were considered and the majority of interviewees agreed their service had been placed in an appropriate area, although they also felt that a wider postcode remit would be an advantage, particularly for rural areas:

"I do think local need is considered. I think, as I say, the historic legacy of [location] not having a great deal of resources, I think that was an important consideration that [location] got an early intervention service and actually credit where it's due there...you talk to any of the other services in any other professions, they will say they're really glad our service came along and they felt it was really needed... But, also the unmet need, so a big part of it was responding to unmet need in the area"

When you move out into the [named] areas they tend to be quite isolated, more rural communities, and very cut-off really from mainstream services in terms of even transport is very poor and just even the availability of services because they are seen almost overlooked".

4.1.3 Views from stakeholders on the proposed model

Several issues emerged from local engagement, mainly regarding concern over duplication of existing services. At times, there were feelings of anger and uncertainty over what was being proposed:

“I suppose maybe not to underestimate that because the conversation with outcomes groups and others was very noisy, very noisy...so, to say that it wasn’t cold, it was hot, the reception that we got. We were kind of roasted quite significantly”.

Primarily this was based in one locality and was in response to a local, community led, family support service being closed down, one that had popular support from the local community:

“I think anger that they felt that government really just was showing its inability to be joined up. That one part of government was concluding investment in something which demonstrably was working and then another part of government then comes up with a fresh approach to say we’ve got a nice new shiny object [new scheme] that we’re going to introduce to you which didn’t take account of what had happened before”.

Others felt that the current services provided support for Tier 2 families already:

“We were told...our model was not welcome because Tier 2 family support needs were fully met in their locality...we had letters...we had really quite a lot of anger and a lot of kind of annoyance and representations to Special Advisor’s about saying you know the Public Health Agency are coming in with something that is neither needed nor wanted”.

4.1.4 The proposed EISS Model

Despite setbacks, the general consensus from stakeholder engagement was that there was a clear gap in service provision for Tier 2 families who did not have social service involvement. Initially, it was agreed EISS would be 12 weeks long, target the 0-18 age range and be available to all families residing within the agreed postcode remit who were not involved with statutory services. There would be 20 services across Northern Ireland and the families would require mainly practical home support from Band three or four family support workers.

However, it was evident there was a case to be made for the service to use more therapeutic approaches. This emerged from the NCB review, and conversations with existing services. While it appeared from stakeholder engagement that Tier 2 families may require primarily practical support, there was a growing realisation when developing the business case that families may have many additional problems with substances, mental health and other issues. The skillset and capacity needed to effectively deal with these families would be more appropriate of a Band five or six level.

In reviewing the business case for EISS, the Public Health Agency (PHA) expressed concern for the financial implication of 20 services:

“Just too big. Too big, too big...we would rather go forward with a small number of services to test the model on behalf of EITP with a revenue consequence of £900,000 per year rather than 2.5 million”.

4.1.5 Revision of the EISS model

The business case was revised and a model for five services (one per Trust area) was selected at a cost of £900,000 per year. The key worker model comprised 2.5 therapeutic workers, one full-time family support worker with support from an administration person. The interventions to be used were the Solihull Approach, Solution—Focused Brief Intervention Therapy and Motivational Interviewing, while the Outcomes Star™ was to be used as the assessment tool for EISS. In addition, 5% of families could avail of Family Group Conferencing. The Incredible Years and Strengthening Families parenting programmes were also available for families who may benefit.

A target was set to support 1,925 families from July 2015 to March 2018. This was equivalent to 140 families per annum per service, on a one-to-one basis. Each family support worker was to be allocated 10 cases to provide support to the family for a period of up to 12 weeks. Families were to be contacted within 10 days of the service receiving the referral and would be on a waiting-list for no longer than four weeks. If the service could not see the family within four weeks the referral could not be accepted.

Tenders were issued and five providers were chosen to deliver the service. In the South-Eastern Trust Barnardo’s was chosen to deliver the service, Action for Children in the Northern and Western Trusts and NIACRO in the Belfast Trust with NIACRO/SPACE in the Southern Trust. The tendering process was, again, different to what usually happened and not what stakeholders and providers were used to. It was set up to ensure that there would not be one regional provider; a lotting system was used with a cap on the number of lots that could be applied for. Each provider was eligible to apply for a maximum of two lots as the sole provider and up to three lots as a consortium.

There were some strengths to this way of tendering, in that it allowed services new opportunities to grow and develop and for their enthusiasm to shine through:

“I think some organisations... [service] were hungry for this. New area of work, very enthusiastic, very interested in the process”

But this new approach to tendering was challenging - it was not what community and voluntary service providers were used to, and there seemed to be an underlying fear of the intentions of ‘other’ service providers:

“Now, I think some of the community characterisations of that are maybe overstated but nonetheless, they would characterise it by saying they will parachute into our communities when they get money and they’re away the moment the money is gone”.

4.2 Implementation process

Having explored the processes involved in the setting up of the EISS service, this section explores the processes of implementation under the following themes: raising awareness of each local service; training of workers; workers' views on the interventions they were trained in; workers' knowledge of other types of interventions; and mentoring.

4.2.1 Raising awareness of the service

To promote awareness of the service the teams took part in a multitude of events:

"We'd go to fairs. We go to, like, if there's even maybe training on, we go to training and we're giving out [advertisements] continually. We've made appointments and gone to primary schools, secondary schools. We linked in with the pastoral care for all the secondary schools. We are continuously, honestly... Went to every single event that we can".

"we were attending local community events and bringing a stand out and saying who we were and what we do, and information packs sent out round the schools and us actually going to the schools and to the GPs and to community paediatrics team meetings or coffee mornings and letting them know who we are and bringing information with us".

EISS also experienced challenges in implementing the service, as for many involved in this process it was a new way of working:

"And I suppose because this is the first time ever that, you know, we have tendered for a programme, normally it's, you know, you're tendering, you have the money, and then you can shape the model as to – not the model – you can shape your staff structure as to what it's going to look like and what the bands are going to be and what the pay rates are going to be as such, and for the first time ever for a contract it was all dictated as such and all laid out and we had to, you know, comply".

Contracts were in place from 1st August 2015, but there were delays in set-up which were mainly attributed to staff recruitment; the services were fully operational at different times:

"Reality was that most of them were not in the position...to recruit staff and to have the service in place until the December [2015]. So, we just knew there was going to be a bit of a lag but we got it going and got it established"

"But I think then that was learning for us commissioners because it is standard, I think it is standard that it's slow to get going and then you push it out and it goes into a mature phase where you have all your staff".

There were some delays in the set-up of the EISS in some of the pilot areas as it took longer than anticipated to recruit, train and maintain staff within the service who could respond to the referrals coming in. Several support workers reported being unsure of their role initially, and concern at the wide-ranging nature of the work:

“I suppose that was the difference for me as I got such a big age group you’re taking in and what the families would be like. So, I suppose, until you get in it and do it for a while, you don’t really know what that looks like in terms – with Sure Start or the different projects or, it’s an age group and what they do, whereas ours is this big open void of 0 to 18 and what did that work look like? So, you had queries about that.”

4.2.2 The referral procedure

Each EISS was aligned with the Family Support Hubs (FSH) in their geographical area from which they could receive appropriate referrals from. Initially the majority of referrals were from the FSHs. There was also the option to self-refer, or to be directly referred from any source including GP’s, Health Visitors, schools, Child and Adolescent Mental Health Service (CAMHS) or Educational Welfare Officers (EWOs).

Contracts were in place from 1st August 2015, but there were delays in set up which was mainly attributed to staff recruitment, but the services were fully operational at different times. By January 2016 all five EISS had recruited their staff and staff had completed training. Referrals, while initially slow, soon started to come in very quickly. One service at the time of interviews had had to close due to being inundated with referrals and not able to meet the service delivery requirements:

“We never have any space. The demand, the phone never quits, every single day, for people ringing up and looking support, and we obviously want to be able to respond and as a volunteer organisation we never turn people away”.

Female 1: “You had to close your – you had to close your referrals

Female 1: Now, we try to manage it to our detriment because we try to work it that we’re taking on more cases and we’re trying – because we don’t want to do that. But we’re not doing ourselves any favours”

As the services were slow to start, it then became difficult to meet all the additional requirements of the job:

“It was meeting after meeting after meeting to try and agree on, and this is at the very start and we’re getting these programmes off the ground, so you’re out delivering, you’re meant to be open to referrals, but you were sucked into all of these meetings, which we needed to be, and don’t get me wrong, we’re glad we were, but that – there was no consideration given to the numbers and how you’re actually out delivering and the time that was spent on developing, like getting it off the ground”.

Referrals were screened for appropriateness when received, either by the FSH or EISS if it was a direct referral. Operational guidelines recommended that contact be made with the family 10 days from receiving the referral, and that a family would wait no longer than four weeks before receiving their first visit. The referral form was praised for being clear, direct and simple to complete, unlike other forms referrers had filled in before:

“We’d say is that we don’t have pages of referral notes to complete, that it’s a very basic referral form and you basically can give the information required and know that the support is going out quite quickly. So, it’s quite immediate, it’s quite rapid in terms of its response”.

Referrals were made for a wide variety of reasons (see appendix 2), but the overarching themes were for family support to help with emotional, behavioural difficulties (school refusal or child anxiety), because of a major upheaval in life (moving home, bereavement or parental separation), practical issues for parenting support with boundaries and confidence or self-esteem. It was the referrer’s decision which, or how many, of the 28 boxes to select. There was also the option to select an ‘other’ reason.

However, what was on the referral form was not always a true reflection of the situation when the family support worker went to the family home. A referral, initially deemed as appropriate, was often found to be more complex. This will be discussed further later. Some referrals were made as a stepping point between assessment and diagnosis (e.g. for autism) – the utility of this function should not be underestimated for families not yet receiving support, but this was a function that EISS was not designed to solely support. It was observed that:

“There’s a big push for a lot of parents in trying to get their children assessed and they see us as a kind of stepping stone Tier 2”

“I think the difficulty, if I’m being honest, just like it did initially when the service first came out, because it was new and it was great, people thought, my worst ones, I’ll send them there. But you’re sending them a possible case that this will not ever change. It hasn’t got the potential for change. I think it’s not an effective use of the service”.

4.2.3 Training

The business case for EISS built in a training budget from the start. Staff were recruited via internal opportunities and external job advertisements and trained in the following interventions: Motivational Interviewing, the Solihull Approach, Solution-Focused Brief Intervention Therapy and the Outcomes Star™. Training was organised by the PHA (see appendix 3 for a description of these interventions). There was also the option of services providing or arranging in-house training in relevant areas. In addition, all staff came to the job with their own wealth of experience and prior training from previous employment.

4.2.4 Staff views of the interventions

Almost all staff and managers felt the interventions complemented each other well and could see the benefits of all three. The majority of family support workers praised the benefits of the Solihull Approach and Solution-Focused Brief Intervention Therapy in particular:

“Everybody loved solution focus because it provided them with resources, things to refer to, good questions are practiced a lot and trying things out”.

“We did get a folder from the Solihull training which was quite specific and different strategies you can use and, you know, it’s a very good resource for things can photocopy... the Solihull thing is very good. The folder’s really thick”.

Positive feelings around Motivational Interviewing were not as prevalent, but several staff could see the benefits:

I found that that’s [motivational intervention] actually a really valuable method of working and it’s funny actually as well, you can work quite concisely... I feel it is a really valuable tool and I do think that it didn’t quite get the, I suppose the message wasn’t fully conveyed in the way that it might be helpful”.

Respondents did not report favouring one specific intervention over others when working with families:

“It’s a real eclectic mix, very eclectic mix as well as people would bring in their own knowledge and experience and different approaches”

Interventions were not used consistently over the one hour session with the parent or over the 12 weeks of the intervention. Respondents suggested this was due to the variable nature of individual families:

“You’re dipping in and out of them, aren’t you? You kind of use them, elements or components of the three at different times”.

Likewise, sometimes it was not appropriate to use a particular intervention or technique at a specific time and they had to be tailored:

“I would use sometimes one-to-one then with young people a lot more so than adults or I use it as a family tool or with the young person; not individually with an adult but always in the family context and I find it useful if you get the right child for it. Sometimes it’s not always appropriate, so it’s just about adapting it to the family and to the child”.

Anecdotally, it was reported that parents found the Solution-Focused Brief Intervention Therapy to be of great value:

“In terms of most of the families they really find the solution focus very useful, to harness people’s strengths and make them feel good and that they can do this, it’s achievable”.

However, parents were not routinely aware of the approach that was being used:

Respondent: “You’re using a range of techniques from all of the things that you’ve been trained in; it’s not that you’ll go in – so [name] comes in to see [name] and we’re just going to use the Solihull approach.

Respondent 2: No, it is a mixture of everything...it isn’t just you go in and say, “Right, I’m going to use my Solihull today” or, “I’m going to use my motivational interviewing”, it is a complete – it is a complete mixture of everything”.

Whilst the practitioners agreed the interventions were quite similar, the most common theme across the three was the positive, solution focused nature of each:

“But, I suppose at the end of the day, they are all very similar really, they are. It’s all about the positives, it’s all about listening, it’s all about looking at the positives, it’s all about motivating the person to actually look for themselves, at what little changes that they can make that you’re not asking them for anything huge”.

Funding was set aside to support 5% of parents to avail of Family Group Conferencing. Incredible Years and Strengthening Families parenting programmes were also available for families whom the support worker thought these programmes may benefit (see appendix 4 for a description of these programmes). These programmes were expected to support the provision of EISS by helping to empower families and to help with parenting issues. They were generally viewed positively:

“Well, I think we were saying the Incredible Years group works really well but I think we only get it twice a year now at the minute. It filters – well the way we use it, filtering parents in; it really complements the work we do, whether it’s – they’re just starting with us, ending with us or they’re half way through”.

“And, the Strengthening Families is good for positive time, when your families who are at breakdown and if it’s a two parent family with one child and the whole – it was just not in a great place and they were to Strengthening Families and it was an excuse to all go out of the house together; it was the first time they’d all been out of the house together and actually sat and done something together, where I wouldn’t have been able to facilitate that”.

Take-up of Incredible Years or Strengthening Families was inconsistent – rates varied over all five pilot sites:

“There does seem to be a very distinction and difference in terms of the uptake of parenting programmes but then the [name] Trust other than the [name] Trust, particularly around the Incredible Years, we have so few families who will go in the first place, and the dropout rate is very big. Families do not stay. Whereas in the [name] Trust that’s not the case at all. You nearly have a waiting list of people wanting to go to it”.

Likewise, use of Family Group Conferencing (FGC) was uneven but was reported in some cases to have worked well:

“We’ve had a good enough uptake of the Incredible Years, Family Conferencing hasn’t been just so good, but we’re getting a bit better and we’re meeting [the Family Group Conferencing Team] around how we can engage families better. But, as I said, with the team maybe it’s more about them engaging with the families”.

Unlike Incredible Years and Strengthening Families, the added benefit of FGC as an additional component of EISS was unclear:

“We have not spent anywhere near as much as we had anticipated on the Family Group Conferencing so we’re very interested to find out in practice because our sense would be that some of those features that we built in as a wraparound have not proved themselves”.

“We only commission it on the basis of we purchase it as we go along as based on need as opposed to saying well, I’m really glad that we didn’t set up say, 20 Family Group Conferences for each service you know because it just wouldn’t have happened. I think that’s definitely we know we’re in for definitely a sense of these features didn’t work”.

The research team spoke to one FGC team. The FGC team had not supported an EISS family to the Group Conference stage but were able highlight a couple of challenges in adapting their model to an EISS family. Throughout the FGC process, a social worker was present and prepared a case for the team. It would be very much a collaborative effort to engage and support the family throughout. With an EISS family, they were referred at the end of the 12 weeks and the family support worker would have no involvement or input in getting the families to the final stages. The FGC team were responsible for identifying the families’ issues:

Respondent 2: “I think what I found that I was nearly doing an assessment because you really are trying to figure out... You know, it was quite complex, some of the issues, so I think, for me, it felt like I was nearly doing an assessment just trying to

figure out what was going on, what were the issues, because the parents were coming from two very different positions and there was a lot of conflict, a lot of animosity and, in some ways, that made it quite difficult”.

There is the possibility that the strategy can be adapted as more families come to FGC from EISS:

“So, we are finding that it’s about trying to work out in those particular, unique circumstances about what will work, so we’re using the principles behind family group conferencing, but we’re, maybe, having to adjust what we do in those particular circumstances”

4.2.5 Staff knowledge of/practice in other interventions

As all staff came to their job with EISS from prior employment; they had built up an extensive skillset and had benefitted from training in various other interventions. One approach that was widely used in EISS was Cognitive Behavioural Therapy (CBT), which the PHA did not provide training in as it was not part of the EISS model. Managers advocated for further training in this approach (two services had already provided training over a two-day event) and several staff were using elements of it in their work with families. Staff felt CBT complemented the training provided by the PHA:

“That’s a lot of how we tend to work, it’s the support. So, there’s a lot of CBT, we’ll do things with a lot of thinking traps, stuff like that”.

4.2.6 Training opportunities

In 2017, staff identified a growing need for training in Autism and Autism Spectrum Disorders. This was based on a growing number of referrals to EISS from families who had children with special educational needs. This was subsequently provided in a two-day course:

“...because we’re such a wide range of people, you know, that, what do you need more expertise in, and autism was a huge one, so they did provide us with the keyhole training which is a two day autism training that, yeah, Autism NI give so that practitioners were more aware of kind of the issues of autism to be able to help families”.

Staff could also attend in-house training organised via their service or an external organisation. This was viewed as important in helping to fill gaps in knowledge, especially if it related to what families were being referred for:

“And then people have been accessing different training in terms of ADHD, autism, things like that. So, we have been trying to accommodate that as much as possible because the level of referrals that come in”

“Some of its PHA organised and some of it’s through [service]. Some of it we source ourselves. [Manager is] really, really good if we see gaps in our knowledge”.

The importance of having expert knowledge of the specific issues that families were experiencing was highlighted:

“I think sometimes even families and things can think weren’t quite specific, whereas we’re do you know, we’re not trained in sort of... we’re not mental health specialists, we’re not specialists in any of that thing, but we have received training in helping to support families with those things, but I think sometimes they think that we can maybe almost identify diagnoses and things, but that’s not what we’re going to be”.

“I think it’s [the training] lacking in some areas because a lot of our work is CBT approach and we’re not qualified and a lot of what’s creeping in now, as I said talking to you earlier, is this family therapy and family mediation and that systemic work and so, we’re not trained in that”.

4.2.7 Mentoring

The mentoring and support of staff was reported as excellent. Monthly sessions were built in for all practitioners where any issue could be raised and talked through with a manager. While mentoring and support from managers was appreciated, the benefits of having a contact with the team were also highlighted:

“[Manager] is only at the top of the stairs or end of the phone if you do need something but even in terms of being really – they’re very good with the staff, at knowing what the limit is”.

“We do have great supervision and we support each other really well”

This was also provided through the form of peer relationships between team members – and emphasised as being extremely important for the well-being of the whole team:

“You know, you never feel out on a limb or on your own or, and sometimes it’s, actually with the families you can say, “Do you know what, I want to talk to my colleague about this”

“Team mates are really good. We would share it, you know? We do resources or talk about maybe a topic”

5. PROCESS EVALUATION 2

Having reviewed perspectives on the set up of EISS, the recruitment, selection, training of workers and their views on the component parts of the intervention model, this chapter explores professionals and parents perspectives in detail around the experience of delivering, managing and receiving EISS and on the implementation of the model in daily practice. The following are considered: arranging a visit; a typical visit; length of visit; what happened in week one and over the following weeks.

5.1 EISS – a practitioner and manager perspective

5.1.1 Arranging a visit

When a case was assigned to a family support worker they made contact with the family. The support worker would arrange a suitable time with the family to call out to their house. Depending on what was disclosed at this visit, arrangements would be made to either continue with home visits or, if possible, arrange school visits with the school's permission.

Sometimes it was very difficult to get in touch with a family at this point. Several attempts were made to contact the families, with an eventual letter being sent out to their home address asking if they still wanted to receive the service.

“So, there are times we do have to be tough because quite simply, ‘Other families are waiting for the service for whatever reason, it’s not seen to be for you at this time, so we’re going to have to close off and you can refer back.’ There’s no big talk or lecture, just... and sometimes for families it’s a relief, they maybe wanted to withdraw but haven’t been able to say or...”

5.1.2 A typical visit

What was really evident was there was no ‘typical visit’. Family situations and reason for referral varied considerably, and staff could not predict what was going to happen prior to walking through the front door. Flexibility, again, was key:

“Yeah, and I suppose each case is sort of ... individual, you know? Even if you have planned a good session, and then, you know, you think, ‘Great, this is great, we’re going to do this today,’ and then you go out and then mum says, ‘This happened this week, it really threw a spanner in the works’”.

“I would say there is the guidance notes from PHA but that doesn’t tell you how to deliver a service to a parent...yes, it tells you these are the forms and these are how many weeks and I’m your worker, safeguarding and everything else, it doesn’t tell you this is how I’m going to work with a family, because you don’t know until you actually get out there”.

5.1.3 Length of the home visit

The EISS Operational Guidance does not specify a length of time for the visit but that a flexible service would be required meet family's needs. Each family support worker tried to set aside at least an hour for each visit but this was not always possible:

Female 1: *"Two hours probably"*

Female 2: *"You've got to block off two hours".*

Female 1: *"It can go more and it does go more doesn't it, quite a lot".*

Female 2: *"I have been in a house for two hours before, you know?"*

Female 1: *"I have as well, but...but it can overlap, especially if you go out and there's different, you know, for parents may be very upset or ... you just can't just kind of"*

Female 2: *"Yeah, I know for – "Oh, there's an hour, let's go!"*

5.1.4 What happened in week one

The first visit to meet the family usually followed the same structure, on which the basis of the activities over the next 11 weeks were planned. The first session for the practitioner was to gather as much information as possible about the family's circumstances. During the visit, information regarding the service was shared, questions were answered and information leaflets left behind for the parent to look at in their own time:

"The first visit is always without any children present, where possible, that's made arrangements where children will be at school or arrangements to care for them. Sometimes young babies and stuff it's not possible, but the first visit is mostly for information, consent, the nitty gritty of our service, as we always say the kind of broken bits for the parents. It's also an opportunity for them to ask questions and it's seen as that part is the really important initial engagement".

"Try to keep it as – in our experience at that first meeting people can be a wee bit worried, so tend to not keep it wordy. Keep it as brief as possible and leave them with the leaflets... We tend to tell them that the work is around helping them find their strengths, working on their strengths, and moving things forward"

In the first week informed consent, ethical procedures including safeguarding and the expectations of the family were covered. The service was mostly described to parents as providing support and its voluntary nature was always stressed:

“Just in terms of, ‘This is a service that offers you support.’ It’s voluntary, the duration, what type of support can be given. We also obviously have the whole safeguarding spade and the clear limits or if there are concerns, what would be done with those concerns, the process for that”.

“Leaflets get left, consent, signed things like that, and an arrangement is made, when they’ve discussed the type of work and what they are hoping to get, arrangements are then made for the child or young person if that is what is required. Really from then it’s about planning the working usually”.

5.1.5 The following weeks

Following on from the first visit, arrangements were made for the second visit where the family support worker would aim to complete the Outcomes Star™. One support worker described the ideal scenario:

“The way I work is, your [first] three weeks you’re, sort of, building up your knowledge and your relationship; then your next five or six weeks you’re actually doing the work, and then you reflect and see what they’ve picked up and help them to maybe talk about how they were going to manage whenever that support’s not there”.

Feedback from interviews highlighted that the ideal scenario did not always work in practice. Again, respondents suggested that this was due to the service being family-led and flexible. The reason for referral plays a key role in deciding how the next weeks will look. With this and the Outcomes Star™ results in mind, an action plan (co-produced with the family) was designed:

“But, it is a lot of mental support as well for the parents and people’s wellbeing is very – people are very low mood, maybe not particularly with any specific diagnosis of anything but really, really struggling with life in general, feeling good about themselves or even feeling positive that they’re doing an OK job and they really struggle, beating themselves up”

“When you’re speaking to the family, that’s when you develop your plan. And it’s not your plan actually, it’s our plan. It’s working with the parent and saying, “Okay, what I’m hearing from you is you would like some support around managing your child’s behaviour, you’d like a wee bit of emotional support. You’d maybe like to see what other services are out in the community that you can avail of,” and then that’s your focus of work”.

The action plan informed the potential structure of the following weeks. Some examples of activities that took place over the 12 weeks are described below.

5.1.6 Activities with children

Games were regarded as a great way to keep children engaged and as something that was fun:

“Usually feelings orientated games so that would be staff asking questions that will incorporate their feelings and what’s going on for them and then I start to build on, if it’s anxiety based, I’ll start to give them the knowledge and the information around their anxiety so we’ll maybe do body mapping activities that will map where the anxiety is in the body and how that feels. We’ll look at calming down strategies and where that all stems from, the brain science behind that”.

“We try and make it fun for kids and you sometimes become aware, they’re not enjoying it or whatever and when you notice that, it’s time to take a step back and it doesn’t happen very often, but you have to prepare for that, you have to anticipate that and you have to be well into trying to change approach if that’s the case”.

Much of the work with children was around managing and acknowledging emotions and improving communication:

“We sort of do a lot of stuff, as well, around emotional literacy and making it okay for kids to say, “I’m worried, I’m scared, I’m frightened, I’m great.” And we try the detox effect, sort of thing about talking about friends and we try and encourage that sort of communication within families”.

5.1.7 Activities with parents

In addition to providing support to children there could also be some work with the parents, in terms of providing emotional support, practical support, ideas for change and signposting on to other services:

“[If] it’s a child under three, so if they’re earning under a certain amount per year, they can access the grant and the grant can provide anything from a cot bed to a pram to bunk beds, lots of different things and that’s delivered straight to their door then from Argos or from wherever it’s coming from, so it’s really good that we have that and throughout the team, everybody can access it”

“There’s practical aspects of it too and charts, different things, and there’s a lot of visual kind of stuff rather than a lot of – reams and reams of information. I tend not to bring that kind of stuff out to parents because it’s off-putting”.

“Obviously, we do a lot of behaviour stuff too that the girls would do as well in terms of behaviour management and strategies and positive parenting and things like that as well and then obviously with signposting and escalating if needs be”.

Listening to parents and allowing them to verbalise their issues in a safe, non-judgemental place was extremely effective in building a relationship and rapport with the parent, and enabled change to happen:

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

“I suppose the benefit from having the same worker first of all going out to see them and again developing that relationship. I suppose as well sometimes they just need somebody else to talk to about their struggles and, you know how they’re not coping with things and how they need help and it’s nice for them just to have that listening ear”.

5.1.8 Documenting the visit and closing a case

It was generally reported that there was a lot of paperwork (sometimes duplicated) to complete for each case. Each practitioner had a minimum of 10 cases, up to 15 or more during case transitions. Paper copies as well as electronic copies were kept detailing the nature of the visit in addition to inputting the Outcomes Star™ data and compiling closing reports for each case. This workload was on top of the time required to see up to a minimum of ten families at least once a week. Time management was key:

“There’s no sort of ... there’s no processing time or little reflection time even doing your closure...there was actually two weeks where I had – the way my cases fell, I had six closures within two weeks. And I really – like I struggled because that expectation of having to get new ones in. It was just – because the work just built up and maybe there was training as well, you know, being out the whole training day eats into your admin time, whereas that would be two hours or three hours for visits and the rest would be admin time, so it is getting that right balance and you’re trying to be, you know? It is a heavy job, its heavy work”.

Towards the end of the 12 weeks, families could be signposted on to other services. This could be for additional support with an issue, or to have someone else to talk to.

“Absolutely. And knowledge and signposting is huge. Sometimes when parents are signposted on they still value that therapeutic input and just that somebody to talk to, I think that’s the biggest thing to come out of this, is somebody to talk to, whether it’s been for the parent and/or the child, mostly both”.

Signposting often occurred earlier than at the end of the 12 weeks. This indicated the reactive nature of the support workers:

“A lot of families are signposted early on in the work. Sometimes middle of the work. It just depends what’s coming out and what their – some of them aren’t open to an awful lot else because they’ve a lot going on, working parents and things, but others are very keen”.

5.2 Positives of delivering EISS

From a practitioner and manager perspective the positives to delivering EISS were numerous. What was evident was how the intervention suited the needs of the families and how this led to positive implementation. From engaging with the service, families were more confident to be signposted on and engage with other services. The positives are therefore discussed below in two categories – the positives to the family, and the wider social and organisational positives.

a) Family positives

a1) Length of the EISS

The length of the service was often quoted by family support workers as being appropriate, in terms of being just long enough to allow a relationship between the family and key worker to be established, but not quite long enough for a dependency to manifest. It allowed for a number of families to be seen relatively quickly:

“I think probably when you weigh it probably 12 weeks is about right, maybe slightly longer just for that relationship building”

“I think in some other services it’s quite open and there’s not an end and it really creates a reliance for families and they do become over reliant and it doesn’t really empower them or it doesn’t give them the opportunities to make the changes for themselves and continue it on”.

While it was recognised 12 weeks was not necessarily long enough to support substantial improvement with every family, staff felt it was long enough to help families get to a stage whereby they could engage with other services:

“I always say that our intervention is a starting block, it’s a starting block. We’re not going to change everything in 12 weeks, but it’s a starting block until you move it on, to making positive changes. And I think that’s... because that’s realistic”.

“...because within the 12 weeks, it’s not necessarily direct goals that have to achieve, but if we can work with the family to get them to a stage so after that 12

weeks where they're ready to engage with other projects or more support long term then there's been a job done so to speak"

a2) A home or school visit

The importance of being able to work around a family's routine, at their convenience, was viewed as significant in the success of the service. This was especially true in rural areas:

Female 1: "And then you've got the bus services. You can't actually get anywhere anyway even if there was something

"And, I guess, one of the good things about this service and a lot of our services are they're outreached. People don't have to come here for an appointment. These guys go to them, at a time that suits you, and if wee Jimmy, wee baby goes down for a sleep at 11 o'clock, we try to find [a suitable time]".

For children who did not want to be singled out in school, there was option to have the appointment at home where they had more control and power over the situation:

"And even for children too because children don't want to access counselling in schools because, "We're going to be seen being taken out of class and I don't want that because then I'm going to get picked on. People are going to ask me why I'm coming out of class." And again, I say, "Look, I'll come and see you after school." It's in their own home. You're giving them that bit of control. We're not sitting in a room where this is my office with my... you know, feeling awkward".

Home visits also reduced the likelihood of appointment cancellations:

"Yes, it is a big advantage being able to go in to the homes because some of our families, I know if you were to say – not necessarily coming here but if we had a community building hired or a community centre hired for a couple of hours...the cancellations, it would be frequent".

A home visit also allowed the opportunity to view and assess a family's living situation. This information could be used in a professional sense if the family were not able to access EISS, or had to be escalated:

"We will at least do a home visit or perhaps see them, so the family and that child has a pair of professional eyes just seeing them".

a3) Being non-judgemental

Being non-judgemental and a good listener was viewed as a key approach staff needed to bring to each case. Families were not being judged on what they were disclosing, or being told what to do. These qualities allowed for relationships to be built and trust to be established:

“I suppose as EISS, I think the organisation and the project is seen as neutral; we’re not representatives of an organisation coming over in to [place] or vice versa, we’re a neutral organisation, so I think it’s worked quite well”.

“I always say to them [families], “My job is so easy. I come and talk to you for an hour a week. You’re doing all the hard work!” It’s coming alongside them. You’re not coming in and you’re not saying, “This is what I’m going to do.” No. You’re saying, “Okay. For next week, try this, and try that.”

Respect for the family and their situation was also paramount:

“And I suppose it’s the respect that we have for parents when we go out, you know, that they have the control, it is about their family and they are key in it. And having that from somebody makes such a difference to them”.

Supporting families who were isolated for one reason or another was also a key success measure:

“Isolation is a big one, the lack of support and the resilience factor as well; I’m just thinking of recent cases that self-esteem and confidence are so low that it’s actually having an impact on the relationship”.

a4) A wide-ranging service

The wide age-range and context remit of EISS was felt by practitioners to be a unique advantage of EISS. It enabled the practitioners to help families who otherwise would not be eligible for any support, due to the lack of strict criteria for access:

“Obviously, the criteria, that’s one major benefit, the criteria is so open because it then means that, you know, you don’t have to go through a whole rigmarole of looking through a really stringent criteria”

“EISS that is able to basically work where there’s no other service there, you know, in regards to the, you know, parenting difficulties, challenging behaviour, you know, relationship difficulties and then like the low level mental health difficulties as well”.

This wide criterion for referrals suited a lot of families and was particularly relevant for those residing in deprived areas:

“I suppose what it has really showed us is that this is not a service that’s exclusive to people who are in deprived areas. It’s very much a service that’s for everybody and people are saying that”.

Being able to help the families in practical ways in addition to the therapeutic work was also viewed as important:

“Even the practice side of things, giving a family a grant or safety equipment for the house, or setting them up for their new baby, they are so thankful and so relieved, for some families who are needing that as well”.

a5) A timely response to initial referrals

The timely response to initial referral was highly praised and one that was viewed to be a unique positive of the service:

The fact that there is, from referral, when they’re referred until they get made first contact, that has to be within ten days and then the first visit needs to be within four weeks. So, I think from that point of view, families are seen quicker and at an earlier stage than they would if they were referred to other services”

a6) Improved parenting skills and child behaviour

One of the biggest indications of the positives of EISS for practitioners was observing the change in parenting behaviour and/or child behaviour over the course of the intervention:

“I think empowering families to help themselves would be ... we are providing the tools, it is only an hour week, but they’re actually the ones putting it into practice, you know, following things through on the whole”.

“Another, yeah, benefit is just see when you see like a young person putting some of the tools into practice, and you actually see that, and you think, “Oh, I’m so proud of you”.

External agencies also noticed the difference in the families:

“Some children too I’ve worked with, I’ve seen big differences in them, even in confidence and things, it’s really good. And then teachers – like whenever you ring them back to tell them, they’re saying, “I can really see a good improvement in her in school. She just seems a lot more together”.

Children were also aware of the differences in their parents:

“I think some of the kids then are seeing a sense of purpose and focus that they wouldn’t have seen in their parents before. So, they have taken, I think, an interest. I have had young people who didn’t have a parent turn up at a school meeting, and then when they came into the school meeting, they were going, “They do care.”

a7) Family-led and flexible

The family support workers praised the flexible nature of the support they could provide a family with and how the family-based nature of their work really made a difference. Providing a ‘no one size fits all’ approach was mentioned frequently:

“And they’re really important points to highlight as well in terms of how this service is different. It is led by the family, identifying and agreeing a plan of work with you and you take your lead from them”

“It’s tailored to each individual’s needs and what each family would make. I think it’s just great...you can just really listen and just help in practical ways as well as behavioural, anything. It’s kind of just whatever the family need that week that you go out, and planning for the next week, and if it doesn’t go that way too it’s OK too and there’s no, like, you have to have done a certain thing”.

The prospect of introducing a manualised approach to dealing with specific family issues was not popular:

“If there was a manual there and you had to come in and you were doing the same thing for every family, which isn’t going to meet every family’s needs because every family’s so different, then it wouldn’t be as good a service as it is now. It’s as good a service now as it is because it’s what we make of it and how we approach the families and the fact that it is very much tailored to their needs”.

“Every case is different and every family are different so it’s hard to be able to – I don’t think it would work if you came along with a manual and said, “Week one to 12, this is what you’re going to do.” Actually, I don’t think I would like the service very much”.

b) Social and organisational positives

b1) Signposting on

Being in the position to signpost families during, or after, receiving the service was also consistently mentioned as a positive of EISS. Signposting to other services reinforced the work the support worker had been doing during the intervention and encouraged the family to continue to make changes:

“It encourages them to keep up what they’ve been doing, and then it’s again bringing in other services and things, signposting them, just make sure that they keep going with the changes that they’ve made and just maintaining them, yeah”.

Signposting enabled services to complement each other holistically:

“I think we work well bringing services together for families. I was out supporting one child where they had a new born baby and just being able to say, “Right, you can get Home Start for that, you can be ready for Sure Start, you can get Eat, Sleep, Learn, Play, you can get fire safety equipment for your home”, so I think we’re actually good at bringing services together for a family; I don’t think we’re in competition but more complementing services that are out there”.

b2) Working in partnership

A lot of families felt nervous at the beginning, almost like they were being assessed by the EISS support workers. Some families were dubious about being involved with the service initially:

“We’ve had some self-referrals like that and they’ve been very dubious and a bit fearful about getting involved...And they are very frightened of that because a lot of them didn’t see that as helpful... it’s just a whole fear, big fear, of social services become involved, it’s really like a whole system like the legal system. It’s a real fear for a lot of people who have had previous involvement or known people who have had previous involvement, a lot of stories circulated”.

“I think with EISS, the – because they’ve been so used to statutory organisations coming in and there’s an additional pressure with it, there’s a stigma attached to it with some parents and one of the first things I would say in the initial meeting is, “It’s voluntary and I know things come up and there’s times you might not be able to meet and that’s fine, we’ll look to rearrange” and it’s just about putting their minds at ease from the beginning”.

Because the service was voluntary it encouraged parents to engage more readily and be honest from the beginning, in contrast to the punitive environment sometimes associated with social services

involvement. There was no pressure or expectation to engage. Instead the support worker was able to work individually and in partnership with the families who wanted support:

“I think when you’re working with the parents, you know, they are wanting the support, so they’re very open, you know what I mean, that’s the nice thing. It’s a voluntary service. No one’s making them, you know, they’re actually ready to receive help, they’re wanting help, they’re saying, “Please come to my house”. So, they are more open and ready just to be like, “This is what’s going on, this is what’s happening”.

“As I say, going back to we’re at an advantage because we’re voluntary; we’re not in – trying to push, it’s done at their pace and we’re listening to them”.

There was also the opportunity to work in partnership with the schools to raise awareness:

“We work in partnership with the school and the school have been very good at doing the wee heading and incorporated that onto their school websites and stuff... They do struggle with it but they are good at putting their notices up and putting flyers out in school bags”.

Helping parents to improve their relationship by working in partnership with their children was viewed as a positive aspect to their job:

“We do a board games, like, and mum was there and she as saying to me afterwards, “If you hadn’t have been here, I wouldn’t have known that!”- “I wouldn’t have heard that.” Do you know, that sort of way? “I didn’t know that.” “I wouldn’t have known that.”

b3) Team relationships

Finally, the relationships between team members was highlighted as one of the most important positive mechanisms in delivering EISS. Feeling supported, knowing other people were having the same issues or worries and a sense togetherness all contributed towards the positive delivery of EISS:

“Team mates are really good. We would share it, you know? We do resources or talk about maybe a topic or, you know, sometimes [name] would say, “Is there anybody wants to talk about... that you’re feeling a bit stuck?”.

“Even down to the admin workers because you’d still be having chats to them or they’ll be helping you out with stuff, you know, whenever you’re really pushed and they are just so efficient so it’s an amazing team. You could go to anyone and I think that’s our benefit as well”.

Staff also felt that skillset and ability of each team member to deal with the individual family situation should not be undervalued:

“And I think maybe that’s been underestimated in terms of the skill and the level of not expertise, I don’t really want to use that word, but just the level of maturity even to deal with some of the issues that come along”.

The teams also benefited from the ability to share resources and rely on one another for advice:

“Or even within our teams, do you know, like, a resource. Sometimes, I say, “Look, a 13-year-old, maybe, you know, have any... have any of you used any resources that you find really good... maybe, do you know that you’re are engaging for behaviour or bullying, have you used anything that you’ve found really good?”.

5.3 Challenges to delivering EISS

There were also challenges to manage during the implementation of EISS. Staff reported experiencing a wide range of pressures, while engaging with parents was difficult at times and there were also organisational challenges to manage. These are considered below using sub-headings of worker challenges, family challenges, and social and organisational challenge.

Delays in set up of the EISS resulted in EISS not being fully operational in all areas until January 2016 which had an effect on the number of families supported and also resulted in underspend on the EISS in the first 5 months this has been used to recruit additional staff to help ensure the contract targets would be met.

a) Worker challenges

a1) Targets

The proposed target of supporting nearly 2,000 families and 140 per annum per EISS was not viewed as achievable:

“It was actually impossible, physically impossible to see 140 cases with the amount of people you have because you have to, you know, you have four quarters of 12 which is 48, you know, so that’s, you know, so that’s 48 cases practitioner, the amount of practitioners. Now, that only leaves four weeks left over to play with, so you have Christmas week, you have Easter week, you have Halloween week...and staff leave!”

Early into the pilot it was clear targets were not being met due to operational issues. A different approach was taken:

“The services really were not really fully up and functioning probably until February so the targets have been revised. Well, they haven’t been revised. I suppose with the way the contract was, the way the new tender process was, is the services get paid for what they’re delivering on and because they had underspent in this first few months because they wouldn’t have had the staff in post so what some of the services have done is they’ve employed additional staff so they should be able then to catch up”.

It was frustrating for the staff to feel they were restricted in supporting families due to targets:

“There was a bit of frustration around that and it’s also a frustration in the sense that, you know, you’re trying to be needs led and, you know, get in there, as they say, we’re trying to get in there within four weeks, get in when they’re aware of the crisis is, but because of the tightness of the targets you’d have no leeway for extension...but if you want to meet those targets you cannot [extend the intervention] and that is extremely frustrating”.

“One target could equal 30 sessions; one family could have 30 plus sessions in 12 weeks and one target equals six sessions but that’s – I don’t think that’s reflected in the targets for us and I think that’s where we’re just feeling the pressure, yes”.

The staff became accustomed to working in a fast-paced manner to try and meet targets:

“We’re always kind of working kind of a bit up here, you know, with that sort of energy because it’s like, “Boom! Boom, boom, boom, boom, boom, close, boom! Boom!” You know, and it, there’s never that – you’re right up there thinking and you’re very much thinking, “What do we need to do next, are we to build on next week?”

“It is rushed at times. It is rushed at times. It can be very rushed”.

Losing a member of also staff impacted on targets:

“A disadvantage being that if you lose one member of staff to sick leave or whatever then you’re really down 25% which has a huge impact on a small service. And then it’s very difficult to backfill those posts because they have all the types of training that they need to have”.

“Because, at the end of the day, if you have staff leaving and you’re not meeting your targets or meeting people within the four weeks, that’ll have an impact on the reputation of the project”.

There was a duty of care from the managers' perspective to their staff. They worried about putting pressure on them to close cases to meet targets.

"So, we all were kind of meeting and going, "I'm really struggling to hit our targets, and we're really struggling with this project, and this is really sucking the life out of all of us, and oh my goodness," and staff are feeling really drained and really exhausted and feeling totally – they're nearly getting burnt out," and that's being honest with you, getting nearly burnt out by the demand of having to meet these targets and hit them on the caseloads and everything else".

"You know, if you're saying, "Can we carry an extra two cases? Could you take an extra? How many have you got? Can you close this, can you close that?" That puts a lot of pressure on staff because I was actually a project worker at the time when we had to close, and I know how that feels".

a2) Caseload numbers

Having high targets meant some family support workers were taking on bigger caseloads to meet them. However, some felt that the lack of flexibility around the frequency of visits undermined their ability on additional cases:

"It would take time to really think around how you change kind of you know the caseload size number or the amount a week so to be able to say, you know, if a family needs two visits a week, they can have that if you are working with the parent and the child and want to see them separately, you know, you can give them two hours instead of one hour in a way that's manageable".

The EISS managers were exceptionally skilled in being able to manage caseloads with the waiting-list and knowing how many referrals they could take each month:

"The managers seem to be very good at managing the through flow and knowing whenever they can take, you know, when they, well, when they have capacity".

"I would go to each practitioner and ask them, "Okay, how many cases will you have closing within the next four weeks?" so that lets us know that it will be, you know, four weeks or less for when we can take, you know, for when that person – a new referral would be seen...".

If EISS could not see a family within four weeks of referral, the referral was not accepted. If this became a frequent pattern the service was 'closed' to referrals until the current families had been supported:

"We did have an issue when we had a full deluge of people at the beginning of the service coming in from – as soon as everybody, all the professionals became aware of it, everybody was referring families. And we were overwhelmed and we had to close our list off".

Caseload numbers varied between services. Some never had more than 10 cases, while other had up to 15, often geographically far apart:

“They’re very firm on the fact that ten clients, ten families is enough because it is very heavy. So, they’re very clear on that, they don’t want to see anymore because of the pressure that that would put on staff, so they’re very protective of their staff”.

“I know some other teams are working with 15, 16 cases which is crazy, constantly, and they have talked about burnout, they have talked about – because it is so fast paced, there is no – and I think it leave little room for reflection”.

Managing a demanding caseload was also linked to additional stress and pressure:

“But even if you close a case on a Friday, that will incur a lot of extra paperwork, closure reports, things like that, they need to be authorised by [name] and then we have to send onto referrers and stuff on the whole. You’re still expected to get a first visit in with a new case for the following week...there’s no kind of ... there’s no let up, it is so fast paced, there is no – and I think it leave little room for reflection. You are getting an opportunity in supervision and things, but you’re literally – it’s just like, “Right, boom, close it down, right, where’s my new case?”

“And then that is affecting you as a worker, you want to be at your best for your visits, but you’re so conscious of everything you have to get done and you want to be the best you can be at your visits but you’re so ... I did, that was really, really hard, and I do have a couple of my cases are – my cases now, I have some where I will need to close three in one week. That means setting up three new ones. That’s an overlap of up to 15”.

a3) Work-life balance

Closely linked to the pressures of meeting targets and having demanding caseload numbers was maintaining an ideal work-life balance:

“Some people bulk their visits, don’t they, maybe into two days, and then – but I find it quite a lot – if you’ve got – you don’t know what you’re going into sometimes. And if you’ve had a heavy session and you maybe have four or five straight in a row”.

“If they were looked at then it would reduce the likelihood of staff illness and stuff like that and people burning themselves out really, because we’re looking after so many families and we’re going out – we could have four or five visits a day depending on our diaries, and if one of those visits is a two hour visit with an awful lot of containment then we need to be able to offload.”

The impact of targets led to stress and tension:

“And, with the time limited, it’s – it makes it feel so much – even when they’re coming and they are extremely intense, but with that short time period that we have and the strict open-end review, closure, everything like that, it’s very – it makes it feel so much more intensive”.

“I think I suppose that is one responsibility, we’re constantly aware of the clock ticking in terms of the waiting list, when they’re going to time out, when our cases our closing, the 12 weeks, the four weeks, the ten days, all these timers that we have. So, that is a big responsibility, I suppose that’s one of the things I’m always constantly aware of is just checking the clock on caseloads and the waiting list”.

a4) A new way of working

The majority of practitioners were not used to working in a short-term focused way which some struggled with. Working in a short-term way could have an impact on building relationships.

“We would very much still see a strong value in relationship based social work and there is a little bit – I sort of feel that it takes a little bit away from that and I think probably there could be adaptations”.

It was also viewed as a major contributor to stress and pressure:

“Well, I think it’s just because it’s short term, it’s just a highly pressured pace of a job compared to services that might have a year, it’s just the makeup of it”.

“For me, it’s probably the fastest pace job I’ve had. I’ve worked the same cases but just in terms of pedalling all the time, it’s – other jobs I suppose in [service] you’d have had your set up and you’d have had six months to a year and you had that time to go but with EISS you’re just, “Go! Go! Go!”

a5) Complex cases

The remit of EISS was to support Tier 2 families, but what overwhelmingly came through was the complexity and variability of what was defined as a Tier 2 family, and the definition of early intervention.

“It’s quite interesting that’s comes out that some of the parents would actually be nearly at the very top of Tier 2 almost at Tier three, whereas the early intervention is you really want to get them at the point before anything does escalate”.

“So, although they come in as Tier 2 actually, when you scratch beneath the surface, you’ve got poverty, sectarianism, mental health, paramilitarism, substance – you’ve got a set of chronic issues and it’s how a service would ever be able to tackle any of those or manage those. A lot of the workers will say, you know, when you scratch beneath the surface, there are chronic issues that underpin”.

At times the families were past the point of what could be defined ‘early’ intervention which was an issue:

“I think that’s important. I think yes, they do need them at the really early stage. If they’d got them at the early stage, they probably wouldn’t need 12-week intervention, they could have a shorter intervention”.

“Early intervention is just means that to me what, you know, the reality of what we see early intervention means that they’re not bad enough or abused enough or there’s no evidence, sorry, that’s the whole thing. There’s not enough evidence that they go to Tier three”.

The definition of early intervention was deemed a challenge across the sector and practitioners were also keen to help educate and inform people not to wait for a crisis before referring to EISS:

“That’s around raising awareness of the service and getting out there to the people that would be picking up those families at that earlier stage like the health visitors, good nurses, school teachers, you know, all of those so that when those problems just start to emerge that that’s when they get them and refer on”.

“That’s the difference though, a lot of services, there has to be some incident or some crucial point to get on board, either severe mental risk or at risk of offending or some incident in school that they can’t manage...trying to explain that [our service] doesn’t have to be negative behaviour as well that is the big one; it doesn’t have to be the negative behaviour, it could be the wee one in the class that became really quiet”.

Families that came in and out of services frequently were an additional challenge as they may have long under-lying problems:

“They’re just a continual family that keeps coming into services but they are bad enough in the sense of crisis, enough or abusive enough that they go to social services, but their parenting capacity is such that they have a hard time maintaining things by themselves, so they just continually seem to come through”.

As previously highlighted, what was on the referral form may not be a true reflection of the family situation:

“GPs or paediatricians who maybe are only seeing, you know, for example, the family’s problems, we’d maybe get a referral in and it would say, you know, like, “Saw this patient today, blah-de-blah,” so they only have really a point of reference as to that child, and maybe don’t have a great awareness of maybe all the other systemic issues that are happening at home”.

Whilst the majority of families referred to EISS are for Tier 2 level support, albeit at a high Tier 2 level, there are families referred who present with a multitude of issues and are at times more complex to support. Due to the nature of the referral form it was impossible to determine the level of support a family would require until the first visit was completed:

“I think that’s the crux for me is just when you pick up a referral, you don’t know if this is going to be a family that needs 30 to 40 sessions in 12 weeks or one that will just have 12 or eight or – they’re just all so different”.

“Well, they’re being classed as Tier 2 but Tier 2 is a lot; I would say personally, we get a lot of need and a lot of intense cases, there’s no doubt about it, but they might have just been closed off so social services obviously are classing them as Tier 2 now but I find it intense work”.

At times, there were multiple children needing support, in addition to the child named on the referral form:

“There’s a family I’m with at the minute and there’s about seven people I need to make a contact with to see what’s going on for the family because it’s, you know, the referral’s quite lengthy and there’s quite a lot going on, so that can take you a week almost getting one phone call.

“For example, the last family I worked with, it was two children who I was seeing every week individually in school and then seeing the mum and so that would count as one target but it was two children getting that support and the same when you have three or five or more”.

There was no way for the support provided to these additional children to be reflected in the targets as an additional child supported:

“Or, like I said, you did have a couple of children and instead of rushing them all in to – trying to get – and spending three hours in the house, instead of taking your time and working with them as you go along, because you have that leeway, or the other child is counted. So, it would be nice if the other child was counted so that we were saying, “Right, OK, we’re going out and we’re spending three and a half hours

here” but that’s justified because we’re working on two children and all the phone calls that come with it”.

Referrals from families who had children with suspected Autism Spectrum Disorders were increasingly on the rise and, with no other service to support them, were referred to EISS.

“Children who were waiting for assessment for ADHD, essentially a big waiting list there and the Trust essentially regarding the family support service as a means of channelling that waiting list to the service”.

Also, there may be underlying mental health issues in some families which were not mentioned on the referral form:

I have had a couple of cases where I’ve, first visit, you know, there’s a mum in this instance, there was suicidal ideation, suicidal thoughts, and then with a plan as well, so straightaway, like I – that had to be sort of, you know, we had to put the safeguarding on case around that, and that was a first visit”.

“The next time I came out and I told mum we were going to do the star and then she started telling me all this stuff about actually her mental health and emotional wellbeing was on the floor and she has thoughts of life not worth living and she’s tried to take her own life several times...there’s all these safety plans in place so her medication is looked after by her older daughter and only brought to her when she needs it; she’s not allowed to wear a belt, she’s not allowed knives in the house, all of this”.

Sustaining this level of involvement was exhausting at times:

“The parent needs support and the child needs support, 12 weeks is not long enough to be able to do that so you do find that your slots, your sessions naturally start to get longer because you’re desperately trying to squeeze so much into so little time and I know that just in certain cases where you do have this split where it’s dad, it’s mum, it’s kids and you’re trying to divide and stretch yourself amongst everyone, there’s times I have gone out and I shouldn’t but I’m sitting for two and a half hours, three hours there with the dad or a mum and I am exhausted. Or I’ve had to combine a child session within a session with mum or whatever afterwards, even if that’s just feeding back what I’ve done with mum but then that suddenly stretches out because mum’s had something that’s come up or there’s been a crisis, so two and a half hours later, I’m crawling back when I’m out of the house because my brain is just frazzled”.

b) Social and organisational challenges

b1) Resources

All of the family support workers highlighted the need for resources. A budget was set aside for the purchase of resources and it was up to the service to decide how it was spent. Often, they made, sourced or obtained resources themselves:

“I think a lot of our work involves researching, as well. You’ll get a new topic in and I’ll be the first on Amazon or some sort of distributor looking for a book, whether it be on OCD or eating disorders”.

“[We] have a lot of resources and files with all different stuff in it that we’ve been able to draw on there, but I suppose a lot of it actually is our own research, just finding things and trial and error with what works for...”

In essence, the resources available varied across each service – there was no consistent approach to tackling an issue and it was ultimately the family support workers decision on what resources would be used/information shared with a family.

“There’s different wee things that we can pull on for anger or for emotions or for lots of bits and pieces that we can take and then obviously keeping our mind on our training, I think it’s becoming second nature now really to use it as we just go along”.

“You really just tailor it to the needs of them and, you know, sometimes you might – like as [name] said, using scrapbooks and things, you might pick colours that you know they like or you just really trying to make it so they’re going to find it fun”.

b2) Geographical issues

The EISS was set up as a relatively small pilot to test a new family support model. In selecting and resourcing five services, with designated catchment sites, there would inevitably be some frustration that the services were not on a scale to enable all families across Northern Ireland to access the service. The key issue was to test the transformational potential of the EISS and to then potentially scale to ensure universal access, based on the features of the service that worked or could be redesigned to ensure optimum impact.

Challenges emerged relating to the resources EISS could avail of, or signpost on to, the postcodes that were eligible and urban/rural differences. Eligibility for EISS was determined a ‘postcode lottery’ and a respondents felt that a wider geographical remit would be more inclusive:

“So, it makes it quite difficult for us because then it’s a postcode lottery for a child whether or not then fit under [location] or [location]. It can the difference of say a few streets sometimes or a road determines whether or not they get [EISS]”.

“Well, I suppose each of the services has a very defined geographic area because they’re small services so they can obviously only cover a small area. Yeah, so the postcode obviously people are excluded”.

Rural areas tended to have less of, and poorer links to, services in the community, limiting the ability of EISS to link families in to other services:

“But you have also to take into consideration that in [location] we have very limited resources in order to kind of respond, you know, to all the needs actually in, as I said, early and based on choice and all that as well. So, a lot of the time what we find is you really have to be creative”

“Yeah, well, just I suppose from the travel point of view and the fact that a lot of these rural areas are very isolated and you know so slightly different there... I suppose when the services, when the early intervention service is finished with them, there is sometimes a lack of things that they can actually then access. So, there is a lack of ongoing support for those families”.

For staff in rural areas, an additional time pressure was created due to the length of time it could take to drive between visits:

“From a geographic point of view, it’s a small area so traveling for the workers isn’t such a big issue whereas in the [location] area and some of the other areas, [location] area, travel is quite a big... yeah, because they cover, the [location] covers [location], that’s a huge travel”.

Staff training days were difficult to attend as the service started to pick up:

“We were finding too that as time progressed, because it was spaced out our caseloads were really building and then we were having to travel to [location] for a couple of hours to do this practice learning session and we’re thinking about ‘we need to get back, we’ve got sessions to get done’. So, there was that, again, element of just time management, it just felt like that was a wee bit too much”.

c) Family challenges

c1) Parental engagement

Engaging with the parents and in turn getting them to engage with the service and support worker was essential if the service was to be effective. At times, it was felt 12 weeks was not long enough to

build a meaningful relationship, one where the parent or child would be confident or willing to share information:

“Obviously there is such an element – such a strong element within social work and social care just to build that relationship so maybe makes that part of the process a wee bit sort of quick for people at times. Maybe not so much the practitioner, maybe more just the family [not] actually wanting to disclose such personal information at such an early part of intervention”.

“I would definitely say when you're starting to work with the kids themselves and the adolescents, more time would certainly be beneficial because it's very, very hard sometimes to get into a kid or get them comfortable, or even to get them to sort of have that self-awareness to try to get to the point where they can kind of make that change”.

Some felt that a longer intervention would allow for extended follow-up with the family if an issue was disclosed after the mid-way point of the intervention:

Female 2: “That’s your problem. See, it’s week seven or eight when they actually start to say to you, “Well, do you know what, this is actually the case.” Or, “Do you know what, remember earlier on I said I don’t have a mental health... I don’t have depression, actually I do.”

Female 1: “And am I right in thinking that some families there’s a multitude of issues, but you’re having to use your star”

Female 2: “We’re focussed which is really good, but at the same time personally, I think, you’re looking at 16 weeks”.

Sometimes parents were not ready to engage, or at a point to realise they may need some additional support. This was seen as frustrating but part of the job:

Female 1: “But it can be frustrating, I think, when a family agree and then aren’t willing to almost...”

Female 2: “You know, try and put in what you’re –

Female 1: “Not even – well, don’t engage, like sometimes they’ll agree but that is them agreeing to engagement, but then when you actually, when you make a call to the door and they’re not there. You know, and you’ve prepared for that visit, so that can be the frustration which of course is part of the frustrations, but ... but they’re just not ready, and that’s fine, you know?”

Regardless of whether or not a parent or family engaged with EISS, there was a realisation that the potential for change may be there and the family would be ready to engage at a later date:

“But they might even be willing and they want to be proactive, but they just – throughout the service – they just can’t get to that sort of trying stage, or maybe they might still meet you every week and you think they’re just maybe not getting it, and that might just be that – but that’s still, you’ve still planted a seed”.

5.4 EISS – the family perspective

This section will discuss how parents perceived the service and what they felt did and did not work well.

5.4.1 Initial contact

None of the parents that were interviewed had heard of EISS before, a common theme that the practitioners shared as well. Knowledge of the service, despite awareness-raising efforts, was not widespread. In essence, the families had no idea what would happen until their referral was picked up. Even at that stage, the initial phone call was not used to explain the service in depth, but to advise of a waiting-list and that contact would be made soon. Expectations were low and there was also caution and suspicion on the part of some families:

“I said I was very apprehensive about... like, we’re just normal people, you know, I don’t want Social Services involved in our lives you know, I... I really was very apprehensive about them coming in to work with me, because I thought that I was really being judged, or questioned”.

“At that stage I was just thinking to myself, you know, nothing is going to help but, you know, I was clinging onto anything that might help because, you know, it’d been going on for so long and we had tried a lot of stuff so I was hoping it would help but I didn’t have high expectations”.

The reasons for referrals were varied: from behaviour management, to toilet issues and severe emotional and mental anxiety. Schools were the most common route of referral while one parent self-referred on GP’s advice. Despite the lack of clarity around the purpose of the service, all of the parents interviewed reported that they were accepting of the support worker coming to their house, albeit they had some uncertainty prior to the first visit. They did not expect the referral to be picked up so quickly:

“I was more nervous, I was more nervous for [name] I think, because he is obviously a shy wee boy, that is all, that is all, just a bit nervous”.

“Yes, it was really quick too, I was surprised because I thought, you know, you could be waiting months in these things but I think that it was like the week after the

service had rang me to confirm that there was an appointment being booked and it was being organised”.

5.4.2 The format of the intervention

Various activities took place over the 12 weeks, the vast majority of which were well received. What came out strongly was the ‘small’ things that worked in terms of family cohesion:

“Maybe just the small things that were relevant and worked and were useful. And that’s kind of where I was struggling because, you know, you were just ending up shouting. And it was about keeping calm and trying to like to say, ‘Well try and do this”.

“He needs something that’s kind of nearly instantaneous or within an hour or two of me issuing the threat so that they can feel the consequence of it and know that that’s as a result of their actions. So, things like ‘No TV time tonight’ or ‘Right, you’re not getting a story, I’m not going to read you that story tonight, you’ll have to read it yourself”.

Sometimes the support worker stayed in the house or, if appropriate, took the child or parent out somewhere different e.g. a coffee shop or bowling alley. This one-on-one contact was appreciated:

“I think he just is enjoying having somebody that is just about him...he is not somebody who would go out of his way to look for somebody or for time, so the fact that it is actually there without him wanting it or needing it, it is there!”

“It was always just somewhere where they were surrounded by people so he was still, you know, comfortable. It wasn’t just one-to-one where they stuck in an office or a room or something and he might have felt agitated or anything. So, she made it as relaxed as she possibly could for him”.

Resources were varied. For example, a family could receive any number of resources and information, including, routine charts, visual timetables, posters, information sheets, games, me-boxes, calm down bottles or Play-Doh:

“She did some things about behaviour. We have like the traffic light system, you know, with the warning, second warning, final warning and then obviously the punishment, so we’ve got those that we’re using as well. We did games, different sorts of... A few social interaction games and things that make a good friend, you know, like the mixing bowl, you know, where you have to put in all the qualities that you thought would make a good friend”.

“She give him like...like sort of relaxation techniques and maybe as to like sort of going over like wee scenarios and then how he could deal with it rather than in the

way, you know, maybe that he was dealing with it. And given wee like leaflets on stuff of as to like taking responsibility, you know, for your actions and things like that”.

5.4.3 Relationship with support worker

The relationships with the family support workers were consistently praised. This demonstrates the excellent ability of the support workers to form such a relationship with the families that they felt able to open up and be honest within 12 weeks of working with them.

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

“With being very empathic, understanding, you know, listening. She understood exactly how I was feeling, you know, where I was at and that we could find solutions and not just sort of go over and over the problem”.

The perception of families that key workers were listening actively to both parent(s) and child also contributed towards a good working relationship, as both parties felt equally involved:

“She was very good at listening to what [name] was like as a child, you know, because they’re all individual and what would work for him and not just like a one fits all, she was brilliant that way. And, you know, asking me about him and what he likes and dislikes and if I said something wouldn’t work she was like oh that’s okay then don’t try that, you know”.

“Absolutely loved [name]. He is now... you know my husband and my mother don’t even know the images that [name] has in his head, and the only people who know is me and [name]. Completely opened up to her”.

In terms of creating a good working relationship, it was important for parents to know that they would also be supported in addition to the children:

“And they’re very, very good at, you know, supporting the parents which I find is really important because obviously it’s about the child so doctors now are trying to fix the child and then the health visitor it’s about the child but see that wee bit of support just on my piece of it, you know, that was great to have that”.

“Oh yes. And not feeling like a failure, not feeling that you’re doing a crap job. She never once... And even she would say, “Oh you’re doing a good job” and sort of reaffirm, you know, I’m not a crap parent, that it isn’t my fault. You know? So,

I think it actually boosted your self-confidence a wee bit more and gave you the confidence to then try new things”.

5.4.4 Finishing up with EISS

The majority of parents were happy to finish with the service when they did and felt well supported throughout:

“I think we actually ended up finishing three weeks early but we did that together because she said, you know, ‘[Name], I think that you’re actually getting on very well now’. I think it was maybe a couple of weeks or something, it wasn’t like that we finished it halfway through, it was really only the two left

A couple of parents did mention it would have been beneficial to have a couple more weeks. This was due to various reasons, for instance, some families missed weeks due to family commitments or sickness but the service is 12 weeks, not 12 sessions:

“As such, he did seem to, you know, interact with her and stuff like that. She seemed to have, you know like a good rapport with him. So, personally I think 12 sessions would have been better than 12 weeks”.

“I think it went far too fast. You know, an extra couple of weeks probably would have maybe... I know for some people, I know it’s all been positive on my side but it’s not even just for me. Some people might need the extra few weeks, you know, whereas some people could be fine with ten weeks”.

For other parents the desire for longer contact with the service was due to personal circumstances:

“I would actually change - I would like to have it longer, definitely. I definitely wish I could say that some kids need it longer than others. I understand that for some kids, three months is plenty of time, but for [name], a lot of his issues are not resolved, and if she finishes they probably won’t be”.

“Yes, I think that would be good yes, instead of having such a structure maybe, not being the 12 weeks and that is the end of... maybe you have a bit of a leeway, some kids obviously need the six and then you could use those other six for somebody who needs them more”.

5.5 Positives of receiving EISS

These are summarised under positives for the family as a whole, and practical positives of the intervention.

a) Family positives

All of the parents were extremely complimentary, positive and enthusiastic about EISS and the family support workers that came into their homes. In addition to the high praise of the family support workers and their resources, also high on a list of positives was the non-judgemental supportive tone of the weekly visits.

“Just the way she came out, just even her manner; she was just very approachable, non-judgemental and not coming out with stuff that we’d tried before, you know, she was listening... Sometimes you feel when you’re dealing with these people that they’re not really listening”.

“Do you know what [she knew what my] frustrations are and what they felt like and [name was] non-judgemental, someone you can actually vent to and get it off your chest, rather than being judged.”

The fact that parents were not receiving a generic one size fits all service, and that there was flexibility built into the service, was commended:

“There were two or three areas that we did need to focus on so that’s what we focused on that were tailored specifically to you; it wasn’t like a generic, you know, one size fits all”.

“Aye, and there’s no flexibility [in other services]. She was very flexible in her approach but it’s just... Basically I think what it was is she was able to adapt to the situation rather than, as you say, being too fixed and inflexible – she’s completely the opposite - and I think that’s what we needed”.

All parents felt well supported in terms of advising on and helping with parenting skills and other practical issues:

“I think that even from a mental health point of view, certainly mine, I’m a hell of a lot happier, so is my husband, the house feels a lot calmer, I’m sure even impacting on the child in terms of all that roaring being minimised. It’s just beneficial in so many ways...this has been the best thing in terms of all the options that have been presented to us, this is the best thing in terms of helping my parenting”.

“I think everything that I needed because my washing machine broke down and she even actually went ahead and got me a new washing machine...So, you know, even the simple things”.

Parents acknowledged that, while they realised the issues would not totally disappear, they could be better managed as they had improved coping skills and confidence:

“Yeah, well, to be honest like don’t get me wrong the problem’s not 100% gone, it’s still there but the way that we’re managing it and coping with it and just understanding about it is completely different. And it’s changed and he’s more relaxed, we’re more relaxed and just helps us cope with it and to know that, you know, it will go away eventually if we just keep being consistent”.

Parents could also see differences in their children after the 12 weeks, even though these changes may be small. These included giving children more confidence and looking at issues from a different point of view:

“I think it has just given him a bit of confidence again. That we are not ... obviously sometimes I think kids think that parents just want to make them do – make them go here, make them do this, and now he has realised that all we want is the best for him. And, I think she has helped him realise that”.

“We have tried the charts before, not just about the toileting, we used charts for different things, and it’s never really been very successful. I don’t know whether it’s an age thing or the fact that it was being done by somebody else but he just seems a lot more eager to fill them, which is brilliant”.

Parents reported feeling in a better position to tackle issues than they were prior to engaging with EISS:

“So, I think it actually boosted your self-confidence a wee bit more and gave you the confidence to then try new things and see if it worked, even if they are small and you think, “How will this help?” but you give it a go, and then when it works you feel great. (Laughs) You feel like “I’ve got control back again”.

“So, it’s really made a difference, it really has, it’s made me... I’m not generally a calm person by nature but it’s made me a lot calmer when it comes to disciplinary issues”.

Likewise, taking a logical teamwork approach towards tackling issues was very beneficial for parents:

“And trying to be logical about what we issue as well, actually trying to think about “Do you know, that’s not going to work,” and even to tell yourself, “Actually do you know what, that’s a bit harsh, why don’t we just try this instead?” and then working together more as a team”.

b) Practical positives

The length of the intervention was felt to be just about right by most parents.

“I think it was pitched just right and didn’t go on for too long either”.

“I liked the 12 weeks for my specific sort of thing but I don’t know in general what other people’s problems are but for ours like the 12 weeks was perfect, it was just the right amount”,

They also appreciated the value of the service being home-based:

“I really, really can’t fault this service at all like in terms of coming down to the house, she does it by just herself. She also – you know, she made a promise to be there and, you know, just her, no one else unless it was something major”.

The voluntary nature of the service was important to several parents. This was due to wariness of statutory agencies, or being seen to ‘need’ help:

“I know some people are sort of really like nervous about, you know, having sort of agencies and stuff like that involved but for me they’re... if you can get the help and it’s available why wouldn’t you utilise it, that’s what it’s there for... they’re there to help, they’re not there to catch you out”.

“I really was very apprehensive about them coming in to work with me, because I thought that I was really being judged, or questioned, or... and from the second they came, you know, that just alleviated it...that any of those barriers that I... that even I, as an adult, was worried about, were broken down straightaway, just how informal that the process was, and they’re there to help us”.

5.6 Challenges of receiving EISS

The challenges that families experienced in receiving EISS were down to practical issues: time management and managing relationships.

a) Time Management

The first challenge was regarding time management and family life. Making time for a weekly visit was difficult for a couple of parents:

“It was great to have, like don’t get me wrong it was hard to fit in because it was another appointment, you know, every week so that was the only side, it was like oh god, I have this today but apart from that once it was there like for me I absolutely loved it, you know, it was great to have”.

For one parent, the weekly visits were too much; fortnightly would have been better for her family:

“You see, and I just thought, you know, I would have liked maybe... I don’t know if I could have done this like once every fortnight. Because, towards the end, there were things going on” [making it hard to fit in a weekly visit].

b) Managing Relationships

As previously highlighted, the relationship between the family support worker and families were invaluable to most parents. A second challenge that emerged was managing a child’s expectation of this relationship - which went from weekly contact to zero in a short space of time:

“I do feel like, for some people, that bond is there and [name] is totally lost without that, and we’ve been just... as I said, we’ve just been kind of left, there’s nobody... although [service] are still working with us, that relationship was there with [name]”.

5.7 The stakeholder perspectives of utilising EISS

Following on from the previous stakeholder views on the set-up of EISS, this section will discuss what stakeholders felt were positive and challenging aspects of the service once a family was referred. Overwhelmingly, there was a view EISS filled unmet need.

“They’ve been a lifeline I can say that from when I started they have been fantastic because it took me a couple of months of my induction to know which organisations I could use once I knew that they were available and they could take my referrals, that was it, god I think I bombard them”.

“I know that it’s made a big difference to us in the past two years, and if it does go, it’s going to leave us with a significant hole, and especially if you’re meeting with a parent and trying to think, what else can I do here? So, I think it would be a real shame if it disappeared”.

5.8 Positives of EISS

The following section looks at the stakeholders’ views of the positives of EISS from both family and organisational perspectives.

a) Family positives

The flexibility assigned to the family support worker and the structure of the 12-week intervention was also praised:

“I think the fact it is very, very flexible. It is time-limited and being time-limited, I think they are very structured in that sense, then”.

“I think any longer than 12 weeks and you create a reliance on it, and what they’re trying to do obviously is give parents skills rather than I suppose be there for them all the time, and if you, you know, they know they’ve got 12 weeks so they know they need to gain the independence to do what they need to do at the end of those 12 weeks, so it’s good that it’s set out from the onset”.

The structure of EISS allowed the family support workers to have more time with families which helped them build up a better overall picture of the situation:

“I just think to have that time to sit down and do the work that the family say that they want to do, as opposed to it being agenda-driven by anybody else”.

“Certainly, from my point of view, you know, you’re sort of getting a better overall picture from health visiting because we go in and we do one visit, they’re in much more regularly to get a better feel for what’s going on, to get a better understanding of issues perhaps. And certainly, if a child does need onward referral their information may be able to support that”.

A home-based service was viewed to be the best way to build a relationship with the family. This was something other services did not offer or did not have time to do:

“I mean if they’ve a couple of children under the age of three and they’ve no family support or anybody to mind their children while they go to the parenting programme well then this is what’s vital, you know”.

“That’s a key issue because having to get out, having to get childcare, having to get somebody to make sure the dinner’s not burnt or pick somebody up from school, whatever it is, going into the homes where... they are where the issues are. And it’s totally different if you see somebody in the office. It’s a totally different experience”.

“I suppose [it’s less] intrusive, you know, when somebody is going out to the house and maybe they can open up a wee bit more as well”.

The wide age-range of EISS was viewed as being beneficial as there were different types of need experienced by children at different ages:

“The older it would tend to be more the primary school age children I would send for EISS because that would be my highest statistic is that age group for primary school age and then maybe use [service] then for the older children where there is risk taking behaviour so not 18’s good, it’s good to have that wide range, you know, definitely”.

“You’re talking about friendship issues. I have children that have gone with regard friendship issues, self-esteem, self-confidence issues, children that maybe are experiencing maybe domestic violence at home; children where there has been a breakdown in the family, you know, split, and there’s children going through that trauma and conflict where there’s a split-up at home, children with behavioural issues, like parents that have sought support to get strategies to support their children – and the list is never-ending”.

b) Organisational positives

The referral system was praised as being easy to use and cases were quickly picked up:

“And I found that the referral system is easy and they are very prompt at picking up the referral and they come back to you about, you know, asking you, you know, getting a wee bit more background information”.

I think for me what I see the benefit is that the service is... they’re able to go into the families a lot prompter, more timely than other services perhaps. I would have used the hub quite a lot but the waiting list was horrendous and I have found that this service has gone in and the quality of the work that they’ve been doing has been of a good standard as well, of a high standard”.

The close links EISS maintained with the referrer were appreciated, something that is not widespread practice in Northern Ireland. This could be through providing a closing report, re-referring the family back for additional support or maintaining close contact in general:

“They keep you well informed, they let me know whenever they’re going to, I’ve ... I’ll, this referral I’m going through now. I’ll get a phone call saying they’ve received it. And then I’ll get a letter later on telling me when they’ve picked it up. I’d also get a phone call from the head of the counsellors to say that they will be going out to visit mum. There’s a very tight communication level, which is brilliant – and they’re few and far between, a lot of places nowadays”.

There was however also the view that the level of feedback was unnecessary:

“I don’t want the feedback all the time with regards to the family that I’ve referred on because they’re not my family anymore, I’m not working with them, I’ve moved onto a new family and when they ring back to say, “Ooh, they’re doing this or

they're doing that," I'm like, "Well, that's OK, but if you need to make a referral, make a referral back in. If you don't just continue on with your work".

c) Staff positives

The staff could not be praised highly enough:

"Well, can I just say, the staff are brilliant, they're so approachable, they are fair and it's a lovely service to deal with when you're a referral agent because you're always on the lookout for a service or a – see a service that can be tailored to the individual needs of the family; that is unbelievable, because most services offer a one-size-fits-all as I've said before, but – and that doesn't fit everybody, whereas EISS does fit everybody because it works with the family and their needs".

"I think the staff are wonderful, they're approachable, they're incredibly professional and there's great communication between themselves and myself.

5.9 Challenges of EISS

As before, the challenges of EISS are expressed in terms of family and organisational challenges.

a) Family challenges

Sometimes, EISS were sent families who would not benefit from an early intervention approach, or indeed may be above Tier 2 criteria:

"I think the most difficult thing is just trying to convince – I certainly have quite a lot of primary schools in the area and would encourage them, rather than trying to refer to us when they're low-level"

Likewise, some parents expectations of what EISS could do had to be managed:

"They [the family] end up going to CAMHS and its referred back to EISS. They kind of go, "I was cheated", which is no reflection on EISS, but at the same time, it just makes it difficult".

b) Organisational challenges

An important point was made regarding the protocol for EISS to cease working with the family if they were escalated to social service involvement. A general point made was that if EISS had started to work with a family, it would be advantageous to allow their work to continue:

“There should have been like a handover, you know? She could have had her 12 weeks done with that family in the time they were pulling up, but then it’s all red tape...if they can, if they could continue with people that they’ve started with, complete the programme, rather than just cut it short because they’ve been referred [on] under a different reason”.

6. ANALYSIS OF MAIN EFFECTS

6.1 The Sample

In total, data were collected from 80 participants at pre-and post-test stages. The two groups were found to be broadly similar, with no notable differences being found at pre-test in relation to key characteristics as shown in Table 1. Overall, and as can be seen from the Table, just over half of the children referred to EISS were female and nearly six in ten children who were referred were between 5 and 11 years old. Nearly three quarters of the families referred had been experiencing issues or difficulties with their children for more than a year.

Table 1: Description of the sample

Characteristics	Intervention		Control		Total	
	n	%	n	%	n	%
Child Gender						
Male	19	40.4	14	42.4	33	41.3
Female	27	57.4	18	54.5	45	56.2
Missing	1	2.1	1	3.0	2	2.5
Total	47	100	33	100	80	100
Trust Area						
Northern	17	36.2	7	21.2	24	30.0
South-Eastern	13	27.7	9	27.3	22	27.5
Southern	7	14.9	9	27.3	16	20.0
Western	10	21.3	8	24.2	18	22.5
Total	47	100	33	100	80	100
Child Age						
2-4	5	10.6	2	6.1	7	8.8
5-11	29	61.7	18	54.5	47	58.8
12-16	12	25.5	13	39.4	25	31.3
Missing	1	2.1	0	0	1	1.3
Total	47	100	33	100	80	100
Duration of Difficulty						
Under a year	12	26.7	6	18.8	18	22.5
Over a year	33	70.2	26	81.3	59	73.8
Missing	2	4.3	1	3.1	3	3.8
Total	47	100	33	100	80	100

6.2 Differences at baseline

Table 2 displays the mean and standard deviation for intervention and control groups at baseline in relation to scores on the outcome measures used. Overall, the Table provides further evidence that the two groups are broadly matched. Only one significant difference between the mean scores for the two groups was found (in relation to parent-child dysfunction outcome scale). However, given the large number of outcomes listed, one would typically expect at least one of these to show differences between the two groups just due to random variation.

Table 2: Comparison of scores on outcome measures at baseline by group

Outcome	Intervention	Control	Sig.
	Mean (SD)	Mean (SD)	
FFS Score	67.45 (8.3)	66.91 (8.7)	.782
FFS_Problem_Solving	21.36 (5.3)	21.27 (5.4)	.942
FFS_Communication	26.43 (2.1)	26.58 (2.2)	.763
FFS_Personal_Goals	19.66 (3.5)	19.06 (3.4)	.447
SDQ_Emotional	5.85 (3.0)	6.21 (2.6)	.571
SDQ_Conduct	4.38 (2.7)	4.94 (2.6)	.359
SDQ_Hyperactivity	7.15 (2.9)	6.58 (2.6)	.355
SDQ_Peer_Problems	3.43 (2.7)	3.36 (2.3)	.911
SDQ_Prosocial	7.02 (2.5)	6.73 (2.7)	.618
SDQ_Difficulties	20.81 (6.6)	21.09 (6.8)	.854
TOPSE_Empathy	48.15 (8.4)	46.58 (8.3)	.410
TOPSE_Play	50.77 (9.3)	47.36 (11.2)	.159
TOPSE_Emotions	52.06 (8.0)	52.18 (8.0)	.948
TOPSE_Control	37.53 (12.9)	34.12 (11.1)	.211
TOPSE_Discipline	41.19 (11.7)	38.76 (13.5)	.407
TOPSE_Pressures	34.19 (7.0)	35.39 (8.0)	.488
TOPSE_Self_Accept	48.91 (10.0)	49.12 (11.7)	.935
TOPSE_Learning	53.38 (9.7)	52.33 (9.0)	.619
PSI_Distress	39.60 (9.0)	40.42 (10.1)	.707
PSI_Dysfunctional	42.70 (7.0)	39.48 (6.7)	.042
PSI_Difficult_Child	32.49 (7.6)	31.48 (6.6)	.532
PSI_Total_Stress	114.79 (18.1)	111.39 (19.4)	.432

6.3 Main analysis

Table 3 presents the findings of the analysis of the main effects of the intervention. As can be seen, for each outcome the adjusted post-test mean scores for both groups is reported alongside the significance of the differences and their associated effect sizes.

A number of multiple regression models were fitted to the data. For each model the post-test score was the dependent variable and the independent variables were the standardised pre-test score, child gender, child age, the group (i.e. intervention or control), Trust area and length of time between testing. The post-test adjusted means are displayed and the Hedges' G effect size which represents

the size of the differences between the control and intervention group and whether they were statistically significant.

Table 3: Main Effects Table

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

As can be seen from Table 3, only two of the 22 outcomes were associated with statistically significant effects ($p < .05$): TOPSE Empathy and TOPSE Play. Taken in isolation, it would be misleading to emphasise these as providing evidence of the effectiveness or ineffectiveness of the intervention. With 22 outcomes, it is expected that at least one of these could show a statistically significant effect just due to random variation. Given this, and given the lack of corroborating evidence in relation to the other outcomes, it is quite plausible that both simply reflect random fluctuations in the data rather than indicating any real effects of the intervention.

Therefore, in formal terms and overall, the current evaluation has not found any robust evidence that the intervention has been effective. However, this conclusion should not be interpreted as providing evidence that the intervention is ineffective. Indeed, the small sample size means that even if the intervention has been effective, this present evaluation would not have been large enough to detect such effects. It is with this in mind that it is worth noting that whilst the effect sizes reported are relatively small (typically between .10 and .30), they are all consistent and what would be expected if the intervention was working. Thus, effect sizes are negative for the negative outcomes (e.g. indicating

reductions in difficult or challenging behaviour) and positive for the positive outcomes (e.g. improvements in empathy, communication and so on).

In summary, therefore, this current evaluation does not provide any formal evidence of the effectiveness of the intervention. Having said this, there are some possible indications that the intervention may be having a small but notable impact in the directions that one would expect. However, such indications need to be confirmed through further research using a more robust evaluative design and a larger sample size. Particularly given the limitations of the current research design, even these potential indications need to be treated cautiously, given that they are unreliable. As before, a note of caution has to apply: although the results demonstrate a small positive effect, they do not provide robust evidence that the intervention is effective. This observation would need verified further using a more robust design.

6.4 Sub-Group Analysis

Sub-Group analysis was performed for:

- Gender;
- Age;
- Duration of difficulty (over or under a year);
- Trust area

Table 4 presents the results from the Sub-Group Analysis, where interaction terms were added to extend the main regressions models to determine whether they were statistically significant.

*Table 4: Summary of evidence in relation to the possible differential effects of the intervention by sub-groups**

Outcome	Subgroups					
	Gender	Age	S Trust	W Trust	N Trust	Duration
FFS Score						
FFS_Problem_Solving						
FFS_Communication						
FFS_Personal_Goals						
SDQ_Emootional						
SDQ_Conduct						
SDQ_Hyperactivity						
SDQ_Peer_Problems						
SDQ_Prosocial						
SDQ_Difficulties						
TOPSE_Empathy						
TOPSE_Play						
TOPSE_Emotions						
TOPSE_Control						
TOPSE_Discipline						
TOPSE_Pressures						
TOPSE_Self_Accept						
TOPSE_Learning						
PSI_Distress						
PSI_Dysfunctional						
PSI_Difficult_Child						
PSI_Total_Stress						

*Dark cells indicate evidence of a differential effects (p<.05).

As can be seen, and at first sight, there would appear to be evidence of seven cases of differential effects of the programme for specific outcomes and particular subgroups. However, this represents just 5% of the total number of possible cases (132) and one would expect about this number to show evidence of differential effects simply due to random variation in the sample. Moreover, these seven cases, as highlighted in Table 4, appear to be random with no real discernible pattern. As such, it can be concluded that the present evaluation has found no evidence to suggest that the intervention has differential effects in relation to the gender or age of the child, the Trust area they are located in or the duration of the problems they have been experiencing by the time they were referred.

7. ANALYSIS OF THE OUTCOMES STAR™

This section will describe the Outcomes Star™ tools used by EISS services, focusing on the specific Stars EISS used in their practice, and provide an overview as to key workers used the Stars. The section will then report the findings regarding an analysis of the data generated through use of the Stars and how these findings compare to those of the outcome measures used by the research team in the evaluation. Methodological considerations relating to the interpretation of the Outcomes Star™ as an evaluative tool will be addressed.

7.1 The Outcomes Star™

The Outcomes Star™ is intended to be used by services to '*support effective key-work and measure service user outcomes in front-line services*'. There are more than 30 Outcomes Stars™ available and these have been developed by the social enterprise Triangle. Each Outcomes Star™ comprises a ten-point scales that measures a range of life domains which are arranged in the shape of a star. The Outcomes Star™ is used by practitioners and service users to collaboratively set objectives, measure a baseline score and then record progress or 'distanced travelled' over time. The ten points of the scale can be converted into a Journey Of Change, with scores of 1-2 indicating being 'stuck', 3-4 indicating 'accepting help', 5-6 'trying to make a difference', 7-8 'finding what works', and 9-10 'effective parenting'. EISS used three Stars; the Family Star Plus, My Star and Teen Star.

7.1.1 The Family Star Plus

The Family Star Plus was the tool most commonly used by EISS as a goal planning tool to outline the steps a parent can take to improve outcomes for their children. The Family Star Plus includes the following ten outcomes areas presented in the shape of a star which were completed in collaboration with the keyworker:

1. Physical health
2. Your well-being
3. Meeting emotional needs
4. Keeping your children safe
5. Social networks
6. Education and learning
7. Boundaries and behaviour
8. Family routine
9. Home and money
10. Progress to work

The parent and keyworker discuss each area and collaboratively decide where the parent is on the scale. The Star is completed at the outset of the intervention to record how things are for the parent and to help identify areas of where support is needed. The ten-point scales are based on the 'Journey of Change' which depicts the steps that people will go through to effect change:

- A score of 1-2 indicates the parent feels **stuck**. They are not able to deal with the problem or accept help.
- A score of 3-4 indicates the parent is **accepting help**. They are aware of their problems and look to other people for help sorting it out.
- A score of 5-6 indicates the parent is **trying** to make a difference or change to their parenting but find it hard.
- A score of 7-8 indicates the parent is **finding what works** in managing their children's needs but will still need a degree of support.
- A score of 9-10 indicates the parent is, or is moving towards, **effective parenting** and does not need support in this area.

7.1.2 The My Star

My Star was used with children and young people to help them consider eight areas of life that may be important to them:

1. Physical health
2. Where you live
3. Being safe
4. Relationships (with parents)
5. Feeling and behaviour
6. Friends
7. Confidence and self-esteem
8. Education and learning

My star uses a five-point scale which is colour-coded for each step. This Star is completed collaboratively as well and the key worker and young person will decide where they are in each area:

- Red indicates the young person is stuck in this area and feel things are bad.
- Orange indicates that things are bad but potentially could change.
- Yellow shows that issues are present but are being worked on.
- Green indicates things are generally OK.
- Blue is the ideal; things are working well.

7.1.3 The Teen Star

The Teen Star was used with teenagers and considered six areas of life on a five-point scale:

1. Family/adults
2. Drugs and alcohol
3. Well-being
4. Safety and security
5. Behaviour and citizenship
6. Structure and education

As before, the Teen Star uses a five-point scale to depict where the individual felt they were in each area:

- A score of 1 indicated the young person felt 'not safe'
- A score of 2 indicated they wanted to 'change'
- A score of 3 meant they were 'making changes'
- A score of 4 indicated they felt 'alright'
- A score of 5 meant they felt 'safe and well'

7.2 Outcomes Star™ as goal planning tools – the supporting research

The use of the Outcomes Stars™ approach to assessment and goal planning have become well-established across several related fields, from family support and autism to mental health recovery and employment. Outcomes Stars™ are increasingly used within services in the context of an Outcomes Based Accountability (OBA) approach, a framework based on the work of Friedman (2005) in the USA. More recently these have been embedded into the UK's approach through a series of international exchange exercises which have since formed part of the approach outlined in UK policy documents such as Every Child Matters. OBA is an approach to evaluating services that involves mapping population level needs within local communities and which maps a course towards delivering these outcomes using quantifiable service performance measures and area indicators.

There are reports that highlight the acceptability and usefulness of the Outcomes Star™. An analysis of more than 3000 Family Stars, for example, found that service users found the process engaging and that practitioners also found it a useful framework to help deliver support (York Consulting, 2013). In a further study, MacKeith (2011) found that the Family Star approach was seen as meaningful and useful by key workers and other practitioners because it relies on a visual process to map need and to record change. The Recovery Star has a larger literature base owing to its widespread use in mental health services, with research suggesting it is well-received by practitioners and service-users as a person-centred approach and that it can support care planning (Lloyd *et al*, 2015).

However, compared to the evidence base for other well-established measures used to evaluate outcomes such as the Strengths and Difficulties Questionnaire (e.g. Goodman, 2001; Mieloo *et al*, 2012; Stone *et al*, 2010), the psychometric evidence for the reliability and validity of Outcomes Star™ approaches in general, and the Family Star (Plus) or the My Star, is lacking. The reliability of the Family Star (rather than the 'Plus' variant) has been tested on a small study population of 24 key workers (Mackeith, 2014), and was found to have low inter-rater reliability for scoring the eight outcome areas contained in this star. However, when these scores were converted into the five areas of the Journey to Change score described above, inter-reliability was better, scoring 0.81 against a threshold of 0.8 for acceptable inter-rater reliability. The small study population is a limitation of this finding and other aspects of the validity and reliability of this measure have not been assessed. The Family Star (Plus) and My Star have had no peer-reviewed assessment of their psychometric properties.

There is some stronger evidence that the mental health variant of the Outcomes Star™ approach is valid, reliable and responsive to change. The Recovery Star is now widely used within mental health services and has slightly stronger psychometric research evidence, although this evidence base is mixed. An analysis of 203 adults (Dickens *et al*, 2012) found the tool has high internal consistency, suggesting that it measures a coherent underlying construct related to mental health recovery. They

also found that the measure did not have redundant items and had good responsiveness. An analysis of the Italian version of the Recovery star based on data from 117 service users and 42 keyworkers also found the measure was seen by both service users and keyworkers as acceptable and easy to use, had convergent validity, high test-retest reliability and good inter-rater reliability (Placentino *et al*, 2017).

Killaspy *et al* (2012), however, analysed data on 172 service users and 120 staff within in-patient mental health services and found that while the measure had good test-retest reliability, it had inadequate inter-rater reliability and therefore could not be recommended as a tool to capture routine clinical outcomes, but rather was a useful tool in collaborative care planning. An assessment of 33 instruments for mental health recovery (Burgess *et al*, 2011) rejected the Recovery Star as lacking adequate peer-reviewed assessment, although since the publication of this review the papers mentioned above (Dickens *et al*, 2012; Killaspy *et al*, 2012; Plecentino *et al*, 2017) have been published.

The evidence base for the validity and reliability of Outcomes Star™ approaches in general is still emerging, while the reliability and validity of the Family Star (Plus) and the My Star have yet to be tested in this way. This limits the strength of conclusions that can be made on the basis of comparing scores across services or other contexts. The research that does exist on the Outcomes Star™ approaches, and particularly on the standard version of the Family Star, is more supportive of its efficacy in helping practitioners and clients collaborate in an engaging format, than on the usefulness of the measure as a comparative indicator of outcomes.

In line with this, the user-guide for the Family Star (Plus) provided by Triangle indicates that service comparisons should be conducted with caution. In order to reach stronger conclusions about the validity and reliability of these specific variants of the Outcomes Star™, psychometric testing needs to be conducted using adequately sized data sets, including the use of inter-rater reliability, comparison to other well-validated tools (convergent validity) and test-retest reliability.

7.3 How the Outcomes Star™ was used in EISS

The NCB was commissioned in 2015 to provide a review of evidence on a range of family assessment tools which could be used to measure and assess family need and measuring change of impact of EISS. The NCB review determined that, based on the available evidence, a measure of family support assessment should:

8. be strengths based;
9. take a whole family approach;
10. take children's views into account;
11. be of high quality;
12. cover at least one domain of family interaction, parenting practices, child needs and development and take family history into account and;
13. be a mix of qualitative and quantitative approaches.

The Outcomes Star™ (consisting of Family Star Plus, My Star and Teen Star) was chosen as the most appropriate assessment measure after considering areas such as target population, domains covered, cost, quality and administration. However, it was determined to not provide a whole family approach or to be of high quality, as assessed in the NCB review. In addition, it was unable to provide one measure of acceptable validity and reliability for the Family Star, My Star or Youth (Teen) Star.

7.4 How the Outcomes Star™ was used by workers and families – evidence from the process evaluation

There is detailed guidance on how the Star should be implemented in services:

- All staff using the Star should be trained in its application beforehand and be provided with clear guidelines on how to use it (preferably by Triangle). The first Star is to be completed within four weeks.
- The Star is to be led from the top of the service: early monitoring and on-going management of how the Star is implemented is essential.
- Effective implementation is necessary for accurate and meaningful Star data and reports. Services need to ensure that all staff really understand the scales and that the scores are being obtained in a collaborative manner.
- Staff should be supervised by managers so that their understanding of the Star is drawn upon – perhaps from cases discussed in supervision meetings and files should be audited frequently to check for accurate completion.
- Co-worker feedback is recommended where staff review each other's cases and compare scores.
- Any reports run should be routinely monitored for consistency and rigour in uploading Star data.

One Outcomes Star™ per family was usually completed in the second or third week of the intervention:

“The action plan and the second session is usually very appropriate because it sets a clear set of goals, where you want to be and how you're going to get there, so that's very useful for families and young people”.

“I do reiterate to the family that paperwork isn't necessarily going to be a big part of this process, but we have to do a wee bit today...and I'll explain to them about what the Star is before bringing it out or if I have a copy with it. Most families usually get it done – if you want, within the second or third visit”.

Flexibility in completing the Outcomes Star™ was emphasised. The priority for support workers was to be responsive to the needs and situation of the family so, if preferred, the initial Outcomes Star™ could be completed later. This could help to build rapport and allow the family to be more open:

“We talked that through with [name] and she was kind of the agreement that we could do the star later if that was okay. And when we were doing it earlier and we felt at the end the family had scored really okay for an area and then lower afterwards, they kind of said, ‘Really didn't want to say before...”

“A lot of our team have been doing the Star early on and then some of them now are leaving it until later, particularly in families that you sense there's a bit of reticence or a wee bit of uncertainty, sometimes you'll get a truer picture”.

Practical considerations included the need for family support workers to be aware of differences in reading ability and be able to work at the family's pace. Sometimes an interpreter was needed:

"Some parents... you also have to work with... I've worked with some traveller families as well who, mum readily admitted to me, "I can't read." I said, "That's fair enough. That's grand." "You do the talking, and I'll do the scoring." Do you know in that sort of way?"

"Again, families where the interpreters may be needed as well. Like work with the families with an interpreter and that's been a couple of visits even just to...the first initial visit was to meet them, it was to do the paperwork, you know? It was to meet with the wee child, so we all, sort of, give ourselves at least a couple of weeks doing that Family Star session, can be really intense for some families".

The results of both Outcomes Stars were entered into a central database. It was voiced that it was not always the best idea to enter the initial Outcomes Star™ results immediately. This was due to the short-term nature of working with families and rapid relationship building. As families became more open and honest their initial scores could change:

"...because later on they will say, 'I really should have scored that much lower but I was afraid to say I was struggling so much'. So we're not always getting a true picture early on".

"We discovered that it maybe took a couple of weeks for a family to open up or even to accept themselves where the issues were, so we – I suppose the staff had raised that hadn't we, that if we had inputted it too soon then it wouldn't have been a true reflection of where the family were, so we've – again, we've had an agreement that we can input those at a later stage, so that's a true reflection".

If an initial score was viewed retrospectively to be incorrect, the family support worker could request a deletion and amend the score for that family after explaining their reasons. This approach is different from the usual way in which data from measures is collated in that results cannot be amended at a later stage.

7.4.1 Practitioner views

Overall, the general view of the Outcomes Star™ was positive and it was viewed as user-friendly. Training in the administration was good and there was support built in from the start. Staff reported using it to be a good conversation opener:

"I actually have found that it is a really good tool for if you're going in to a family home and you – and all that's on it is boundaries and behaviour and that's all they've talked about and then you start going around the star and the mum (?) will – I'll talk about home and money and, "Well actually I'm really struggling", or – do you know what I mean?"

“The Star’s a good way of getting conversations going and covering all areas”.

It was noted, from a commissioners’ point of view, that the tool was a convenient source of data on service progress:

“The Outcome Star is really good because we can get the data...you can run quite detailed reports and you can look at where the services are. So, from an administrator or full-on commissioner’s point of view, it is really good and the reports you can get down are good. And also, you can see the change”.

The action plan was viewed as helping to provide a sense of control to the parent, as well as giving them a focus for the goals of the intervention:

“I also like the action plan thing at the back and it helps me to actually focus, because there are some families and everything will be a three and I’m going, “We’ve got 12 weeks, let’s pick one or two of those” (laughter) and then it actually means that the parent is focused as well and saying, “Right, this is what [name] is here for”.

“I like the idea that it gives the parents a bit of control as well [to] decide what to focus, what we say is, “You tell me where you want the area of support. You tell me where you want me to support you at.” So, you can see there where you scored. Which one is going to make within the 12 weeks is going to impact your family most and be more positive for your family”.

The Star was viewed as an asset-based tool and practitioners felt that it showed parents their strengths rather than only where they were having issues:

“I think it’s a great tool though because it lets them see their strengths as well, it lets them see the areas that are going well, because, you know, quite often – and it’s pointing that out, you know, it’s saying, “Look, there’s so much going well here, but maybe a couple of these areas could be just a wee bit strengthened, and I hate saying – I don’t say points or anything but you could try and say like a scale and just areas that could be improved a wee bit more”.

The tool provided a visual record of progress for families, who appreciated being able to compare where they were at the end of the intervention compared to 12 weeks ago.

“I think they find it useful. The fact that it’s so visual, it’s quite simple and they can actually see when they have made progress and in what areas”.

“Yeah, I suppose the families again, liked the service being co-designed. Their visits are co-designed with the families so I suppose that’s where the Outcome Star, strengths of the Outcome Star, the service is a strengths-based, needs-led service”.

There was however some initial resistance within services to using the Outcomes Star™ as an assessment measure, with some viewing it as difficult to complete with a parent or of limited use:

“I struggled a little bit with the Family Star. I do think there are faults in it. I think it could be improved a lot and I have said, “One of the things I find most difficult is the language...It is also time consuming.

“You tend to feel a bit guilty then if you’re not covering what they really need you to cover and really things are that dire for them at that time that they do need help in those other areas too”.

7.4.2 Parents’ views

Similarly to the views of the family support workers, parents reported liking the Outcomes Star™ in terms of its visual simplicity and helping them to focus on key areas:

“Yes, I did [like it] because it gave me an idea of the areas we needed to focus on.

“Yeah, I thought it was a good idea. You sort of maybe mark yourself higher than what you’d originally thought, you know, when you see what the options are. So, yeah, I did find it helpful, yeah. Just putting things down on paper sometimes makes it a bit more tangible, do you know what I mean, where you are”.

7.5 Data generated by the Outcomes™ Stars

Data generated by the Outcomes Star™ can be used in several ways. Because the keyworker inputs demographic data, the individual scores on the ten outcome domains and any field notes at both completion time points, reports can then be generated at an:

1. Individual level
2. At a service level
3. At a service comparison level

Raw data is provided for each case, for each of the ten areas, along with the amount of change between the testing points – the starting, end and change points. This can also be shown in percentage format for each Star area for those who made: positive change (reported a higher score on the Star); no change; and/or negative change (the Star score decreased). There is also the possibility to show the average overall mean score of change per service and so it is possible to compare change across services for each of the domains. The data allows the service to show the level of progress a family can make and if there are any areas of concern, or negative outcomes where no change is happening however Triangle have guidance procedures to follow:

The guidance from Triangle (see Triangle Consulting, 2016) on the use of the Outcomes Star™ however is that the distance between each score on the ‘Journey of Change’ is not to be implied or interpreted as equal, or ordinal, as the differences between scores are individual to the parent. interpreted The data generated is ‘ready-made’ and while the raw data can be downloaded these may provide false

reports i.e. if one is to use average or whole Star figures. This can smooth the reality of the results – combining the 10 areas of life may lead to the presumption of a higher score. E.g. service users who are ‘high starters’, or scoring high on the majority of outcome areas (i.e. 9 or 10), may skew the results of the ready-made reports. Removing these parents from each scale may provide more accurate reports. The data also does not show if an initial Star was deleted (due to retrospective reporting from the parents) or the extent of the keyworker influence on the reported scores.

7.6 Analysing change in the Family Star Plus

Change was analysed in the Family Star Plus by assessing the percentage of parents whose scores improved, stayed the same, or decreased, from initial score to final score, in line with guidance on using the Stars’ data provided by Triangle. Table 5 reports these proportions and the number of cases that these are based upon. A total of 1010 cases were available for this analysis. Key workers and parents only tended to use some of the domains in their assessments and gave initial scores of 10 to all other domains. The number of cases reported in the table below therefore represents the total number of cases when those with initial scores of 10 have been removed. As the table indicates, for cases where a domain was scored 9 or less at the initial test, the majority of parents had perceived an improvement by final score in all domains, with the exception of three domains: physical health, home and money and progress to work. In each of these domains the majority of participant scores stayed the same. The largest proportion of cases where scores increased was in the domains of meeting emotional needs and boundaries and behaviour.

Table 5: Proportions of score changes by domain

Domain (n. of cases)	Decreased (%)	Stayed the same (%)	Increased (%)
Physical health (313)	2.6	55.9	41.5
Your well-being (736)	3.5	25.1	71.4
Meeting emotional needs (738)	2.7	18.8	78.5
Keeping your children safe (359)	0.8	45.7	53.5
Social networks (514)	1.4	35.0	63.6
Education and learning (606)	2.8	33.2	64.0
Boundaries and behaviour (858)	2.6	16.4	81.0
Family routine (633)	2.5	28.6	68.9
Home and money (323)	3.1	48.0	48.9
Progress to work (156)	4.5	57.1	38.4

These data are encouraging, indicating the broad range of improvements that parents perceived by their final measurement. The three domains where the majority of scores stayed the same are perhaps not surprising given the focus of EISS and the intervention toolkit it uses, which does not focus on physical health, financial needs or employment. However, it needs to be remembered that these figures represent the parents’ perceptions of whether they, or their child, had improved, rather than being based on more objective ratings of the child’s behaviour. They are thus susceptible to bias.

Moreover, without a control group, we are unable to conclude that improvements in the other seven domains were directly a result of the intervention rather than due to other factors.

7.7 Analysing change in the My Star

As with the Family Star Plus, change was analysed in the My Star by assessing the percentage of participants (in this case children and young adults) whose scores improved, stayed the same, or decreased, from initial score to final score, in line with guidance on using the Stars' data provided by Triangle. The table below reports these proportions and the number of cases that these are based upon. A total of 270 cases were available for this analysis- this lower number of cases reflects the fact that My Star was used much less often than the Family Star Plus.

In line with how the Family Star Plus was used in the service, key workers and participants only tended to use some of the domains in their assessments and gave initial scores of 5 to all other domains. The number of cases reported in the table below represents the total number of cases when those with initial scores of 5 have been removed.

As Table 6 shows, for cases where a domain was scored 4 or less at the initial test, 6 of the 8 domains showed an increase in scores by the final test for the majority of participants. More than 8 in 10 participants reported an increase of at least one point in the domain of feelings and behaviour, a domain focused on by over 86% of available participants. Similarly, confidence and esteem improved by at least one point for almost three quarters of participants and was a domain focused on by 62% of participants. The two areas where the majority of participants showed no improvement were physical health and where you live, but a very small minority of participants focused on these domains during the intervention.

Table 6: Proportions of score changes by domain

Domain (n. of cases)	Decreased (%)	Stayed the same (%)	Increased (%)
Physical Health (65)	1.5	56.9	41.6
Where you live (41)	0.0	61.0	39.0
Being safe (51)	2.0	35.3	62.8
Relationships (77)	1.3	29.9	68.9
Feelings and behaviour (234)	1.3	12.8	85.9
Friends (89)	2.2	28.1	69.6
Confidence and esteem (169)	0.0	26.0	74.0
Education and learning (111)	0.9	43.2	55.8

As with the Family Star Plus, these data are promising, particularly for the two areas of most focus when working with children and young people; feelings and behaviour and confidence and esteem. Unlike the Family Star Plus, these ratings are not parental perceptions of child's behaviour but rated by the child or young person themselves; however they still represent a subjective rating. And, as with the Family Star Plus, the lack of a control group means we are unable to conclude that improvements were directly a result of the intervention rather than due to other factors.

7.8 Reliability and Validity of the Family Star Plus as a Measurement Tool

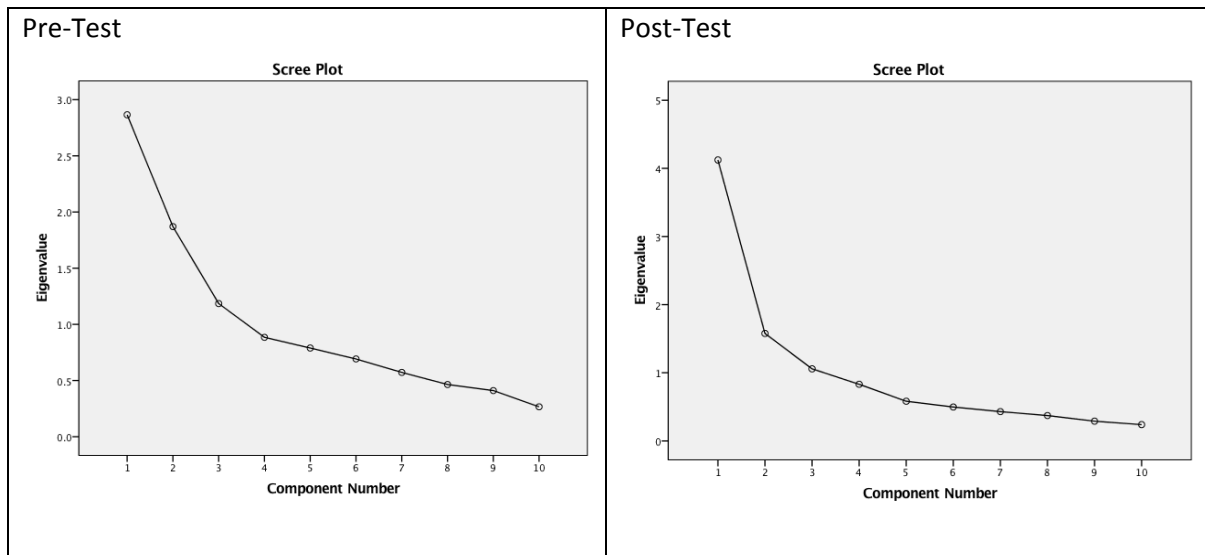
The advice provided by Triangle (Triangle consulting, 2016) makes clear that the Outcomes Star™ has been designed as a diagnostic tool, not an objective measurement tool. Indeed Triangle note that the individual scores should not be treated as numeric values because we cannot assume that the distance between each value is the same (i.e. an improvement from 2 to 3 may not necessarily reflect the same level of change as an improvement from 7 to 8). Rather, the Outcomes Star™ is meant simply to help key workers and parents make a subjective assessment of where they believe their child is, in each domain, and then to reflect upon this subsequently in relation to whether they believe there has been an improvement or not. It is for this reason, and the fact that the scores are not numeric values, that the table above summarises the data in the form of percentage changes rather than attempting to calculate mean scores and mean changes in scores for each domain.

Moreover, Triangle are also clear in their guidance that the scores given are subjective and specific to each child and that they should not be compared across children. In particular, it cannot be assumed that children who have been given the same rating by their respective parents and key workers are equivalent in terms of having the same levels of need and/or being in the same position. As such, Triangle also advise that these scores should not be considered to be ordinal in nature (i.e. that the ratings provide an objective and comparable assessment of the position of each child). With this in mind, whilst some have used the Outcomes Star™ to generate mean scores across domains for each child and then to use these to calculate mean scores and mean changes in scores for whole samples of children, this is an inappropriate use of the Outcomes Star™.

However, because there is an increasing use of the Outcomes Star™ as a measurement tool, it is worth considering its psychometric properties as a 10-item scale. In terms of its internal reliability, Cronbach's Alpha for the pre-test (0.69, based on 78 cases) and post-test (0.83 based on 70 cases) suggest that the Outcomes Star™ was sufficiently reliable. This, in turn, indicates that the scores given for the 10 items are fairly well correlated; providing some justification for assuming that they tend to measure the same underlying condition and hence can be combined to generate a mean score.

To explore this further, a principal components analysis (PCA) was conducted to test the construct validity of the Outcomes Star™. For the Outcomes Star™ to have good construct validity, it should be the case that all 10 items do, indeed, tap into the same underlying condition or construct; in other words, that the 10 items represent a uni-dimensional scale. However, the PCA conducted on both the pre-test scores and the post-test scores suggest that there are actually three notable underpinning constructs that the 10 items are variously tapping into. This is illustrated in the two scree plots shown in Figure 2 where, in both cases, there are three discernible constructs (or components) that have eigenvalues greater than one and also that are distinguishable from the rest.

Figure 2. Scree Plots for Principal Components Analyses Conducted on the 10 Items of the Outcomes Star™ at Pre-Test and Post-Test



To explore these three components further, Tables 7 and 8 below show how each of the individual scores on the Outcomes Star™ correlates with the three components. As can be seen, and in relation to the pre-test scores (Table 7), if we focus on those components with correlations of 0.6 or above (highlighted in bold), it can be seen that the domains of ‘boundaries and behaviour’ and ‘family routine’ are most strongly associated with the first component. This would appear to suggest that this domain may represent the parents’ ability to establish routine, structure and discipline. The second component seems to be correlated most closely with the domains of ‘physical health’, ‘your well-being’ and ‘social networks’. As such, it appears that this second component may represent the parents’ ability to manage their own and their child’s well-being and connectedness. Finally, the third component correlates most strongly with the domains of ‘meeting emotional needs’ ‘home and money’ and ‘progress to work’. As such it seems to describe the parents’ perception of their ability to provide a stable emotional, financial and home environment for their children.

*Table 7. Loading of Domains onto the three Components (Pre-test Scores)**

Domain	Component 1	Component 2	Component 3
Physical health- Parents' rating of their attention to their child's physical health	0.114	0.694	0.080
Your well-being- Parents' rating of their own well-being	0.034	0.839	-0.033
Meeting emotional needs – Parents' rating of the emotional support they gave their child	0.168	0.279	-0.668
Keeping your children safe – Parents' rating of their ability to keep their child safe	0.594	0.081	-0.001
Social networks –Parents' rating of their level of social connection	0.206	0.680	0.144
Education and learning – Parents' rating of their child's progress in education and learning	0.561	0.221	-0.261
Boundaries and behaviour – Parents' rating of their ability to manage their child's behaviour	0.878	-0.021	-0.111
Family routine – Parents' rating of the consistency and quality of their family routine	0.792	0.159	0.285
Home and money – Parents' rating of the stability and quality of their home and finances	-0.105	0.447	0.683
Progress to work – Parents' rating of their progress out of unemployment	0.230	0.348	0.689

*Varimax orthogonal rotation

A similar picture emerges when analysing the post-test scores, as shown in Table 8, where the domains of 'education and learning', 'boundaries and behaviour, and 'family routine' correlate most strongly with the first component, suggesting again that this component may describe parents' perception of their ability to establish and maintain routine, structure and discipline. The second component is correlated most closely with the domains of 'physical health and 'your well-being', indicating that, as before it could represent parents rating of their ability to manage their own, and their child's physical and mental well-being. Finally, the third component is correlated most closely with the domains of home and money, and progress to work. This component may represent parents' perception of their ability to provide a stable financial and home environment for their family.

*Table 8. Loading of Domains onto the three Components (Post-test Scores)**

Domain	Component 1	Component 2	Component 3
Physical health- Parents' rating of their attention to their child's physical health	0.176	0.840	0.138
Your well-being- Parents' rating of their own well-being	0.127	0.791	0.383
Meeting emotional needs – Parents' rating of the emotional support they gave their child	0.530	0.584	-0.170
Keeping your children safe – Parents' rating of their ability to keep their child safe	0.594	-0.061	0.378
Social networks –Parents' rating of their level of social connection	0.485	0.352	0.460
Education and learning – Parents' rating of their child's progress in education and learning	0.642	0.390	-0.025
Boundaries and behaviour – Parents' rating of their ability to manage their child's behaviour	0.858	0.187	-0.034
Family routine – Parents' rating of the consistency and quality of their family routine	0.815	0.178	0.227
Home and money – Parents' rating of the stability and quality of their home and finances	0.084	0.072	0.847
Progress to work – Parents' rating of their progress out of unemployment	0.044	0.170	0.805

*Varimax orthogonal rotation.

Overall, therefore, and taking the two PCA analyses above, a broadly consistent picture emerges in the sense that the 10 Outcomes Star™ domains tend to tap into three underlying constructs.

7.9 The reliability and validity of the My Star as a measurement tool

Psychometric analyses were conducted on the My Star with the same caveats as provided above for the Family Star Plus, on the basis of Triangle's advice not to use the Stars as an objective measurement tool but as a diagnostic one, and again noting that calculating mean scores is not advised as the data is not ordinal or scale.

Chronbach's Alpha could not be conducted on the My Star scales, because computing scales for first and final scores, after removing values of 5 at pre- test, resulted in sample sizes that were too low (7 and 5 respectively) for this test. The low sample size also made a principle components analysis (PCA) too unstable for accurate interpretation. Finally, the concurrent validity and responsiveness to change could not be tested due to the lack of matched data sets.

7.10 Reliability and validity of the Outcomes Stars: A Summary

The Family Star Plus and My Star would appear to work well as subjective diagnostic tools; enabling the key worker and participant to reflect upon, identify and provide some level of assessment of their current position with regard to various domains. Moreover, and if restricted to use with the individual family, they also provide a helpful tool in assisting the key worker and participant to determine whether they feel that progress has been made over time.

It is important to note, however, that the Outcomes Stars were never intended to be objective measurement tools. For the reasons set out above, and acknowledged explicitly by Triangle, the designers, the ratings agreed by the key worker and participants should not be treated as numerical values and thus it is inappropriate to perform statistical analyses of these in relation to calculating means and levels of change over time. Moreover, the ratings given are subjective and specific to each child and thus are not comparable across children. As such, it is not appropriate to calculate mean scores for samples of children or, similarly, to attempt to calculate mean changes over time. Rather, the appropriate way to report the findings, in line with the original guidance provided by Triangle, is simply to report the proportions of children that are deemed to have improved over time.

Whilst the Outcomes Stars should not, therefore, be used as an objective measurement tool, especially when seeking to measure the effects of an intervention, there appears to be an increasing tendency to do this. While this was not possible for the My Star data, the psychometric properties of the Family Star Plus, if used as a 10-item scale, have been explored in this chapter. As noted, whilst it would appear to have sufficient internal reliability there are questions concerning its construct validity. Further research is also required to assess its concurrent validity.

There is also reason to believe that the concurrent validity may well be limited given that whilst the Outcomes Stars data tend to show improvements, these findings are not reflected when using the various battery of objective measures that have been used in this study. This, in turn, provides further suggestive evidence of the subjective nature of the Outcomes Stars and their increased risk of bias. Whilst the main objective measures used in this study require respondents to independently rate a range of behaviours at each time point, the Outcomes Star™ by its nature encourages a more simplistic and subjective assessment of whether there has been an improvement or not. If it is believed that there has been an improvement then the key worker and parent are encouraged simply to give a higher score compared to the previous score given. This approach to rating behaviour is known to lead to exaggerated estimates of likely effects.

8. DISCUSSION AND RECOMMENDATIONS

This chapter will discuss the evaluation's findings in relation to the EISS model and the implications of these for future iterations of the service. This chapter is structured around the logic model presented on page 3, which outlines how EISS should in principle operate to achieve its aims. The discussion is structured around five questions:

1. What does our data suggest works in the EISS model?
2. What does our data suggest does not work or requires improvement?
3. Why have significant improvements in outcome measures not been found?
4. What are the implications of the evaluation's findings?
5. Which aspects of the EISS model need to be refined in future delivery of the service?

From this, we suggest some recommendations to be considered for the further rollout of EISS.

8.1 Limitations of the evaluation

We first note some limitations of the evaluation methodology as this limits the strength of the conclusions we can make about the lack of significant changes in our main effects analysis. As previously mentioned, a randomised controlled trial (RCT) would have been the preferred design for this evaluation, allowing for random assignment of participants to control or intervention groups. This was not possible as the services had been established prior to the evaluation and were operating in a way that meant an RCT design was unfeasible. There was also a resistance to using a matched control group design as described in our methodology section. The waiting-list control design used in the evaluation was the next best option, but is less robust than a full RCT design.

Secondly, the sample size was lower than the target set at the outset, for a number of reasons including recruitment procedure (parents were asked to participate by EISS managers), the fact that one EISS did not take part in the evaluation, lack of contact from the parent when the research team contacted them or that some parents were unable to be contacted for post-test measures. This limits the generalisability of the main effects analysis and limited the statistical power of sub group analyses we were able to conduct.

As a result of these limitations, the current evaluation has not found any robust evidence that the intervention is, or is not effective. As we noted in the main effects chapter, while the effect sizes reported are small, they are all consistent with what we would expect if the intervention was effective; they are negative for the negative outcomes (e.g. indicating reductions in difficult or challenging behaviour) and positive for the positive outcomes (e.g. improvements in empathy, communication and so on). This provides some indication that the intervention may be having a small but notable impact. This would need to be confirmed through a more robust research design, a larger sample size, and longer term follow up to assess whether changes in outcomes are maintain over time, compared to controls.

Despite these limitations of the main effects analysis, we have provided detailed insights into the processes and mechanisms that may have impacted the success of the pilot EISS model, as well as

psychometric analysis of the Family Star Plus tool. These findings will be discussed in depth in the following sections.

8.2 What worked well and why

EISS is an innovative pilot project with a unique toolkit and is a service which emphasises collaborative and joined-up working, which has been lacking in approaches to family support in Northern Ireland to date. It was extremely well received by both children and families and the family support staff were enthusiastic in advocating for the service. There is a lack of strong evidence in the literature on best practice to guide a novel approach such as EISS, but there are key learning points from our evaluation on what worked well.

The personable approach of the workers enabled parents to be honest about situations and issues - and possibly more receptive to change. The parents knew that someone was there for them and this allowed for a relationship to be built and confidence in parenting to grow. Showing parents an alternative course of action, or presenting matters from the child's view, again something that parents referred to as 'simple', often effected positive change in family relationships. Being so flexible and family-led increased the chances of positive outcomes. Families felt respected, listened to and valued as there was no one size fits all approach.

EISS delivered a non-stigmatising and non-judgemental voluntary service and while the changes that occurred may be small to start with, this positive experience could start the process of 'patient activation'. Patient Activation is now an important area of focus for the NHS and refers to the idea of delivering knowledge, skills and confidence to individuals that will help them in future to manage their own health and wellbeing. It is relevant in the EISS model because the service has targeted families who are often difficult to engage with and because we know that the stigmatising nature of social services is a deterrent to some families seeking the help they need. In addition, parental engagement is of vital importance to the success of any family support intervention. We found that families reported a very positive experience with EISS, largely because they felt it was their choice to engage and that the service was non-judgemental, and this in turn could 'activate' families to increase their engagement with their own health and wellbeing, and their use of lower tier health and social care services in the future, preventing escalation to higher tier need of the Hardiker Model.

The length of the service was judged by key workers and families as being just about right. This was important in terms of being long enough to allow a family to feel supported, but not long enough for a dependency to form. The possibility to extend the service to 16 weeks for some families may be beneficial when used with the appropriate families. The home-based nature of EISS was very appreciated and, while intensive for the key worker to travel from home to home, allowed for a different type of relationship to be built which increases the chances of positive outcomes. Responding quickly to referrals and making first contact within ten days was also a unique attribute of EISS that worked well. Families were seen in a more timely manner rather than having to wait for long periods while their issues escalated.

The qualitative research highlights considerable positive feedback on the view of EISS representing a key and important service offer to families with children with emerging vulnerabilities and on the sense of the model being 'fit for purpose' with Family Support Hubs. The EISS currently represents a

coherent family support option across the region and the opportunity to build on that model through future commissioning of family support contracts exists. This potentially can achieve the long-term transformative effect linked to the aim of the Early Intervention Transformation Programme. EISS requires a longer term research and evaluation focus to test the early intervention outcomes of the service model.

8.3 The EISS target population

EISS targeted a broad population of families with children aged 0-18, within Tier 2 of the Hardiker Model, who have needs that require additional support and who are not currently involved with social services. This broad target population is an important area of unmet need in Northern Ireland and represents a set of families at risk of escalation to higher need and the requirement for social services involvement, and the associated stigma and health and social care costs that this involves. We found a strong consensus in the process evaluation amongst practitioners and stakeholders that EISS provided a service for which there was a large demand, particularly in rural or socially deprived areas where there was not the same level of resources as in urban areas.

Inevitably, the broad target population meant that EISS received a wide range of referrals from families requiring support for a vast set of issues which created a challenging environment for the staff involved. We found evidence that delivering a service to such a broad population led to stress for key workers, on top of the pressures relating to the targets and caseload numbers they were required to meet. The wide remit of EISS led to referrals being made for families who were at the top end of the Tier two threshold and possibly were not the target of EISS as they were past being appropriate for an 'early' intervention. Catering to such a wide range of needs requires a broad set of skills, training and therapeutic approaches. This challenge was however mitigated by a strong supportive team environment allowing for issues to be talked through and advised upon where needed. The broad nature of the target population also contrasts with the more narrowly defined target populations of other early interventions described in the literature review. Most early intervention studies addressing identified needs as they arise do not use a population defined by the Hardiker model but focus more narrowly on a specific condition such as conduct disorders.

8.4 The wider context and resources associated with EISS

As outlined in the logic model, the EISS approach is contingent on a joined-up way of working between Family Support Hubs (FSHs) and other statutory and non-statutory organisations. It also requires resource building, training for staff and available resources to step-up or step-down families. We found that EISS had a very good working relationship with the FSHs and they were very appreciative of the gap in services that EISS were able to fill. The FSHs could see the benefits in EISS being available in additional areas/wards. EISS was also perceived well by local community and voluntary organisations, despite some initial resistance when EISS was being set-up. This is encouraging and goes some way to show the value of the work that EISS did with families and the need for the types of support EISS offered. It also suggests that EISS is helping to deliver on the initiatives referred to in the literature (Families Matter (DHSSPSNI, 2009); Healthy Child, Healthy future (DHSSPSNI, 2010);

Learning to Learn: A Framework for Early Years Education and Learning (DENI, 2012) Transforming Your Care: Vision to Action (HSCB, 2013), and; Making Life Better (DHSSPSNI, 2014) which promoted a collaborative working approach.

Training was also deemed to be of high quality by the family support workers, and if supplementary training was needed, then this could be provided. As well as the statutory training, staff in each service could ask to attend training days or have in-house training provided, potentially training that other key workers in different services would not avail of. Staff also brought their own skill-sets to their job roles. These additional skillsets could however have also impacted on the fidelity of implementation of the service, as the type of support provided to the family depended on the person assigned the case and their prior training and experience.

The programme designers provided training to enable practitioners to work with the families on an individual basis and use whatever approach fitted best. Motivational Interviewing, Solution Focused Brief Intervention Therapy and the Solihul Approach are all used together. It is therefore difficult for practitioners to be definitive as to what they are using as the approach varies based on the needs of the family. The programme designers have made clear that the interventions within the EISS were never meant to be the same and that one of the strengths of the EISS is that it is an individual service tailored to the needs of the families focusing on their strengths and needs. However, the implication of this is that it may be difficult for managers to ensure that the service is being delivered consistently. This issue is aggravated by the fact that staff require an extensive set of skills in order to support the wide ranging and complex needs being presented by families, as well as an ability to be flexible in delivering the service.

EISS worked within a difficult context of service gaps in various trusts. The lack of alternative services for people outside of EISS target population was a key factor in the wide range of referrals that EISS had to process, and this was also an issue for step-down and referral at the end of the intervention. Part of the EISS model involves supporting meaningful and sustainable change for families by ensuring they have access to adequate step-down services, this is currently undermined in an environment where such services are unavailable.

8.5 The referral process

In the majority of cases, the referral process worked well and appropriate families were referred to EISS in a timely manner. However, inappropriate referrals were received: the broad nature of EISS as well as the lack of alternative services, both of which are described above, are likely to be contributing factors to the issue of inappropriate referrals raised in our process evaluation data. For instance, families who had children with ADHD or Autism and required specialist support were being referred, in the absence of an appropriate service, to EISS staff who did not have these specialisms, (as it was not the remit of EISS to provide this type of support). Key workers were not trained in these developmental areas and reported difficulties managing parent's expectations regarding the support they would receive. Parents may have expected something different to what EISS key workers could provide, in terms of resources, practice, knowledge and advice. Training was subsequently provided for key workers when this issue was raised but this arguably stretched an already under-pressure service to beyond its capacity, as well as beyond its original remit.

Our review of the literature illustrates that comparable early intervention approaches, which have reported statistically significant improvements in similar outcomes for families compared to control groups, have tended to target much narrower populations. Moreover, these interventions have ensured that participants meet this carefully defined target group using tight screening procedures such as scoring a standard deviation above the mean on the SDQ. This process means that a well-demarcated need is included in the intervention and allows for the implementation of an intervention approach that was designed to meet it, delivered by staff with the appropriate training for this group.

The timing of referral is another important consideration here, in regards to how early the service is intervening to meet a need. There is some evidence to show that appropriate timing of referral can lead to better outcomes and a principle of early intervention is that the earlier a need is met the more successfully it can be treated. It is evident from our main effects analysis that most families had been experiencing problems for over a year. This may be considered too late for an 'early' intervention, however this is difficult to tell because a clinical measure of severity of issues was not captured at the beginning of the intervention. A larger sample size would allow a comparison of outcomes according to length of need; it may be that EISS is more effective for families whose need is addressed within a certain time period i.e. three to six months after a problem emerges.

8.6 Implementation of the 12 week intervention

EISS has a flexible approach and is led by the needs of the family, and this placing of control into the hands of the family was a factor that both practitioners and parents in our process evaluation interviews appreciated and which was felt to have increased families' engagement in the process. We found evidence that in practice, however, this meant that interventions were 'dipped' in and out of, rather than an approach where once a need was identified with a family, an intervention was chosen and delivered with fidelity for the full-recommended period. Interventions such as Incredible Years emphasise the importance of adhering to the manual to provide the best chance of improving outcomes (Eames et al, 2008).

The implication of this lack of fidelity is that each individual family is not guaranteed to be provided the same service and level of quality and this could impact on their outcomes. While all EISS staff were trained in the interventions offered, our process evaluation suggests that they were not delivered to the parents in a consistent way, rather they were used in an 'eclectic' way. Comparison is therefore difficult due to variability in management practices, use of resources, the different skillsets of the staff and the fact that different services were delivering EISS across Northern Ireland.

EISS is not unique here, as 'programme drift' is a common issue during the implementation of interventions in the community, and in the context of EISS the variety of services delivering the intervention was always likely to heighten this issue. A number of processes are commonly used in interventions to ensure high fidelity to manualised intervention, and these can be followed even in a service which is family needs led, providing that once a need is identified in collaboration with the family, the intervention is then provided according to the manual. These processes include the use of manuals, supervision, peer shadowing, regular refresher training, and tools to rate the degree of adherence to manuals – these tools are most valid and reliable if scored by an independent evaluator (Mowbray et al, 2003; Eames et al, 2008). In the case of Incredible Years, ongoing monitoring is emphasised beyond initial training and manualisation as well as administrative and organisational

support in terms of providing adequate time and resources for practitioners to learn the new intervention and deliver it consistently (Webster-Stratton, 2004).

It is also important to recognise the potential tension between delivering a service which is family- and needs-led, flexible and person-centred, with one which is manualised to ensure high-fidelity. Practitioners did not respond favourably to the prospect of manualisation in the service as they did not think sticking closely a manual would work in the situations they were used to dealing with. However, in practice, manuals such as those provided by Incredible Years do include room for family-led approaches, particularly in identifying the area to focus on during the intervention and in emphasising family participation in the process. The evidence-based interventions used in EISS also stress the importance of following the intervention processes through from start to end once an approach has been chosen based on the needs and context of the family.

Our process evaluation data suggests that the Outcomes Star™ was implemented inconsistently during the intervention. The timing of its use varied across each service; we found that it was mainly administered in week two, but at times it was week four or five before a baseline star was completed. This is likely to impact on not only the baseline score a family is recorded as having, but also on how goal planning is conducted. At least 20 different members of staff administered the Outcomes Star™ which may have created variability in how it was delivered, in the absence of inter-rater reliability evidence for the Stars. The Outcomes Star™ emphasises collaboration between parent and keyworker and, we found that pre-test scores were sometimes amended retrospectively if parents felt they were too high or low in the first instance).

The programme designers did have guidelines within the operational guidance as to how the Outcomes Star™ was to be used within the EISS and it was agreed the Star did not need to be input onto the database until the end of the intervention. However, this has large implications for the validity of the measure i.e. is it accurately capturing how a parent is feeling at that time point.

8.7 The outcomes that EISS aimed to address

The evaluation was expected to produce significantly better scores at post-test for intervention families in each of the areas EISS aimed to improve:

- 1) Improved family functioning
- 2) Reduced parental stress
- 3) Improved parenting self-efficacy
- 4) Improved child conduct and emotions

The evaluation found improvement in two out of twenty-two outcomes: TOPSE empathy and TOPSE play. This indicated that intervention parents were reporting feeling more confident in these areas of playing with their children or responding to their feelings. It may be that differences were noticed in these outcomes because EISS provides parents with the tools to make changes, small changes, that are feasible in the short-term (or within 12 weeks). For example, the process evaluation described how parents were introduced to new and different ways of interacting with their children, through promoting routine charts or rewards charts or playing games. Several parents realised that asking

questions when playing games could elicit a more honest response from their child and/or open lines of communication.

A number of reasons may have contributed to the lack of significant findings on other outcomes including the SDQ, Family Functioning Questionnaire and Parental Stress Index:

a) Population

The broad population and set of needs addressed by the service, as discussed above, may be a factor in the lack of consistent improvement in outcomes, and it may be that EISS is most effective for a sub-population such as families whose children had a specific type of difficulty, were under a particular threshold of severity, or who had experienced the need for a specific time period. A larger dataset would have allowed more detailed sub-group analysis to address these questions, or in the case of severity, the use of a clinical screening measure would allow this analysis.

b) Length of follow up

The length of follow up for post-test may have been an issue as the majority of families were moving in the right direction according to post-test scores by 12-week follow up. A three, six or one year follow up may have found significant differences from the control group on these measures, in line with our studies reported in the literature chapter which did not find significant differences at the end of the evaluation but found them during further follow ups.

The support staff and parents were both accepting of the fact that instantaneous change would not occur over the 12 weeks, and indeed, expectations were managed from the start. Most parents gladly accepted the support offered but acknowledged that significant leaps would not be made in this time period and that this was something to work on long-term. Qualitative reports from both staff and parents suggest that changes were visible in.

c) Fidelity

The lack of fidelity in implementation that our process evaluation data has suggested may have meant that families had received an intervention that was too variable to result in significant improvements consistently across our dataset, compared to the control group. As noted above, fidelity is emphasised in much of the early intervention literature, and within specific approaches such as Incredible Years. The potential for tension between providing a flexible service and fidelity to manualised interventions is one that can be solved within a toolkit approach such as EISS; flexibility is provided during the initial stage where the Stars are used to identify needs and the focus of the evaluation, once an appropriate intervention type is chosen from the toolkit, fidelity to manualisation helps ensure a consistent and evidence-based service is offered.

d) Triangulation with the Outcomes Star™

In contrast to our measures, the Outcomes Star™ suggested small improvements for families across all the domains they sought to address. However, strong conclusions cannot be drawn from this data as no control group was available for the Outcomes Star™ data, meaning that we cannot assess whether the improvements were significantly different from a similar population not receiving the intervention, or whether they would have improved by similar amounts over time without receiving the service.

Our psychometric analysis provides some encouraging evidence that as an outcome measure the Family Star (Plus) has adequate reliability and validity, however this evidence base is small in comparison with the evidence base for the reliability and validity of measures such as the SDQ, TOPSE, and the PSI. In addition, we found that the Family Star (Plus) may have three underlying constructs, undermining the use of an overall mean score for this measure. Triangle advise not to treat this data as ordinal or scale and thus mean scores are not recommended. Thus, we cannot advocate the Outcomes Star™ as an adequate substitute for established outcomes measures as a means of robustly measuring changes for families who received the service.

8.8 Recommendations

1. EISS target population

The current model addresses a broad population and we have described a number of potential issues with this including its impact on outcomes and on staff. Staff reported facing a wide range of family situations, with issues they were not familiar with, inappropriate referrals, increasingly complex cases and having to provide support for several members of the same family. Future iterations of the model could take these challenges into account and could consider whether the broad population, covering 0-18 year olds across a wide range of social, emotional and behavioural issues at Tier 2 level of need, is a feasible target in light of the challenges discussed in this evaluation. If this refinement is accepted it was naturally change the objective and ethos of EISS.

2. Context and resources

EISS meets an important need and is well-viewed, but its success requires a whole system approach where other appropriate resources are available locally for staff to refer families too. In the context of financial restraints this is a difficult issue to address but one that should be acknowledged within further iterations of the EISS model.

3. Referrals

The model should consider using tighter screening processes to ensure that a well-defined Tier 2 population is being considered, both in terms of level of need and length of difficulties.

Increasing the clarity of who and what EISS is for may help reduce the burden of inappropriate referrals and the impact that this has on each service's workload, as well as help manage the expectations of families being referred and the stakeholders who refer them.

4. Implementation

There is a vast literature focusing on intervention fidelity and the benefits of achieving maximum fidelity on a specific program. If EISS was designed to be delivered to achieve maximum fidelity on individual components, fidelity to the programme would be important, as evidenced in the literature. However, EISS was never intended to be a manualised programme. It was designed using an overall approach and used Outcomes Star™ to identify appropriate supports. There is some tentative evidence to suggest that this type of approach could work, however it is difficult to generalise this too far, and is beyond the scope of the evaluation. Any effects of the EISS may be due to its emphasis focusing on need and introducing a range of supports.

On this basis, EISS can be evaluated in terms of fidelity, for example, did all the key workers use the Outcomes Star™ properly, or, were the correct timescales maintained. It is recommended that future iterations of EISS consider whether higher fidelity in service provision can be achieved across delivery of interventions, timescales and use of the Outcomes Star, while retaining the ethos of the service and with an acknowledgement that this can be difficult to achieve in community, multi-agency contexts.

5. Future research

A longer follow up for measuring changes in those receiving the intervention, such as at three, six, 12, or 18 months, would provide important insights into the impact of the service. Outcomes may be found to be significantly improved compared to control with longer term follow up and future use of services could be assessed to show whether or not EISS prevented escalation of need. In turn, an analysis of cost-benefit could be conducted using data on future higher tier service use.

A full RCT methodology with a larger study sample is recommended as the most robust approach to evaluation the impact of EISS, with a control group receiving treatment as normal and follow-up after the same time period as the intervention group. A larger sample size would allow a thorough breakdown of sub groups to assess for whom the intervention does and does not work.

REFERENCES

- Abel, G. A., Barclay, M. E. and Payne, R. A. (2016) Adjusted indices of multiple deprivation to enable comparisons within and between constituent countries of the UK including an illustration using mortality rates. *BMJ Open*, 6(11), e012750.
- Asmussen, K, Feinstein, L. Martin, J. and Chowdry, H. (2016) *Foundations for Life: What Works to Support Parent Child Interaction in the Early Years*. The Early Intervention Foundation: London.
- Bagner, D. M., Coxe, S., Hungerford, G. M., Garcia, D., Barroso, N. E., Hernandez, J. and Rosa-Olivares, J. (2016) Behavioral parent training in infancy: a window of opportunity for high-risk families. *Journal of Abnormal Child Psychology*, 44(5), 901-912.
- Boydell, L. (2015) *A Review of Effectiveness of Interagency Collaboration at the Early Intervention Stage*. Dublin: Centre for Effective Services.
- Bywater, T., Hutchings, J., Daley, D., Whitaker, C., Yeo, S. T., Jones, K., Eames, C. and Tudor- Edwards, R. (2009) Long-term effectiveness of a parenting intervention for children at risk of developing conduct disorder. *The British Journal of Psychiatry*, 195(4), 318-324.
- Braet, C., Meerschaert, T., Merlevede, E., Bosmans, G., Van Leeuwen, K., & De Mey, W. (2009) Prevention of antisocial behaviour: evaluation of an early intervention programme. *European Journal of Developmental Psychology*, 6(2), 223-240.
- Centre for Excellence and Outcomes. (2010) *Grasping the Nettle: Early Intervention for Children, Families and Communities*. London: C4EO.
- CWDC. (2011) *Providing Intense Support for Families with Multiple and Complex Needs*. Leeds: Children's Workforce Development Council.
- CYPSP. (2017) *Family Support Hubs Report Card – Annual Report Card 2016/2017*. Retrieved from: http://www.cypsp.hscni.net/wp-content/uploads/2017/10/Annual_Family_Support_Hub_Report_Card_2016_17.pdf [Retrieved on 02/01/18]
- Department of Education. (2013) *Learning to Learn: A Framework for Early Years Education and Learning*. Belfast: Department of Education Northern Ireland.
- Devaney, J., McAndrew, F. and Rodgers, T. (2010) 'Our Children and Young People – Our Shared Responsibility: The Reform Implementation Process in Child Protection Services in Northern Ireland' in A. Stafford., S. Vincent. and N, Parton. (eds.) *Child Protection Reform Across the United Kingdom*. Edinburgh: Dunedin Academic Press.
- DHSSPSNI. (2009) *Families Matter - Supporting Families in Northern Ireland Regional Family and Parenting Strategy*. Belfast: Department of Health.
- DHSSPSNI. (2010) *Healthy Child, Healthy Future*. Belfast: Department of Health.
- DHSSPSNI. (2014) *Making Life Better: A Whole System Strategic Framework for Public Health*. Belfast: Department of Health.
- DCLG. (2012) *Working with Troubled Families*. London: Department for Communities and Local Government.

- Dickens, G, Weleminsky, J, Onifade, Y and Sugarman, P. (2012) Recovery star: validating user recovery. *The Psychiatrist*, 36, 45-50.
- Domian, E. W., Baggett, K. M., Carta, J. J., Mitchell, S. and Larson, E. (2010) Factors influencing mothers' abilities to engage in a comprehensive parenting intervention program. *Public Health Nursing (Boston, Mass.)*, 27(5), 399-407.
- Doyle, O., Delaney, L., O'Farrelly, C., Fitzpatrick, N. and Daly, M. (2017) Can Early Intervention Improve Maternal Well-Being? Evidence from a Randomized Controlled Trial. *PloS one*, 12(1), e0169829.
- Draper, K., Siegel, C., White, J., Solis, C. M. and Mishna, F. (2009) Preschoolers, parents, and teachers (PPT): a preventive intervention with an at risk population. *International Journal of Group Psychotherapy*, 59(2), 221-242.
- Eames, C., Daley, D., Hutchings, J., Hughes, J. C., Jones, K., Martin, P. and Bywater, T. (2008) The leader observation tool: a process skills treatment fidelity measure for the Incredible Years parenting programme. *Child: Care, Health and Development*, 34(3), 391-400.
- Eames, C., Daley, D., Hutchings, J., Whitaker, C. J., Jones, K., Hughes, J. C. and Bywater, T. (2009). Treatment fidelity as a predictor of behaviour change in parents attending group-based parent training. *Child: Care, Health and Development*, 35(5), 603-612.
- Fitzsimons, P and Teager, W. (2018) *The cost of late intervention in Northern Ireland*. Early Intervention Foundation: London.
- Friedman, M. (2005) *Trying Hard is Not Good Enough*. Trafford Publishing; UK.
- Hardiker, P., Exton, K. and Barker, M. (1991) *Policies and Practices in Preventive Child Care*. Avebury: Gower.
- Health and Social Care Board. (2013) *Transforming Your Care, Vision to Action, A Post Consultation Report*. Belfast: Health and Social Care Board.
- IPC. (2012) *Early Intervention and Prevention with Children and Families: Getting the Most from Team around Family Systems*. Oxford Brooks University: Institute of Public Care.
- Jones, K., Daley, D., Hutchings, J., Bywater, T. and Eames, C. (2007) Efficacy of the Incredible Years Basic parent training programme as an early intervention for children with conduct problems and ADHD. *Child: Care, Health and Development*, 33(6), 749-756.
- Kayrouz, N., Milne, S. L. and McDonald, J. L. (2017) Social disadvantage and developmental diagnosis in pre-schoolers. *Journal of Paediatrics and Child Health*, 53(6), 563-568.
- Killaspy, H, White, S and King, M. (2012) Psychometric properties of the Mental Health Recovery Star, *British Journal of Psychiatry*, 201, 65-70.
- Komoto, K., Hirose, T., Omori, T., Takeo, N., Okamitsu, M., Okobu, N. and Okowa, H. (2015) Effect of Early Intervention to Promote Mother-Infant Interaction and Maternal Sensitivity in Japan: A Parenting Support Program based on Infant Mental Health. *Journal of Medical and Dental Sciences* 62(4), 77-89.
- Lau, E. X., Rapee, R. M., & Coplan, R. J. (2017) Combining child social skills training with a parent early intervention program for inhibited preschool children. *Journal of Anxiety Disorders*, 51, 32-38

Leijten, P., Raaijmakers, M. A., Orobio de Castro, B., van den Ban, E. and Matthys, W. (2017) Effectiveness of the incredible years parenting program for families with socioeconomically disadvantaged and ethnic minority backgrounds. *Journal of Clinical Child and Adolescent Psychology*, 46(1), 59-73.

Lindsay, G., Strand, S. and Davis, H. (2011) A comparison of the effectiveness of three parenting programmes in improving parenting skills, parent mental well-being and children's behaviour when implemented on a large scale in community settings in 18 English local authorities: the parenting early intervention pathfinder (PEIP). *BMC Public Health*, 11(1), 962.

Lloyd C, Williams PL, Machingura T, Tse S. (2015) A focus on recovery: using the Mental Health Recovery Star as an outcome measure. *Advances in Mental Health*, 16, 27-23.

Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011) A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice. *Child development*, 82(1), 193-208.

Maggi, S., Irwin, L. J., Siddiqi, A. and Hertzman, C. (2010) The social determinants of early child development: an overview. *Journal of Paediatrics and Child Health*, 46(11), 627-635.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S. and the Commission on Social Determinants of Health. (2008) Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, 372(9650), 1661-1669.

McGilloway, S., NiMhaille, G., Bywater, T., Leckey, Y., Kelly, P., Furlong, M., Comiskey, C., O'Neill, D. and Donnelly, M. (2014) Reducing child conduct disorder behaviour and improving parent mental health in disadvantaged families: a 12-month follow-up and cost analysis of a parenting intervention. *European Child and Adolescent Psychiatry*, 23(9), 783-794.

McKeith, J. (2011) The development of the Outcomes Star: a participatory approach to assessment and outcome measurement. *Housing, Care and Support*, 14(3), 98-106.

McKeith, J. (2014) Assessing the reliability of the Outcomes Star in research and practice. *Housing, Care and Support*, 17(4), 188-197.

Mieloo C, Raat H, van Oort F, Bevaart F, Vogel I, Donker M. (2012) Validity and reliability of the strengths and difficulties questionnaire in 5–6 Year Olds: Differences by gender or by parental education? *PLoS ONE* 7(5): e36805. <https://doi.org/10.1371/journal.pone.0036805>

Montgomery, A., Devlin, N., Doherty, F. and Foley, F. (2016) *EITP Workstream 2: An Audit of Evidence-Based Parenting Programmes in Northern Ireland*. Belfast: Centre for Effective Services.

Mowbray, C., Holter, M. C., Teague, G. B. and Bybee, D. (2003) Fidelity criteria: development, measurement, and validation. *The American Journal of Evaluation*, 24(3), 315-340.

Murphy, E. (2015) *Comparison of in Work Poverty in NI, GB and ROI*. Northern Ireland Assembly Research and Information Service Briefing Paper 46/15, NIAR 537- 2014.

NCB. (2014) *Informing the Development of a Regional Early Intervention Service for Northern Ireland Report 2: Towards a Shortlist of Potential Approaches and Interventions for the Delivery of EIS*. Belfast: National Children's Bureau.

NISRA. (2017) *2016 Mid-year Population Estimates for Northern Ireland*. NISRA Statistical Bulletin: <https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/MYE16-Bulletin.pdf>

- NISRA. (2017) *Northern Ireland Multiple Deprivation Measure 2017*. Belfast: NISRA
- OFMDFM. (2006) *Our Children—Our Pledge. A Ten-Year Strategy for Children and Young People in Northern Ireland 2006-2016*. Belfast: Office of the First Minister and Deputy First Minister.
- Placentino, A., Lucchi, F., Scarsato, G., Fazzari, G. and Rex, G. (2017) The mental health recovery star: validation study and features of the Italian version. *Riv Psichiatr*, 52(6):247-254.
- Pontoppidan, M., Klest, S. K., & Sandoy, T. M. (2016) The Incredible Years Parents and Babies Program: A Pilot Randomized Controlled Trial. *PLoS one*, 11(12), e0167592.
- Ramey, C. T. and Ramey, S. L. (1998) Early intervention and early experience. *American Psychologist*, 53(2), 109.
- RCPCH. (2014) Securing better health for Northern Ireland's infants, children and young people: A vision for 2016. Retrieved from http://www.rcpch.ac.uk/system/files/protected/news/RCPCH%20NI%20vision_Embargoed%2019Nov.pdf [Accessed on: 21/11/17].
- RCPCH. (2017) *State of Child Health: 2017 Recommendations for Northern Ireland*. Belfast: RCPCH.
- Saías, T., Lerner, E., Greacen, T., Emer, A., Guédeney, A., Dugravier, R. and Guédeney, N. (2016) Parent-provider relationship in home visiting interventions. *Children and Youth Services Review*, 69, 106-115.
- Seabra-Santos, M. J., Gaspar, M. F., Azevedo, A. F., Homem, T. C., Guerra, J., Martins, V. and Moura-Ramos, M. (2016) Incredible Years parent training: What changes, for whom, how, for how long? *Journal of Applied Developmental Psychology*, 44, 93-104.
- Sourander, A., McGrath, P. J., Ristkari, T., Cunningham, C., Huttunen, J., Lingley-Pottie, P. and Fossum, S. (2016) Internet-assisted parent training intervention for disruptive behavior in 4-year-old children: a randomized clinical trial. *JAMA Psychiatry*, 73(4), 378-387.
- Sneddon, H. (2014) *EITP Workstream 2: Parenting Programmes Review*. Belfast: Centre for Effective Services.
- Stallman, H. M. and Ralph, A. (2007) Reducing risk factors for adolescent behavioural and emotional problems: A pilot randomised controlled trial of a self-administered parenting intervention. *Australian e-Journal for the Advancement of Mental Health*, 6(2), 125-137.
- Stone, LL., Otten, R., Engels, RC., Vermulst, AA. and Janssens JM. (2010) Psychometric properties of the parent and teacher versions of the strengths and difficulties questionnaire for 4- to 12-year-olds: a review. *Clinical Child and Family Psychology Review*. 13(3):254–74.
- Triangle Consulting. (2016) *The Outcomes Star: Guidelines for Researchers*. Triangle Consulting.
- Valentine, K. and Katz, I. (2015) How early is early intervention and who should get it? Contested meanings in determining thresholds for intervention. *Children and Youth Services Review*, 55, 121-127.
- Walsh, C. and Doherty, F. (2016) *Belfast Intensive Family Support Service – IFSS: A Blended Model of Delivery*. Belfast: Northern Ireland: The Extern Organisation.
- Waugh, I. and Rodgers, H. (2017) Children's social care statistics for Northern Ireland 2016/17. Belfast: Community Information Branch, Information and Analysis Directorate, Department of Health, Social Services and Public Safety. Retrieved from <https://www.health-ni.gov.uk/sites/default/files/publications/health/child-social-care-16-17.pdf> [Accessed on: 21/11/17].

Webster-Stratton, C. (2004) *Quality Training, Supervision, Ongoing Monitoring, and Agency Support: Key Ingredients to Implementing the Incredible Years programs with Fidelity*. Washington: University of Washington.

Webster-Stratton, C., Jamila Reid, M. and Stoolmiller, M. (2008) Preventing conduct problems and improving school readiness: evaluation of the incredible years teacher and child training programs in high-risk schools. *Journal of Child Psychology and Psychiatry*, 49(5), 471-488.

Wiggins, T. L., Sofronoff, K. and Sanders, M. R. (2009) Pathways triple P-positive parenting program: effects on parent-child relationships and child behavior problems. *Family Process*, 48(4), 517-530.

Wolfe, I., Macfarlane, A., Donkin, A., Marmot, M., & Viner, R. (2014). *Why Children Die: Death in Infants, Children, and Young People in the UK—Part A*. Royal College of Paediatrics and Child Health. Retrieved from <https://www.rcpch.ac.uk/sites/default/files/page/Death%20in%20infants,%20children%20and%20young%20people%20in%20the%20UK.pdf> [Accessed on: 21/11/17]

York Consulting. (2013) *Family Star Evaluation: Summary Report*. Family Action: London.

APPENDICES

Appendix 1: EISS Questionnaire

EISS

Evaluation of the Early Intervention Support Service 2017

HOW TO FILL IN THIS SURVEY:

There are four parts to this survey. Please answer all the questions. Depending on your answers some questions can be skipped; instructions alongside the questions will guide you through this.

This questionnaire should take about 20-30 minutes to complete. Please take your time and make sure you have selected or circled a response to every question.

Remember:

1. There are no right or wrong answers – this is not a test;
2. Please answer all questions as honestly as you can;
3. No other individual apart from me will see your answers.

Unique ID Code _____

EISS Area _____

Date _____

i. Are you...? Please put an X in one box.

Male

Female

i. What age are you?

ii. What age is your child? (that you are in contact with the service for)

iii. What is your child's date of birth?

Part A

This part has 24 statements describing situations that sometimes happen in families. For each statement there are four possible answers.

Please select which response (“**Always**”, “**Often**”, “**Sometimes**” or “**Never**”) best describes what usually happens in/with your family.

In our family we collaborate together to find the best way to solve our problems	A	O	S	N
I can talk with my family about the things that make me unhappy	A	O	S	N
I have little time for my own hobbies and interests because I spend most of my free time caring for my family	A	O	S	N
When a decision has been made about what to do about a family problem we all lend a hand to carry it out	A	O	S	N
If I am unhappy with the behaviour of someone in my family I tell them and suggest some ways to get along better	A	O	S	N
Despite many problems that I have to deal with in my family, I always find a little time for myself	A	O	S	N
When we have dealt with a problem in the family, we usually discuss what we have done and whether it helped	A	O	S	N
If someone in the family does something kind for me I thank them	A	O	S	N
It is important that everyone in the family has time for themselves	A	O	S	N
I find it helpful to tell what I think about a problem in my family because they seem to take account of my opinion	A	O	S	N

When someone in the family does, or says, something I like I tell them openly that I am pleased	A	O	S	N
I succeed in doing what I promise myself to do	A	O	S	N
If we have a family problem we all meet together to discuss it	A	O	S	N
When I am angry with someone in the family I tend not to speak to him/her	A	O	S	N
I manage to do some things alone without my family	A	O	S	N
When we have a problem in our family we plan together what to do about it	A	O	S	N
If one of my family members does something kind for me, I almost never thank them as I do not think it is necessary	A	O	S	N
I have to deal with so many difficulties in my family that I have almost completely given up my interests	A	O	S	N
When we have a problem in our family I can suggest solutions without worrying about being criticised	A	O	S	N
When I need my family to help me with something, I ask kindly and do not make demands or orders	A	O	S	N
I meet friends outside my family	A	O	S	N
In our home it is difficult to decide how to solve a problem because we never agree about anything	A	O	S	N
When I say to family member that they have done something I do not approve of, I tell them in a polite way so not to offend them personally	A	O	S	N
I can easily find interests that keep me busy	A	O	S	N

Part B

Part B contains 30 questions relating behaviours your child may display. For each question please circle your answer:

- Circle **NT** (Not True) if the statement does not sound like your child
- Circle **ST** (Somewhat True) if this behaviour is displayed sometimes
- Circle **CT** (Certainly True) if this statement sounds like your child

Please answer all questions based on your child's behaviour over the last six months.

Considerate of other people's feelings	NT	ST	CT
Restless, overactive, cannot stay still for long	NT	ST	CT
Often complains of headaches, stomach aches or sickness	NT	ST	CT
Shares readily with other children (treats, toys, pencils)	NT	ST	CT
Often has temper tantrums or hot tempers	NT	ST	CT
Rather solitary, tend to play alone	NT	ST	CT
Generally obedient, usually does what adults request	NT	ST	CT
Many worries, often seems worried	NT	ST	CT
Helpful if someone is hurt, upset or feeling ill	NT	ST	CT
Constantly fidgeting or squirming	NT	ST	CT
Has a least one good friend	NT	ST	CT
Often fights with other children or bullies them	NT	ST	CT
Often unhappy, down-hearted or tearful	NT	ST	CT
Generally like by other children	NT	ST	CT
Easily distracted, concentration wanders	NT	ST	CT
Nervous or clingy in new situations, easily loses confidence	NT	ST	CT

Kind to younger children	NT	ST	CT
Often argumentative with adults	NT	ST	CT
Picked on or bullied by other children	NT	ST	CT
Often volunteers to help others (parents, teachers, other children)	NT	ST	CT
Thinks out before acting	NT	ST	CT
Steals from home, school or elsewhere	NT	ST	CT
Gets on better with adults than with other children	NT	ST	CT
Many fears, easily scared	NT	ST	CT
Sees tasks through to the end, good attention span	NT	ST	CT

1. Overall, do you think your child has difficulties in one or more of the following areas:
1) emotions, 2) concentration, 3) behaviour or 4) being able to get on with people?

- No
 Yes - Minor difficulties
 Yes – Definite difficulties
 Yes – Severe difficulties

If you answered 'No' please go to Part C on page 5. If you have answered 'Yes', please answer the following questions about these difficulties.

2. How long have these difficulties been present?

- Less than a month
 1-5 months
 6-12 months
 Over a year

3. Do the difficulties upset or distress your child?

- Not at all
 Only a little
 Quite a lot
 A great deal

4. Do the difficulties interfere with your child's everyday life in the following areas?

HOME LIFE Not at all Only a little Quite a lot A great deal

FRIENDSHIPS Not at all Only a little Quite a lot A great deal

CLASSROOM LEARNING Not at all Only a little Quite a lot A great deal

LEISURE ACTIVITIES Not at all Only a little Quite a lot A great deal

5. Do the difficulties put a burden on you or the family as a whole?

Not at all Only a little Quite a lot A great deal

Part C

Part C contains 48 statements relating to parenting. When answering please think about the child you are most concerned about.

Please answer on a scale of 0 – 10 of how much you agree with a statement

0 = totally disagree, 5 = neither agree nor disagree, 10 = completely agree

1. I am able to show affection towards my child.
2. I can recognise when my child is happy or sad.
3. I am confident my child can come to me if they're unhappy.
4. When my child is sad I understand why.
5. I have a good relationship with my child.
6. I find it hard to cuddle my child.
7. I am able to have fun with my child.
8. I am able to enjoy each stage of my child's development.
9. I am able to have nice days with my child.
10. I can plan activities that my child will enjoy.
11. Playing with my child comes easily to me.
12. I am able to help my child reach their full potential.
13. I am able to explain things patiently to my child.
14. I can get my child to listen to me.

15. I am able to comfort my child.
16. I am able to listen to my child.
17. I am able to put myself in my child's shoes.
18. I understand my child's needs.
19. As a parent I feel I am in control.
20. My child will respond to the boundaries I put in place.
21. I can get my child to behave well without a battle.
22. I can remain calm when facing difficulties.
23. I can't stop my child behaving badly.
24. I am able to stay calm when my child is behaving badly.
25. Setting limits and boundaries is easy for me.
26. I am able to stick to the rules I set for my child.
27. I am able to reason with my child.
28. I can find ways to avoid conflict.
29. I am consistent in the way I use discipline.
30. I am able to discipline my child without feeling guilty.
31. It is difficult to cope with other people's expectations of me as a parent.
32. I am not able to assert myself when other people tell

me what to do with my child.
33. Listening to other people's advice makes it hard for me to decide what to do.
34. I can say 'no' to other people if I don't agree with them.
35. I can ignore pressure from other people to do things their way.
36. I do not feel a need to compare myself to other parents.
37. I know I am a good enough parent.
38. I manage the pressures of parenting as well as other parents do.
39. I am not doing that well as a parent.
40. As a parent I can take most things in my stride.
41. I can be strong for my child.
42. My child feels safe around me.
43. I am able to recognise developmental changes in my child.
44. I can share ideas with other parents.
45. I am able to learn and use new ways of dealing with my child.
46. I am able to make the changes needed to improve my child's behaviour.
47. I can overcome most problems with a bit of advice.
48. Knowing that other people have similar difficulties with their children makes it easier for me.

Part D

Part D contain 36 statements. Please think of the child you are most concerned about when answering these questions. Please read each statement carefully and circle the response closest to how you feel (see below). Your first reaction to each question should be your answer.

- Circle the **SA** if you **'Strongly Agree'** with the statement
- Circle the **A** if you **'Agree'** with the statement
- Circle the **NS** if you are **'Not Sure'**
- Circle the **D** if you **'Disagree'** with the statement
- Circle the **SD** if you **'Strongly Disagree'** with the statement

I often have the feeling I cannot handle things very well.	SA	A	NS	D	SD
I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
Since having this child I am unable to do new and different things.	SA	A	NS	D	SD
Since having a child I feel I am almost never able to do the things I like to do.	SA	A	NS	D	SD
I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
There are quite a few things that bother me about my life.	SA	A	NS	D	SD
Having a child has caused more problems that I expected in my relationship with my spouse (male/female friend).	SA	A	NS	D	SD
I feel alone and without friends.	SA	A	NS	D	SD
When I go to a party I usually expect not to enjoy myself.	SA	A	NS	D	SD
I am not as interested in people as I used to be.	SA	A	NS	D	SD
I don't enjoy things as I used to.	SA	A	NS	D	SD
My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
Most times I feel my child does not like me and does not want to be close to me.	SA	A	NS	D	SD
My child smiles at me much less that I expected.	SA	A	NS	D	SD

When I do things for my child I get the feeling my efforts are not appreciated very much.	SA	A	NS	D	SD
When playing, my child often doesn't giggle or laugh.	SA	A	NS	D	SD
My child doesn't seem to learn as quickly as other children.	SA	A	NS	D	SD
My child doesn't seem to smile as much as other children.	SA	A	NS	D	SD
My child is not able to do as much as I expected.	SA	A	NS	D	SD
It takes a long time and is very hard for my child to get used to new things.	SA	A	NS	D	SD

For question 22, please circle a response from choices 1-5.

1. I feel that I am:
 1. A very good parent
 2. A better than average parent
 3. An average parent
 4. A person who has some trouble being a parent
 5. Not very good at being a parent

I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD
My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
My child generally wakes up in a bad mood.	SA	A	NS	D	SD
I feel my child is very moody and easily upset.	SA	A	NS	D	SD
My child does a few things which bother me a great deal.	SA	A	NS	D	SD
My child reacts very strongly when something happens that they don't like.	SA	A	NS	D	SD
My child gets easily upset over the smallest thing.	SA	A	NS	D	SD
My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD

For question 32, please circle a response from choices 1-5.

2. I have found that getting my child to do something, or stop doing something, is:
 1. Much harder than I had expected
 2. Somewhat harder than I expected
 3. About as hard as I expected
 4. Somewhat easier than I expected
 5. Much easier than I expected

For question 33 think carefully and count the number of things that your child does that bother you (doesn't listen, is overactive, fights, etc)

3. What would the number be between?
 1. 1-3
 2. 4-5
 3. 6-7
 4. 8-9
 5. 10+

There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
My child turned out to be more of a problem than I expected.	SA	A	NS	D	SD
My child makes more demands on me than most children.	SA	A	NS	D	SD

END OF QUESTIONNAIRE

Thank you for taking part!

Appendix 2: The EISS referral form

Early Intervention Support Service Request for Support Form

The Early Intervention Support Service works with families to enable them to make changes through a combination of practical support, parenting programmes, and brief, solution-focused approaches. The service also offers Family Group Conferencing, which is a process led by family members. The aim is to support families to find their own solutions to problems, particularly where there are concerns about children's welfare.

Request for support cannot be considered unless signed consent from family is provided					
About the Parent(s)/Carer(s)					
Name of Person(s) with Parental Responsibility:					
Date of birth:					
Relationship to Child/ren:					
Address:			GP name:		
Postcode:			Address:		
Telephone number:			Telephone number:		
About the child/ren					
First Name	Surname	DOB	Gender	School	Ethnicity
Current address (if different from above):					
Address:					
Postcode:					
Family composition (please tick as appropriate)					
One parent family		Two parent family			
Home both parents		Home one parent + partner		Home one parent	
Kinship/carer(s)		Guardian		Unknown	
				Other Please specify below	
Additional Information					
Is an interpreter required for child(ren)?		Y / N	Which language?		
Is an interpreter required for parent/carer(s)?		Y / N	Which language?		
Does either carer or child/ren have a disability or other additional support needs? Please give details					

22

Additional Referrals				
Has a referral been made to any other service or agency including the Family Support Hub for any member(s) of this family? If yes please provide details of additional referrals made in box below			Yes	No
Has the child/young person previously worked with the social work service? If yes please provide details below			Yes	No
Services currently supporting the family e.g. HV/CAMHS/Surestart/Homestart				
Service	Contact name	Agency Address	Number	email
Reason for request for support (please tick as appropriate)				
Adult mental health issues		Bereavement support (child)		
Bereavement support (adult)		Child care support		
Counselling services for children/young people		Counselling services for carer(s)/parent(s)		
Counselling families		Disability support		
Domestic violence		Drug/alcohol related harm child/young person		
Drug/alcohol related harm/abuse parent(s)/carer(s)		Education & employment support		
Emotional & behavioural support pre-school		Emotional & behavioural support primary school		
Emotional & behavioural support post primary school		Emotional & behavioural support carer(s)		
Family breakdown		Financial support		
Housing		Homelessness		
Offending (at risk) behaviour		Parenting programme/support		
Practical support		School attendance		
Self-harming child/young person		Self-care support		
Young carer		Youth activities/support		
Other reason please state:				

Brief description of current concerns/issues prompting request for support
Outline of any work that has been undertaken with the family/individual including any successes
Family/individual views: What is the family/individual hoping to achieve from the request for support?
Strengths already existing in the family to help them make the changes?
Concerns and or Risks: Are you aware of any concerns and or risks that the EISS should be aware of before contacting or visiting the family/individual e.g communication difficulties, history of aggression to professionals, domestic abuse etc

24

About the person completing this form	
Name:	Telephone number:
Agency (if applicable):	Email:
Address:	
Signature:	Date:

Consent			
Parent(s)/Carer(s)			
Are the parent(s)/carer(s) of all the children/young people aware the request for support is being made?	Yes	No	
Do they consent to the request for support being made?	Yes	No	
If NO please explain			
Child(ren)/Young Person(s)			
Are all the children/young people in the family aware the request for support is being made?	Yes	No	
Do they consent to the request for support being made?	Yes	No	
If NO Please explain			

Consent to request for support		
Family MUST consent to request for support, the request cannot be considered unless signed consent is provided. Sign below to confirm agreement with this request.		
Name	Signature	Date
Name of young person (if 12years or over):		
Name of young person (if 12years or over):		
Name of young person (if 12years or over):		
Name of person with parental responsibility:		
Name of referrer:		

25

Implied consent to request for support	
For requests for support made by telephone, the worker who spoke with the family and completed the referral may sign it on behalf of the family. This person must be clear with the family that they have agreed to give consent for support and for the above information to be retained. Families must sign the consent form at their earliest convenience and before the support service begins. Sign below to confirm agreement with this request.	
Signature of person completing form:	
Date:	

Consent to share information	
I, (INSERT NAME), agree for the information within this form to be shared with (INSERT ORGANISATION/BODY/INDIVIDUAL)	
Signature of person with parental responsibility:	
Date:	

By signing this request for support form, families give us consent to talk to the person who completed the form and the family support hub coordinator. We will make contact with the family within ten working days of receiving the request and will seek consent to talk to other professionals who are involved with the child / young person as appropriate.

Please return this form to: Contact details of individual organisation

Additional information recorded from contact with referrer

Appendix 3: Description of Interventions

EISS family support workers were trained in three family support interventions that were selected as being most appropriate for workers after a review of evidence. These are discussed in further detail below. All information is adapted from NCB (2014) Report 2: Towards a Shortlist of Potential Approaches and Interventions for the delivery of EISS.

1. Solution-Focused Brief Intervention Therapy

Solution-Focused Brief Intervention Therapy (SBFT) is an approach which seeks to effect change using a goal directed and collaborative approach before potential problems escalate. SBFT is a brief intervention with a wide span of application: from weekly 30 minutes sessions, a 20 minute brief counselling session or a five minute session providing information on a specific topic. SBFT is flexible and fits well with the needs of Tier 2 families whilst also fitting with other interventions. It is very much an empathetic approach and can be used across all age groups and with a range of problems. It can be delivered with individuals or in a group setting, and there is extensive evidence for its effectiveness. A wide range of robust evaluations report positive impacts in family and child outcomes.

2. Motivation Interviewing

Motivational Interviewing (MI) is a technique that is used by the family support worker to help improve or modify an issue using a client-centred approach. The three main concepts of 'Collaboration', 'Evocation', and 'Autonomy' allow the support worker to enhance motivation to change and to work on a plan for change. Sessions are delivered using an OARS acronym: Open-ended questions; Affirmations; Reflective Listening and Summaries. It is delivered directly to the family member and can be delivered as a single session but can be more effective if there are several sessions.

3. The Solihull Approach

The Solihull Approach aims to help parents address challenging behaviour in children. It is based on a model which incorporates child development, behaviour and psychotherapy concepts. It can be used with children up to 18, largely on a one-to-one basis with the parent although it can be delivered in groups. There is limited evidence to conclude long-term impacts but plenty of non-experimental evaluations have show an increase in short-term outcomes.

Appendix 4 : Description of Parenting Programmes and Family Group Conferencing

Additional programmes identified by EISS which were thought to be able to effect change and empower families were available to some families. These are discussed below.

1. *Incredible Years*

The Incredible Years Programme is an international evidence-based programme designed to promote social and emotional competence and to reduce or prevent anti-social behaviour in children aged 0-12. It consists of three programmes: for parents, teachers and children. It has been evaluated by multiple RCTs and has proven results for children with Oppositional Defiance Disorder/Conduct Disorder and for improved outcomes for children who live in a high-risk populations. There are encouraging outcomes from the parent programmes as well as the teacher/classroom programmes.

EISS parents attended a 12 week course focusing on school-age children (6-12). A trained facilitator used group discussion, idea sharing and problem-solving techniques to address the issues parents were facing, particularly: teaching children to take responsibility, rules and consequences and parent involvement in setting up routines e.g. homework.

1. *Strengthening Families*

The Strengthening Families Programme is an internationally recognised evidence-based programme designed to help improve parenting skills, reduce problem behaviours and improve emotional and social skills. It is a group based programme lasting for 14 weeks. Parents and young people both work together to improve relationships, bonding and communication and are directed by two trained facilitators. Families come together one night a week where a meal is provided and childcare and/or transport arranged. It is mainly used for older children between 12-16.

2. *Family Group Conferencing*

Family Group Conferences can help to resolve family difficulties and improve outcomes for vulnerable children by integrating families into the decision making process. The coordinators help the families to make a plan. There are several stages to the process:

1. Referral to the agency;
2. Preparation for the meeting (meeting with all relevant members and discussing issues);
3. The meeting (a private meeting whereby the family can discuss issues and agree on an action plan);
4. Review of the plan

Information on the benefits on Family Group Conferencing is scarce. There is some evidence for short-term impacts and it is a popular tool used mainly for high-risk families to prevent/reduce an escalation of problems.

Appendix 5: The Outcomes Star™ assessment tool

The NCB was commissioned in 2015 to provide a review of evidence on a range of family assessment tools which could be used to measure and assess family need and measuring change of impact of EISS. The Outcomes Star™ was chosen as the most appropriate assessment measure after considering areas such as target population, domains covered, cost, quality and administration.

The Outcomes Star™ measures progress made by families towards a selection of goals including relationships, mental health, work, self-esteem and responsibilities. Initially, the Family Star, My Star or Teen Star is chosen and completed collaboratively with the family. Each Star contains a number of domains which are scored on a ladder scale between 1 – 10, although Teen Star is between 1 – 5. As the intervention was time-limited, two or three areas were chosen to work on with the families. Once the families decided which areas to work on, the domains were scored and plotted on the Star diagram. The remaining domains were assigned the tops score of 5 or 10. The same process allowed at the end of the 12 weeks to measure change.

The Family Star, My Star and Teen Star charts can be found in Appendix 6.

Appendix 6: My Star, Family Star and Teen Star



Star Chart



Licensed to Public Health Agency until 11/03/2018

My Star™

The Outcomes Star for children and young people

Name

First

Review

Retrospective

Date of completion

Completed by

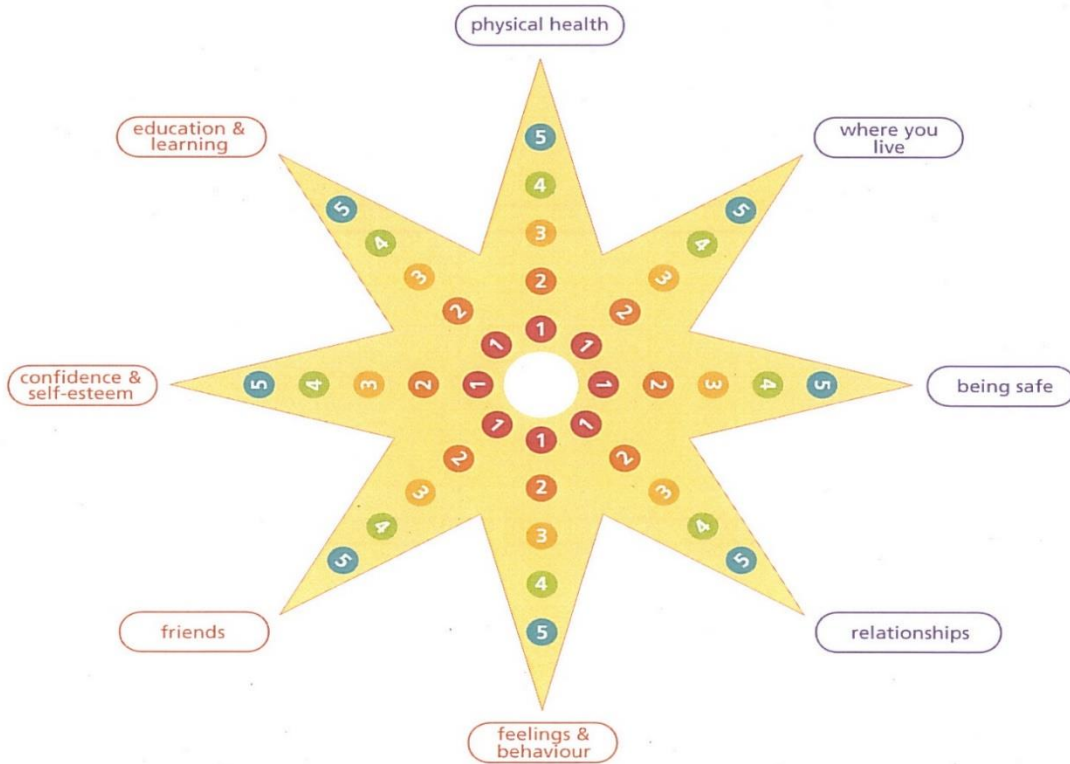
Worker and me

Worker alone

Me

How well other people look after you

How you are managing



Name: I was involved in completing this Star Chart



My Star™ © Triangle Consulting Social Enterprise Ltd | www.outcomesstar.org.uk
The Star Chart must be used with the Scales and workers trained by a licensed Star trainer

Star Notes

1 Physical health

2 Where you live

3 Being safe

4 Relationships

Star Notes

5 Feelings and behaviour

6 Friends

7 Confidence and self-esteem

8 Education and Learning

Action Plan

Priority area and stage/step	Goal	Action	By who?	By when? (date)

Signatures:

Name

Date

Worker

Date





Star Chart



Licensed to Public Health Agency until 11/03/2018

Family Star Plus™

An Outcomes Star for parents

Parent

First

Review

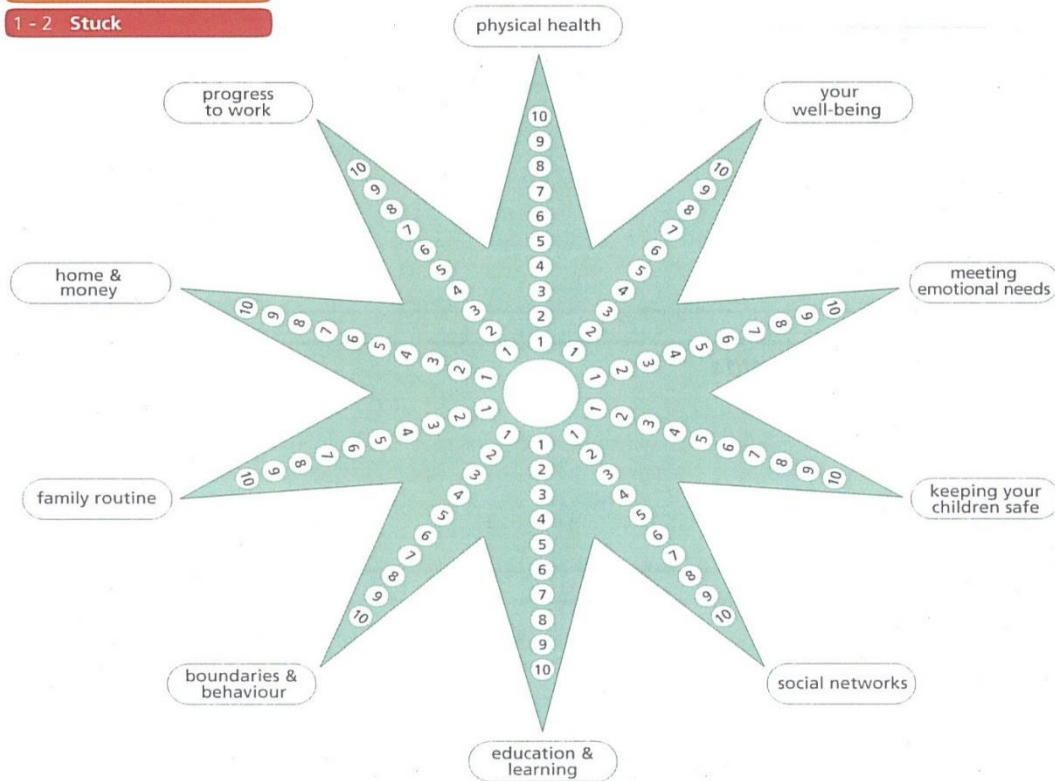
Retrospective

Date of completion

Completed by Professional and parent
Professional
Parent

- 9 - 10 Effective parenting
- 7 - 8 Finding what works
- 5 - 6 Trying
- 3 - 4 Accepting help
- 1 - 2 Stuck

Number of children



Parent: I was involved in completing this Star Chart



Family Star Plus™ © Triangle Consulting Social Enterprise Ltd | www.outcomesstar.org.uk
The Star Chart must be used with the Scales and workers trained by a licensed Star trainer

Star Notes

6 Education and learning

7 Boundaries and behaviour

8 Family routine

9 Home and money

10 Progress to work

Action Plan

Priority area and stage/step	Goal	Action	By who?	By when? (date)

Signatures:

Parent

Date

Professional

Date



Star Notes

1 Physical health

2 Your well-being

3 Meeting emotional needs

4 Keeping your child safe

5 Social networks

Appendix 6: Teen Star



Star Chart



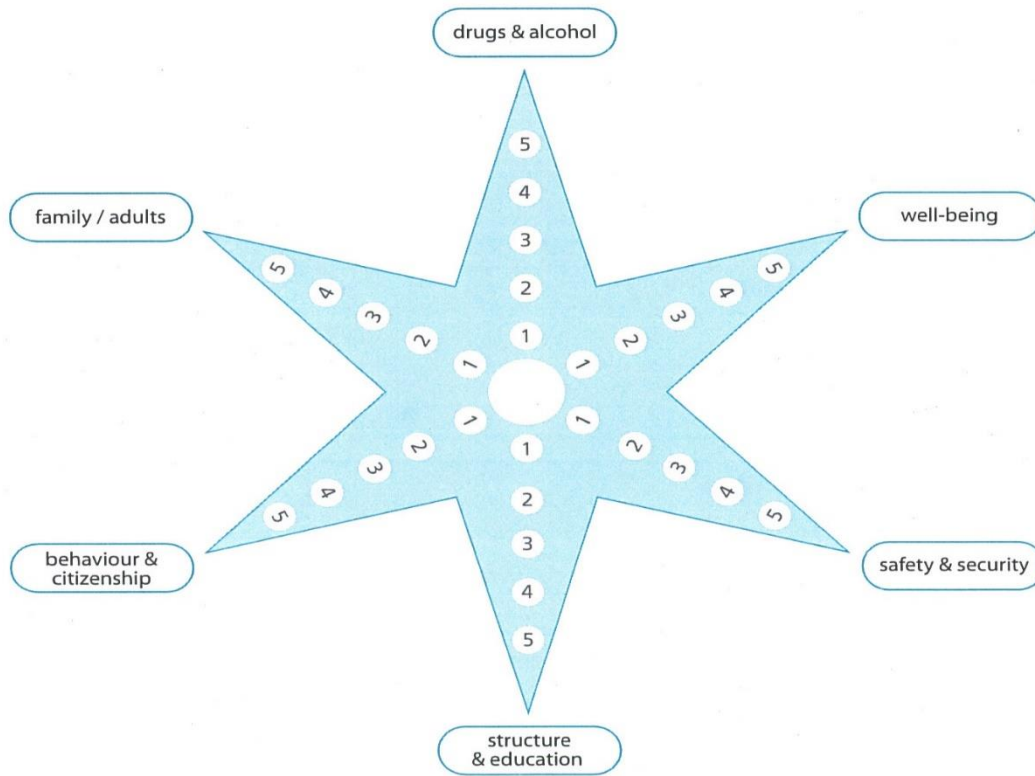
Licensed to Public Health Agency until 11/03/2018

Teen Star™

The Outcomes Star for teenagers

Client First Review Retrospective

Date of completion Completed by Worker and client
 Worker alone
 Client



Client: I was involved in completing this Star Chart



Teen Star™ © Triangle Consulting Social Enterprise Ltd | www.outcomesstar.org.uk
 The Star Chart must be used with the Scales and workers trained by a licensed Star trainer

Star Notes

Drugs and alcohol

Well-being

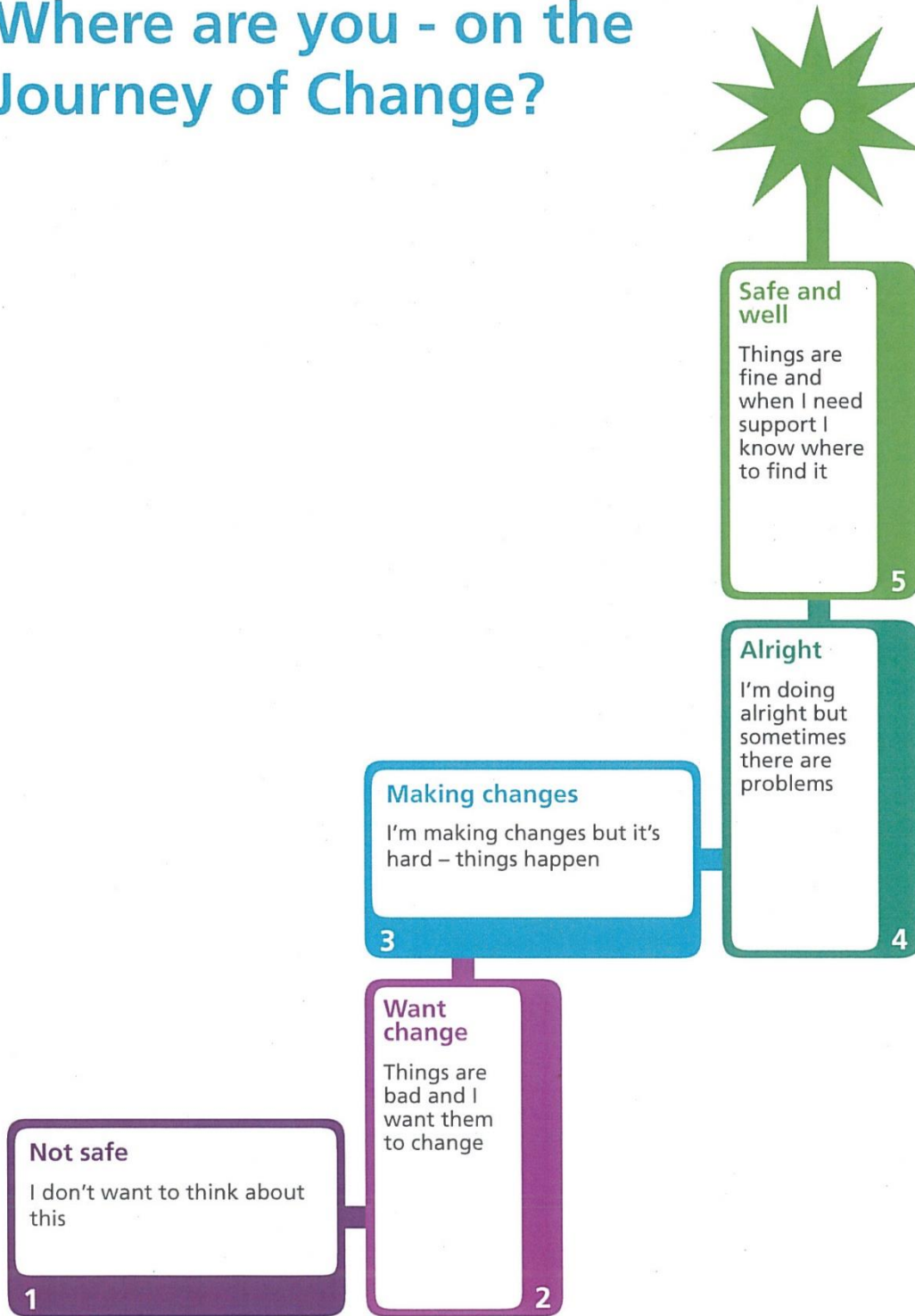
Safety and security

Structure and education

Behaviour and citizenship

Family and other key adults

Where are you - on the Journey of Change?



Action Plan

Priority area and stage/step	Goal	Action	By who?	By when? (date)

Signatures:

Client

Date

Worker

Date

Other agency /advocate

Date

Worker

Date



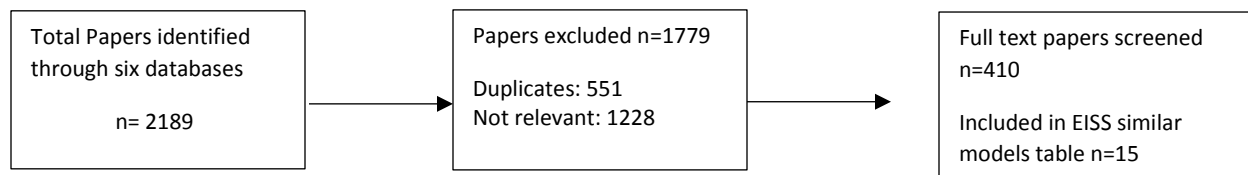
Appendix 7: The Literature Review Search Strategy

A thematic rather than a full systematic review was chosen as the most appropriate methodology for a number of reasons. Firstly, there is a wide variety in how early intervention is defined and put into practice in the literature, according to different conceptual approaches, diagnoses and populations. Secondly, the use of the Hardiker model (Hardiker et al, 1991) to assess need is not common outside Northern Ireland, and so an accurate comparison of the evidence base in the wider literature to the broad Tier 2 population EISS is aimed at was not feasible.

This chapter therefore aims to place the evaluation of EISS within the context of this wider literature, as well as within the policy environment and level of need in Northern Ireland. It will cover how early intervention is defined and how it has been implemented, identify some of the key mechanisms and processes involved in successful early intervention approaches, and look at the evidence for the effectiveness of family based early intervention support over the last decade in addressing conduct, behavioural and emotional issues.

Six databases of peer reviewed research (Embase, Medline, Psychinfo, Child Development and Adolescent studies, Education Resources Information Centre, and the Social Sciences Citation Index) were searched to identify primary research on early intervention research involving families that aimed to address child conduct, emotional, social needs, or parental skills, stress and confidence. Only English language, quantitative research from 2007-2017 with pre-post outcomes data was included for the evidence review of early intervention impact. Papers were matched as possible as possible to Hardiker Tier 2 by applying a set of exclusion criteria on search results. Papers presenting outcomes associated with early intervention approaches for universal populations (equivalent to Hardiker Tier One) were excluded, as were those which recruited participants through social services, secondary mental health care or other routes equivalent to Tier Three and higher.

Papers were also excluded were excluded if they looked at a more targeted population or condition such as fetal alcohol syndrome, preterm infants, cerebral palsy or autism, as the literature on targeted early interventions such as these is vast and often examines condition-specific outcomes. In practice, interventions aimed at child and young people populations identified as having an early or developing risk or need often overlaps with both Tier One and Tier Three of the Hardiker model, therefore a brief discussion of these interventions with some examples is included in the chapter.



In addition to this systematic search for models similar to EISS, a more general search was conducted to review commonly used definitions of early intervention, as well as the Northern Ireland policy and deprivation data.

Search terms for the review were developed on the basis of key EISS documents, discussion within the research team, and with reference to other systematic reviews of early intervention services for young people and families (such as Anderson et al., 2003). To understand the wider context of the service, available statistics in Northern Ireland were reviewed, as well as relevant strategy and policy documents that drove the development of EISS.

Table of thematic search terms

Search terms	Notes
(Child* OR (pre school*) OR youth* OR pupil OR Nurser* OR (early childhood education*) OR (primary education) OR Kindergarten OR Elementary OR (Primary class*) OR (Primary school*) OR (reception class*) OR Post-primary OR (1st year*) OR (First Year*) OR (Junior high) OR (Middle school) OR Infant OR adolescen* OR teenag* OR (secondary school*) OR (grammar school*) OR (Junior infant*))	Child population
(Parent* OR Mother* OR Father* OR Family OR Families)	Parent and family population
(Hardiker OR UNOCINI OR (Understanding the Needs of Children in Northern Ireland) OR (Threshold* of need*) OR (Threshold* ADJ3 Intervention*))	Models of diagnosis
((Social* exclu*) or vulnerab* or (conduct adj5 disorder*) or (behaviour* adj5 problem*) or (Emotional* ADJ5 difficult*) OR (Emotional* ADJ5 problem*) OR (Parent* Adj5 Stress*) OR (Parent* ADJ5 Engage*) OR (Additional need*) OR (Child* ADJ5 Disadvantage*))	Problem areas addressed
((Solution Focus* Brief Therap*) OR (Motivational Interview*) OR Solihull OR (Outcomes Star™))	EISS interventions
(Early Intervention*)	Wider EI search term
((Life start) OR (Sure start) OR (Target* ADJ3 parent* ADJ3 program*) or (home ADJ5 visit*) OR (Key Worker*) OR (Family group conferenc*) OR (Solution Focus* Practice*) OR (Incredible Years) OR (Family Support) OR (Brief Intervention Therap*))	Related intervention approaches, mechanisms, principles
((Famil* ADJ5 relationship*) OR (Parent* ADJ5 Child* ADJ5 Relationship*) OR (parent* ADJ5 engag*) OR (Parent* ADJ5 Self-Efficac*) OR (Parent* ADJ5 confiden*) OR (Parent* ADJ5 skill*) OR (Social* Inclu*) OR (Pro-social* behavio*) OR (Famil* adj5 Well-being*) OR (Famil* ADJ5 Cris*) OR (Parent* adj5 Knowledg*) OR (Parent* ADJ5 Skill*) OR (Parent* ADJ5 stress*))	Intermediary outcomes (from logic model as well as terms related to them)

Appendix 8: The Included Papers

Table 9 : Family Support early intervention evaluations 2007-2017a

Author, Year*	Intervention	Population	Study Design	Key findings
Lau et al 2017	Cool little kids, Social Skills Facilitated play (modified)	N=72 (39 in intervention) Children aged 36-65 months With social inhibition & anxiety, and their parents	RCT with waiting list control; 6 and 12 month follow up.	Intervention group showed significantly lower rates of anxiety disorders compared to waiting list, while mothers reported reduced anxiety and overprotection at 6 and 12 months.
Seabra-Santos et al 2016	Incredible Years Parent training	N=124 (68 in intervention) Children aged 3-6 years, at risk of disruptive behaviour, and their parents.	RCT between group with waiting list control, 12 and 18 month follow up	Intervention group showed significant reduction in behavioural problems and increase in social skills, caregivers improved parenting skills and confidence
Sourander et al 2016	Internet version of Strongest Families telephone-based program	N=464 (232 in intervention) Children aged 4 with high childhood disruptive disorder symptoms and their parents	RCT with 6 and 12 month follow up	Intervention group significantly improved in externalising symptoms compared to control group at 12 month follow up, as well as in secondary measures including parental psychiatric measures.
Bagner et al 2016	Infantbehaviour program	N = 60 (31 in intervention) Infants aged 12-15 with, behavioural problems, and their mothers	RCT with 3 and 6 month follow up	Intervention group displayed more compliance, lower externalising and internalising behaviour problems at 6 months compared to control. Mothers displayed higher proportion of positive and lower proportion of negative behaviours with their infants compared to control. No significant differences for parenting stress.
Komoto et al 2015	Japanese Early Promotion Program (JEPP)	N= 135 (15 in intervention) Infants aged 1-3 months, and mothers deemed requiring additional childcare support	Intervention with control, 12 month follow up (intervention group only)	Intervention group mothers showed reduced parental stress and significantly improved parental-child relationship indicators, including ability to understand infant cues and respond properly, while infants showed enhanced responsiveness, compared to controls.
McGilloway et al 2014	Incredible Years Basic parent programme (IYBP)	N=149 (103 in intervention) Children 32-88 months with behavioural problems and their parents	RCT with waiting list control, 6 and 12 month follow up (12 month - intervention group only)	Improved child behaviour and adjustment compared to baseline in the intervention group, and significant reduction in parental stress, improvement on parental well-being and functioning. All outcomes were sustained at 12 month follow up.

Posthumus et al 2012	Incredible Years Basic and Advance parent programmes	N=114 (72 in intervention) Children aged 4 years and their parents	Case-control intervention with intervention and control group based on geographical area. 24 month follow up	Observed and self-rated parenting skills were significantly improved, while observed child problems were reduced in the intervention group; these improvements were sustained at 24 month follow up
Lindsay et al 2011	Incredible Years, (vs) Triple P, (vs) Strengthening Families Strengthening Communities	N=1121 (240 in Incredible Years, 515 in Triple P, 366 in Strengthening Families) Parents and their children whose behaviour gave them most concern.	Per-protocol comparative analysis of pre-post outcomes in three programmes (no controls)	Significant increases in outcomes in all groups in parenting style, satisfaction, self-efficacy and mental well-being, but Strengthening Families was significantly less effective than the other two programmes in the latter three outcomes. Child behaviour was improved in all three programmes but Strengthening Families had significantly lower reductions in conduct problems than Incredible Years
Lowell et al 2011	Child FIRST Intervention	N=197 (58 in intervention) Children aged 5-36 months, and their mothers, who had behavioural/emotional problems (child) and/or psychosocial risk (parent).	RCT with 12 month follow up (and 36 months for child protective services use).	Intervention group mothers had reduced stress at 6 but not 12-month follow up, reduced psychopathology symptoms at 12 months, and reduced protective service involvement at 3 years post baseline, compared to control. Children had reduced externalising symptoms at 12 months compared to control.
Braet et al 2009	Parent management training (PMT)	N=64 (34 in intervention) parents and their children aged 4-7 years, with behaviour problems.	RCT with waiting list control and 12 month follow up	Intervention group had significantly improved child behaviour, reduced parental stress, improved parental skills and mother-child interactions compared to control
Wiggins et al 2009	Pathways Triple P-Positive Parenting Programme	N=60 (30 in each intervention) Parents and their children aged 4-10 who were concerned about parent-child relationship, and/or child conduct or emotional problems.	RCT with 3 month follow up	Intervention group had significantly improved parenting-child relationships and reduced behaviour problems, sustained at three month follow up
Bywater et al 2009	Incredible Years Basic Programme	N=128 (79 in intervention) parents and their children at risk of conduct disorder	RCT with waiting list control and 18 month follow up	Intervention group had significantly improved child and parent behaviour, parental stress and depression maintained at 18 month follow up. Child contact with social services also reduced at 18 months.

Jones et al 2008	Incredible Years Basic Parenting Training Programme	N=79 (50 in intervention) parents and children who had both conduct problems and early onset ADHD	RCT with waiting list control and 18 month follow up	Intervention group had significant improvements in ADHD symptoms compared to control, which were maintained at 18 months
Hutchings et al 2007	Incredible Years Basic Programme	N=153 (104 in intervention) parents and their children at risk of conduct disorder	RCT with waiting list control, 6 month follow up	Intervention group significantly improved in most measures including parenting stress and depression and child problem behaviours with exception of parental criticism and child deviance, compared to control
Stallman et al 2007	Self-Directed Teen Triple P	N=51 (17 in enhanced intervention group, 18 in standard) Adolescents ages 11-14 and their parents, who had concerns about child behaviour	RCT with waiting list control and 3 month follow up	Parents in enhanced intervention group reported significantly reduced adolescent behavioural problems and over-reactive parenting strategies than standard intervention or waitlist condition, at post-intervention and maintained at 3-month follow up.

Table 10: Family Support early intervention evaluations 2007-2017b

Author, Year	Mode of intervention	Referral pathway and screening	Cost-analysis	Measures
Lau et al 2017	Six sessions, 90 mins long, delivered weekly (with some weekly breaks) in groups of 5-7 families, delivered by clinical psychologist in community.	Intervention advertised in childcare centres and preschools. Responding parents screened.	None	Self-rated measures Short temperament scale for children (STSC) Behavioural Inhibition Questionnaire (BIQ) Preschool Anxiety Scale- Revised (PAS-R) Anxiety Disorders Interview Schedule for Children and Parents IV- Parent Version (ADIS-IV-P) Child Anxiety Life Interference Scale–Preschool Version (CALIS-PV) Depression Anxiety Stress Scales (DASS)
Seabra-Santos et al 2016	14 sessions, 120 mins long, delivered weekly, in groups of 8-12 parents, in community/ mental health centres.	Caregiver rated child as at risk of disruptive behaviour- above 80 th percentile on at least two scales: Strengths and Difficulties Questionnaire (SDQ), Hyperactivity Scale (HY) or Conduct Scale (CS).	None	Self-rated measures: Strengths and Difficulties Questionnaire (SDQ) Preschool and Kindergarten Behaviour Scales – second edition (PKBS-2) Beck Depression Inventory (BDI) Brief Symptom Inventory (BSI) Parenting scale (PS) Parenting sense of competence scale (PSOC)
Sourander et al 2016	11 sessions delivered weekly online, and 45 minute weekly telephone call from a coach. 7 and 10 month booster sessions.	Children recruited from annual child health clinic check-ups, above 80 th percentile on Strengths and Difficulties Questionnaire (SDQ)	None	Self-rated measures: Child Behavior Checklist for preschool children (CBCL) Parenting Scale Inventory of Callous-Unemotional Scale, 21-item depression, anxiety and stress scale
Bagner et al 2016	5-7 sessions, 60-90 mins long, delivered weekly in family home, by doctoral clinical psychology students.	Recruited through primary care paediatric centre, if mother rated child above 75 th percentile on problem scale of Brief Infant-Toddler Social and Emotional Assessment	None	Self-rated measure: Infant-Toddler Social and Emotional Assessment (ITSEA) Observed measure: Dyadic Parent-Child Interaction Coding System-Third Edition (DPICS-III)
Komoto et al 2015	[Number of sessions not stated] 60-90 mins long, delivered by nurses and psychotherapists in a clinical counselling room.	Referral from paediatric clinics on basis of paediatrician deeming parent as needing support.	None	Observed measures: Nursing Child Assessment Teaching Scale (JNCATS) Child-Adult Relationship Experimental Index for Infants (CARE-Index)

				Self-rated measures: Japanese Parenting Stress Index (JPSI) Subjective Well-Being (SUBI) Center for Epidemiologic Studies Depression Scale (CES-D) Rosenberg's Self-Esteem Scale (RSES).
McGilloway et al 2014	14 two hour sessions, 120 mins long, delivered in groups of 11-12 members by trained facilitators, in community based services.	Families recruited via public health service waiting lists, schools, community agencies and self-referral. Behavioural problems identified on basis of caregiver rating child above clinical cut-off on intensity or problem subscale of Eyberg Child Behaviour Inventory (ECBI)	Reduction of costs per child by 40% in the intervention group at 12 months compared to baseline, due to reduced use of services	Self-rated measures: Eyberg Child Behaviour Inventory (ECBI) Strengths and Difficulties Questionnaire (SDQ) Connors Abbreviated Parental Rating Scale (CPRS) Social Competence Scale Parental Stress Index- Short Form (PSI-SF) Beck Depression Inventory (BDI) O'Leary-Porter Scale
Posthumus et al 2012	18 two hour sessions (11 basic and seven advanced), delivered in groups at community centres by certified group leaders	Families invited to study by mail, children selected if parents scored them above 80 th percentile on Aggressive Behaviour scale of Child Behaviour Checklist (CBCL).	None	Observed measure: Dyadic Parent-child Interaction Coding System - Revised (DPICS-R) Self-rated measures: Eyberg Child Behavior Inventory (ECBI) Parent practices interview (PPI) Child Behavior Checklist (CBCL)
Lindsay et al 2011	Incredible years: 17 two hour sessions Triple P: Five two-hour face to face sessions and three on telephone SFSC: 12 three-hour sessions All delivered weekly in community settings, in groups, by trained facilitators	Local recruitment in 18 local authorities, parents asked to select child who gave them most concern.	None	Self-rated measures: Warwick-Edinburgh Mental Well-being Scale Parenting Scale-Adolescent Being a Parent Strengths and Difficulties Questionnaire (SDQ)
Lowell et al 2011	A mean of 22.1 weeks of weekly 45-90 min sessions with individual	Referral from a primary care centre and a mother's nutritional	None	Self-rated measures: Infant-Toddler Developmental Assessment (IDA)

	families, predominantly in family's home, delivered by developmental/mental health clinicians	program. Children screened positive for social-emotional/behavioural problems on Brief Infant-Toddler Social and Emotional Assessment (BITSEA), and/or parent screened high for psychosocial risk on Parent Risk Questionnaire (PRQ)		Infant-Toddler Social and Emotional Assessment (ITSEA) Parenting Stress Index (PSI) Short form Parent Satisfaction Questionnaire (PSQ) Center for Epidemiological Studies Depression Scale (CES-D) Brief Symptom Inventory (BSI)
Braet et al 2009	24 weeks involving 11 two-hour sessions in small groups of 8-10 parents, led by psychologists delivered in university setting	Parents recruited via kindergarten leaflets and pupil guidance centres and selected if parent scored their child 60 or more on externalising scale of Child Behaviour Checklist (CBCL).	None	Observed measures: Mother-child interactions coded for permissivity, control adjustment, adjustment of maternal behaviour, maternal feelings, maternal acceptance, and involvement Self-rated measures: Child Behaviour Checklist (CBCL) Parenting Stress Index (PSI) Short Form Ghent Parental Behaviour Scale (GPBS) Therapy Attitude Inventory (TAI) Social Support List (SSL) Wally Child Social Problem-Solving Detective Game Disruptive Behaviour Disorders (DBD) rating scale
Wiggins et al 2009	Nine weeks of weekly two-hour sessions delivered in groups of ten, delivered by trained therapists	Parents self-referred in resource to advertisements for study in community, if concerns about a problematic relationship with child and child emotional or behavioural problems. Screening involved borderline to clinically significant scores on the Parenting Relationship Questionnaire and borderline to abnormal scores on behavioural subscales of Strengths	None	Self-rated measures: Parenting Relationship Questionnaire (PRQ) Parenting Scale Parent's Attributions for Child's Behaviour Measure (PACBM) Child Behaviour Checklist (CBCL) Strengths and Difficulties Questionnaire (SDQ)

		and Difficulties Questionnaire (SDQ).		
Bywater et al 2009	12 weekly 120-160 min sessions delivered in groups by trained leaders.	Parents recruited through sure start areas, if parent rated child over clinical cut-off points on Eyberg Child Behaviour Checklist (ECBC) problem or intensity scales.	Primary care, hospital services and social services costs per child had reduced at 18 months, but special education costs had risen.	Self-rated measures: Eyberg Child Behaviour Checklist (ECBC) Strengths and Difficulties Questionnaire (SDQ) Conners Abbreviated Parent Rating Scale (CAPRS) Kendall Self-Control Rating Scale (SCRS) Parenting Stress Index- Short Form (PSI) Parenting Scale Beck Depression Inventory (BDI) Observed measure: Dyadic Parent-Child Interaction Coding System (DPICS)
Jones et al 2008	12 weekly 120-160 min sessions delivered in groups by trained leaders.	Parents recruited through sure start areas, if parent rated child over clinical cut-off points on Eyberg Child Behaviour Checklist (ECBC) problem or intensity scales	None	Self-rated measures: Eyberg Child Behaviour Checklist (ECBC) Strengths and Difficulties Questionnaire (SDQ) Conners Abbreviated Parent Rating Scale (CAPRS) Observed measure: Dyadic Parent-Child Interaction Coding System (DPICS)
Hutchings et al 2007	12 weekly 120-160 min sessions delivered in groups by trained leaders.	Parents recruited through sure start areas, if parent rated child over clinical cut-off points on Eyberg Child Behaviour Checklist (ECBC) problem or intensity scales.	None	Self-rated measures: Eyberg Child Behaviour Checklist (ECBC) Strengths and Difficulties Questionnaire (SDQ) Conners Abbreviated Parent Rating Scale (CAPRS) Kendall Self-Control Rating Scale (SCRS) Parenting Stress Index- Short Form (PSI) Parenting Scale Beck Depression Inventory (BDI) Observed measure: Dyadic Parent-Child Interaction Coding System (DPICS)
Stallman et al 2007	Self-directed intervention – parents provided ten weekly modules using a workbook and video package.	Parents responded to community outreach advertisements, if they were concerned about child's	None	Self-rated measures : Strengths and Difficulties Questionnaire Extended Version (SDQ)

	Enhanced condition also received a weekly phone call by a trained clinical psychologist.	behaviour. No diagnostic screening was conducted.		Parenting Scale – Adolescent version (PSA) Depression Anxiety Stress Scales-21 (DASS-21) Client Satisfaction Questionnaire (CSQ) The Conflict Behavior Questionnaire (CBQ–A)
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