



The Royal
Children's
Hospital
Melbourne

Sustained home visiting for vulnerable families and children

A literature review of effective processes and strategies

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This paper was prepared by:

Dr. Tim Moore, Senior Research Fellow
Dr. Myfanwy McDonald, Senior Project Officer
Sujitha Sanjeevan, Project Officer
Dr. Anna Price, Postdoctoral Fellow

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The Murdoch Childrens Research Institute and
The Royal Children's Hospital Centre for Community Child Health
The Royal Children's Hospital
50 Flemington Road, Parkville, Victoria
Australia 3052

Website: www.rch.org.au/ccch



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1. EXECUTIVE SUMMARY

This literature review considers service delivery processes and strategies, and effective methods of engaging with vulnerable families that are associated with better outcomes for these families. It complements a recent literature review undertaken by the Centre for Community Child Health (CCCH) (CCCH, 2012) that examined Australian and international research evidence regarding the most effective components of sustained nurse home visiting programs. This review was intended to inform the development of an Australian sustained nurse home visiting program to improve outcomes for vulnerable families and children. The current literature review investigates additional information that should be considered in developing an Australian sustained nurse home visiting model for vulnerable families, and considers:

1. The importance of how services are delivered, as distinct from what is delivered – what features of the process of service delivery are associated with better outcomes?; and
2. Working with vulnerable families – what is known about effective ways of engaging and working with vulnerable parents and families?

A thorough search of the relevant literature was undertaken of these two topics, along with a range of related service delivery issues, looking for the most rigorous studies as well as the most authoritative and thorough summaries of the evidence.

1.1 Key findings

The key findings of this literature review are as follows:

- There is general support for the notion that process aspects of service delivery matter for outcomes – that *how* services are provided is as important as *what* is provided.
- A number of key elements of effective service delivery processes have been repeatedly identified in the research literature. Effective services are:
 - relationship-based;
 - involve partnerships between professionals and parents;
 - target goals that parents see as important;
 - provide parents with choices regarding strategies;
 - build parental competencies;
 - are non-stigmatising;
 - demonstrate cultural awareness and sensitivity; and

- maintain continuity of care.
- These process variables appear to be of particular importance for the most vulnerable families, who appear to be less likely to make use of professional services that do not possess these qualities.
- Other key factors identified include: the importance of providing practical support to address families' most pressing needs; and the need to coordinate services to address the barriers that parents face in accessing services as well as the background factors that have led to the families having difficulties in caring for their children.
- Three elements of effective help-giving/family-centred practice have been identified: relational help-giving, participatory help-giving, and technical quality and knowledge. The third of these refers to the service provider's knowledge of and ability to deliver the strategies available to help parents achieve the goals they have identified. The effective use of evidence-based strategies is critical for ensuring that changes occur in the way that parents interact with and care for their children, which is in turn a prerequisite for change in the children themselves.
- There appears to be a number of primary or threshold factors associated with enhanced early intervention outcomes. These include: shared decision-making between parent and professional; positive relationship between the parent and professional; non-stigmatising presentation of intervention; cultural awareness and sensitivity; flexible settings/hours; and provision of crisis help prior to other intervention aims. These factors are necessary but not sufficient for positive outcomes. For positive change to occur, secondary factors come into play. These include the deployment of evidence-based strategies and programs to address the needs identified by the parents.

Professional attitudes and perceptions also appear to be important – e.g. seeing vulnerable/marginalised families as facing barriers to accessing and using services rather than irresponsibly failing to use them.

- Ways of effectively engaging and empowering vulnerable and marginalised families have been identified. These include:
 - services that help them feel valued and understood, and that are non-judgmental and honest;
 - services that have respect for their inherent human dignity, and are responsive to their needs, rather than prescriptive;
 - services that allow them to feel in control and help them feel capable, competent and empowered;
 - services that are practical and help them meet their self-defined needs;

- services that are timely, providing help when they feel they need it, not weeks, months or even years later; and
- services that provide continuity of care – parents value the sense of security that comes from having a long-term relationship with the same service provider.
- The concepts of ‘complex’ and ‘multiple’ needs are used by various disciplines and service sectors in a variety of ways. However, the essence of complex needs as implying both *breadth of need* (more than one need, with multiple needs interconnected) and *depth of need* (profound, severe, serious or intense needs).
- It is the cumulative effect of multiple environmental stressors and risks that make families more vulnerable. At all three levels (individual, family and community), parents’ problems are likely to be multiple, overlapping, and cumulative. If parents have problems in one area they almost certainly have problems in other areas of their life, further compounding parenting difficulties. The greater the number of stress factors that were reported by parents, the less likely they were to be ‘coping’ with parenting.
- We do not know how many families or what percentage of families can be considered vulnerable, and therefore would benefit from additional support and services. We have data on the numbers of children who fall into particular risk categories, such as poverty, but not on how many children and families are exposed to multiple risk factors, or whether the number of such families has increased.
- The previous literature review (CCCH, 2012) identified a number of manualised home visiting packages that have been shown to be moderately effective. The present review has identified a number of more flexible models for working with vulnerable families that are more consistent with process features and therefore might serve as models for the current project.

Specific strategies

A number of specific strategies for working with disadvantaged and multi-problem families are investigated in the review:

- *Multi-systemic therapy*. This approach is not obviously applicable to an intensive home visiting service. It appears to be too intensive and costly, there is not enough evidence of its effectiveness, and its usefulness with families with young children is unknown.
- *Wraparound models of service delivery*. This is more obviously applicable approach, but hard to do well, partly because of the difficulties in coordinating

services for sustained periods. Moreover, it has had limited use with families of young children.

- *Key worker and transdisciplinary models.* For families with multiple and complex needs who require many different forms of service, key worker and transdisciplinary models of service have an obvious relevance. While there is some evidence of the effectiveness of these models, they are difficult to implement well, depend upon well-integrated services, and require experienced and well supported staff.
- *Motivational interviewing.* Supporting evidence for this approach is moderately strong, but It has not been applied to this target group. However, the key elements seem relevant and worth pursuing as a strategy that home visitors might have at their disposal. It functions as a support strategy rather than a wholesale approach.
- *Video feedback techniques.* Video feedback is an infant mental health strategy for promoting parent-infant interactions. While there is evidence of its effectiveness, the technique requires considerable skill and training to do well and avoid doing harm, and therefore might be best left to infant mental health specialists (or only used under the supervision of such specialists).
- *Measuring parent/professional relationships.* Assessing parent/professional relationships is a valuable aspect of service delivery, and there are some tools available for the purpose. A formative evaluation of parent-professional relationships may be especially useful in a home visiting program. A formative evaluation allows the program as a whole, and individual practitioners, to reflect upon their practice and, where necessary, amend their practice in a timely manner in order to enhance the effectiveness of the program.

1.2 Recommended core features of the Sustained home visiting model

Based upon the findings from this literature review, the recommended core features of a prospective home visiting model are as follows:

- The process variables identified as essential for effective service delivery represent the *threshold* features of the model – the bedrock on which the service is based. These service features are the starting point for all service delivery as well as the core qualities that continue to infuse all subsequent service delivery. The key qualities include relationship-based, partnership-based, capacity-building, provision of choices, addressing immediate practical issues, and addressing background factors. To ensure that service delivery is faithful to these core practices, measures of process fidelity should be regularly used.

- The identification of goals and of strategies to achieve these goals needs to be done in partnership with parents. To help ensure that the process of selecting goals and strategies is done systematically, decision-making algorithms and guidelines should be developed. To ensure that the goals and strategies are compatible with parental values and priorities, measures of values fidelity should be regularly used.
- The strategies used should be evidence-based. Service providers should be able to draw on a suite of evidence-based strategies to address the range of challenges that parents face in caring for their children. To ensure that evidence-based strategies are delivered consistently and rigorously, measures of program fidelity should be regularly used.
- It is clear from the literature reviews that delivering an intensive home visiting service for vulnerable families is a complex and skilled process. Families' needs and circumstances vary greatly, and the service model needs to be flexible enough to cater for these variations while maintaining a constant core of evidence-based practice. In the framework just outlined, the constant core is provided by the process features of service delivery, while the flexibility comes from the deployment of evidence-based strategies according to family need.
- For such a model to be effective, a service delivery framework and program logic model will need to be developed.
- Consideration will also need to be given to the training of service deliverers in process delivery skills and in content strategies.

2. BACKGROUND

This literature review complements an earlier review – *Sustained home visiting for vulnerable families and children: A review of effective programs* (McDonald, Moore and Goldfeld, 2012) – that reviewed the Australian and international research evidence on home visiting programs. The aim of that review was to utilise information from rigorously evaluated key home visiting programs to assist decision-making regarding the potential components of an Australia-wide home visiting program for vulnerable families and their children.

This review was tabled and discussed at a meeting of the Project's Expert Reference Group (ERG) in Canberra on 14th February, 2012. The ERG recognised that there were other forms of research evidence not covered by this review that would need to be taken into account in designing an Australian home visiting program.

Accordingly, it was agreed that ARACY should commission CCCH to conduct a second literature review focusing on two main topics:

- the importance of *how* services are delivered (as distinct from *what* is delivered) – what features of the process of service delivery are associated with better outcomes; and
- working with vulnerable families – what is known about effective ways of engaging and working with vulnerable parents and families.

The ERG identified a number of other related service delivery topics they would like up-to-date information and evidence about:

- multi-systemic therapy and wraparound models of service delivery;
- key worker and transdisciplinary models;
- implementation science – issues of program and process fidelity;
- motivational interviewing and associated strategies;
- videoing techniques for promoting parent-child interactions; and
- ways of measuring the quality of the relationship between parents and professionals.

The ERG was interested in the evidence regarding effective ways of working with two specific groups of families:

- disadvantaged families whose children arrived at school poorly equipped to benefit from the learning and social opportunities that schools offer (e.g. as indicated by Australian Early Development Index (AEDI) results); and
- families with multiple problems who require a great deal of support.

3. METHODOLOGY AND FORMAT OF REVIEW

The methodology used for this literature review was not systematic in a technical sense – i.e. systematically searching the research literature for studies meeting pre-ordained criteria. This is partly because of time constraints, but also because of the nature of the evidence; some of the topics at least, do not lend themselves to this kind of analysis. Nevertheless, the aim has been to conduct a thorough search of the relevant literature in each case, looking for the most rigorous studies as well as the most authoritative and thorough summaries of the evidence.

The report is structured in four main sections.

Part A: Services for disadvantaged families

- process features of effective service delivery; and
- working with vulnerable families

Part B: Services for multiple problem families

- multi-systemic therapy;
- wraparound models of service delivery; and
- key worker and transdisciplinary models.

Part C: General service delivery issues

- implementation science;
- motivational interviewing;
- video feedback techniques; and
- measuring parent/professional relationships.

Part D: Summary, conclusions and implications

PART A: SERVICES FOR DISADVANTAGED FAMILIES

4. Process features of effective service delivery

Process features of service delivery are those that relate to the way in which services are delivered rather than the content of what is delivered – that is, *how* services are delivered rather than *what* is delivered. There are two key questions to be addressed in regards to process features of service delivery:

- Do process features of services delivery matter, i.e. do they make a difference to the efficacy and effectiveness of services?
- If so, what process features of service delivery are important for effective service delivery?

Both of these questions are addressed below. Evidence relating to these two questions comes from a number of different sources and service sectors, including

- studies of home visiting services;
- psychotherapy efficacy research;
- research on family-centred practice and family-centred care;
- infant mental health practice and research; and
- family partnership training models.

This discussion is followed by a consideration of the implications of the findings regarding the process features of effective service delivery for service delivery. A summary of the key findings, along with some concluding points are then presented.

4.1 Do process features of services delivery matter?

The first question to be addressed is whether process features of services delivery matter, that is, whether they make a difference to the efficacy and effectiveness of services.

In order to answer this question, the discussion below begins by briefly exploring what is known about relationships and their impact on our development and well-being. This is followed by an examination of the evidence regarding the nature and importance of relationships in human services.

The importance of relationships

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Relationships have a profound effect on our development and well-being throughout our lives. Relationships are critical to almost all aspects of healthy child development (e.g. intellectual, social, emotional) and lay the foundation of children's long term outcomes in a range of critical areas such as self confidence and mental health (National Scientific Council on the Developing Child, 2004; Richter, 2004). However, relationships continue to be important for adult well-being. In fact, there is strong evidence that the relationships of all types have a significant impact on the development and well-being of those involved (Moore, 2006). This is true of the relationships between professionals (such as home visitors) and parents, managers and staff, staff and colleagues, and trainers and trainees.

How do relationships have such significant effects? The study of interpersonal neurobiology has revealed that subconscious neurological pathways enable our brains to read the body and facial signals given off by others, and detect their intentions and emotional states. In effect, our (right) brains are able to communicate directly with other people's (right) brains independently of conscious communication processes or awareness (Schore, 2001a, 2001b, 2005; Siegel, 2008, 2012). These interactions constitute a 'social synapse' that resembles the synaptic connections between the neurons in our brains (Cozolino, 2006). It is through the social synapse that relationships, both intimate and professional, change our brains and in the process shape to our ongoing mental, physical and social health and well-being (Cozolino, 2010). New findings regarding neural plasticity (Begley, 2009; Cozolino, 2008; Doidge, 2007) have shown that our brains continue to grow and change throughout our lives, and that the principle medium through which this occurs is our human relationships (Cozolino, 2008).

Relationships also have flow-on effects. What are known in the mental health field as 'parallel processes' operate at all levels of the chain of relationships and services, so that our capacity to relate to others is supported or undermined by the quality of our own support relationships (Bronfenbrenner, 2001; Gerhardt, 2004; Gowen & Nebrig, 2001; Mikus et al., 1994/95; Moore, 2006, 2007; Mothersole, 1999; Pawl, 1994-95; Pawl & St. John, 1998). Thus, there is a flow-on effect, in which relationships influence relationships. This flow-on effect can be seen in the relationships between early childhood professionals and parents of young children; we model for parents how to relate to their young children by the way we relate to them:

People learn how to be with others by experiencing how others are with them – this is how one's views and feelings (internal models) of relationships are formed and how they may be modified. Therefore, how parents are with their babies (warm, sensitive, responsive, consistent, available) is as important as what they do (feed, change, soothe, protect, teach). Similarly, how professionals are with parents (respectful, attentive, consistent, available) is as important as what they do (inform, support, guide, refer, counsel) (Gowen and Nebrig, 2001).

This suggests that relationships of all kinds share common characteristics. There are ten key features that appear to be common to all kinds of relationships (Moore, 2006, 2007):

- attunement/engagement;
- responsiveness;
- respect;
- clear communication;
- managing communication breakdowns;
- emotional openness;
- understanding one's own feelings;
- empowerment and strength-building;
- moderate stress/challenges; and
- building coherent narratives.

The commonalities that we find in all different types of relationships suggest that parallel processes operate across the full spectrum of relationships, not just in the relationship between professionals and parents. They can be seen as forming a cascade of parallel processes (Moore, 2006, 2007). Thus, the capacity of professionals to support parents effectively is partly dependent upon the nature of the support they receive from their superiors, as well as from their colleagues and their own personal networks.

Having established that relationships play an important role in the development and well-being of children and adults, we will now examine the evidence regarding the nature and significance of relationships between professionals and parents.

Relationships between parents and professionals

Numerous researchers have concluded that the relationship between parents and professionals is the key to effective practice (Barnes, 2003; Barnes and Freude-Lagevardi, 2003; Berlin et al., 1998; Bruner, 2004; Daro, 2009a; Davis & Day, 2010; Dunst, et al., 1988; Dunst & Trivette, 1996; Scott et al., 2007).

On the basis of a detailed analysis of what makes early childhood interventions work, Berlin et al. (1998) conclude that

... the most critical dimension of early interventions is the relationship between the program and the participants. The benefits of program services will not be fully realised unless the participant is genuinely engaged (p. 12).

Within the early childhood intervention field, the importance of the relationship between the workers and the parents has long been recognised (Dunst, et al., 1988; Dunst & Trivette, 1996; Hornby, 1994; Kalmanson & Seligman, 1992). As Hornby (1994) put it,

The competence of professionals in working with parents is as important as expertise in their own professional areas in determining the effectiveness of their work with children with disabilities.

Kalmanson & Seligman (1992) argued that this was the case even when the relationship itself is not the focus of the intervention:

The success of all interventions will rest on the quality of provider-family relationships, even when the relationship itself is not the focus of the intervention. Effective and sympathetic working relationships enhance parents' all too often neglected recognition that is their efforts that are ultimately most important to their infants. Families with special needs often feel that their particular difficulties set them apart from others, and a good relationship with a professional can enhance the sense of being understood and supported. This, in turn, can lead to changes in the parent-child relationship.

The same applies to family support and strengthening programs. Bruner (2004) argues that for such programs, 'relationships and practices, not program structure or curriculum, are key to achieving success.' He suggests that mixed findings regarding the efficacy of such programs is likely to be due to the failure to measure this critical aspect of service delivery.

Daniel Stern (2008), one of the leading figures in infant development and mental health, has come to recognise the importance of the nonspecific factors in relationships between professionals and parents:

Most of us have been dragged kicking and screaming to the realization that what really works in psychotherapy is the relationship between the therapist and the client. That's what does the work. We are all devastated by this reality because we spent years and a lot of money learning a particular technique and theory, and it is very disheartening to realize that what we have learned is only the vehicle or springboard to create a relationship—which is where the real work happens. But that is where it is, from my point of view. We need to have a technique, and we cannot have a technique without a theory. We have to do something and act like we know what we are doing in a therapy session, otherwise we cannot create a relationship. The relationship, of course, is not symmetrical, but we need not delude ourselves that the technique is what achieves most of the results.

As Stern points out, outcome studies show that it does not matter too much which technique professionals employ. If they have been well trained in an evidence-based technique, believe in the technique, and have had some experience in its use, all of the professional techniques cure roughly equally. Basically, there is something that is common to every therapeutic approach: the

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nonspecific factors built into the relationship. These include good listening, taking time, being supportive, and being open and welcoming (Stern, 2008). This growth in the general recognition of the importance of the quality of the professional/parent relationship has occurred in the context of significant changes in ways of working with parents. Over the past few decades, many forms of human service have seen a shift away from a service delivery model in which the professionals controlled the process of diagnosis and treatment to one which seeks to base service on needs and priorities identified by parents, building upon existing family competencies and mobilising local resources. This approach, which is known as *family-centred practice* in social work and early childhood intervention services, and as *family-centred care* in medical settings and services, represents a profound shift in the *manner* in which services are delivered.

From a philosophical perspective, family-centred principles and practices have been adopted as recommended practice by various professional and scientific groups and in a variety of settings, including the following:

- community paediatric and medical care (American Academy of Pediatrics, 2003, 2012; Brewer et al., 1989; Coulter, 2005, 2011; Institute of Medicine, 2001; Kuo et al., 2012; Perrin et al., 2007; Shaller, 2007; Shelton & Stepenek, 1994; Smith & Coleman, 2010);
- hospital care (American Hospital Association, 2009; Muething et al., 2007; O'Malley et al., 2008);
- early childhood intervention services (Bailey et al., 2011, 2012; Blue-Banning et al., 2004; Davis & Day, 2010; Dunst, 1997, 2000; McWilliam et al., 1998; Moore, 1996; Moore & Larkin, 2006; Rosenbaum et al., 1998; Sandall et al., 2004; Turnbull et al., 2000);
- social work and family support services (Maton et al., 2004; Petr, 2004; Saleebey, 2006; Ruch et al., 2010; Scott & O'Neill, 1996); and
- mental health (Dishion and Stormshak, 2006).

Numerous statements of the key principles of family-centred practice and family-centred care exist (e.g. Bailey et al., 2012; Dunst, 1997; Kuo et al., 2012; Moore & Larkin, 2006; Rosenbaum et al., 1998; Trivette & Dunst, 2000). Bailey et al. (2012) summarise the key features of a family-centered approach thus:

The essential assumption of a family-centred approach is that young children cannot be viewed apart from their families, nor can services be provided without a consideration of the family context. In fact, families are seen not as clients receiving services but as partners in making decisions about goals and activities. Core principles of a family-centred approach include focusing on family strengths, respecting family diversity and values, encouraging family decision making and empowerment, communicating with families in an open and collaborative fashion, adopting a flexible approach to service provision, and recognizing the value of informal support systems.

According to Moore (2010), the rationale for working in a family-centred way is as follows:

- If service providers and families work collaboratively to identify family goals and priorities, then services are more likely to address families' most salient needs. If professionals determine what the goals of intervention should be, then the issues that are most important for families and have most impact on their lives are likely to be overlooked.
- If service providers and families work as partners to determine what action should be taken, then there is a greater probability that the desired outcomes will be achieved. If decisions about goals and actions are made by professionals, then are less likely to be realisable in the circumstances in which the family lives.
- If service providers listen to families and establish good working relationships with them, then parents are more likely to listen to what the professionals have to say and to make better use of professional services. If families feel that the professionals do not really understand their views or their circumstances, then they are less likely to trust and listen to what the professionals have to offer.
- If service providers support family decision-making, then families are more likely to develop the confidence, competence, and ability to make decisions about their child and family over their lifetime. This is important because support services for families drop away significantly as the child gets older, and families need to become more self-reliant.
- If service providers and parents share and respect each other's knowledge and expertise, then better solutions for the child and family are likely to be found. If parent knowledge of the child and family is ignored, then the intervention strategies are less likely to be effective.
- If child and family needs are met solely or primarily through professional sources of help, then families are more likely to become dependent upon professional services. If service providers help families identify and mobilise family and community sources of help, then their dependence on scarce professional resources is reduced.

According to this rationale, family-centred practice increases the likelihood that the knowledge and expertise that professionals have to offer will be used and found to be useful by parents.

Evidence

There is a significant body of evidence to support the importance of the relationship between professionals and parents, and of the effectiveness of

family-centred practices. The following discussion looks at the evidence of effectiveness in a range of different fields and service delivery modalities.

Evidence from reviews of home-visiting services

A number of reviews of the evidence regarding home-visiting services have concluded that establishing and maintaining a positive partnership with parents is an essential feature of effective practice (Daro, 2009a; Gomby, 2005; Scott et al., 2007). For instance, on the basis of a review of the evidence regarding the elements of effective partnerships with parents, Scott et al. (2007) concluded that positive partnerships between practitioners and parents of young children are central to achieving the objectives of services. They also noted that the principles of practice and the personal qualities required for developing and sustaining positive partnerships with parents apply to all families, but are of critical importance for parents who struggle to nurture their children against the odds of adversity in the past or in the present.

Evidence from reviews of doctor/patient relationships

There is good evidence that the quality of doctors' interviewing skills in medical consultations influences patient satisfaction and compliance as well as actual health outcomes (Di Blasi et al., 2001; Nobile & Drotar, 2003; Stewart et al., 1999). For instance, on the basis of a systematic review of the research, Di Blasi et al. (2001) concluded physicians who adopt a warm, friendly, and reassuring manner are more effective than those who keep consultations formal and do not offer reassurance.

The importance of doctors' communication skills is highlighted in a review by Stewart et al (1999). They found that complaints and malpractice actions about doctors are usually due to communication problems rather than issues of technical competency. They also found that effective communication promotes patient adherence to recommended treatment plans, and have a generally positive effect on actual patient health outcomes such as pain, recovery from symptom, anxiety, functional status, and physiologic measures of blood pressure and blood glucose.

Another review of parent-provider communication (Nobile & Drotar, 2003) found that effective parent-provider communication is associated with parental satisfaction with care, adherence to treatment recommendations, and enhanced discussion of psychosocial concerns. Moreover, interventions designed to improve parent-provider communication resulted in more discussion of psychosocial concerns, better recall of information from the visit, and improved parent-provider communication.

Although doctors who communicate better generally get better results, there is evidence that some people may value or benefit more than others from such

patient-centred approaches. In a large-scale study, Little et al. (2001) explored patient's preferences for patient-centred consultation in general practice. They found that, from the patients' perspective, there are at least three important and distinct domains of patient-centredness: communication, partnership, and health promotion. While most patients wanted such an approach rather more than they wanted a prescription or an examination, those who were vulnerable - either psychosocially or because they are feeling particularly unwell - expressed a stronger preference for patient-centred care. The preference for a patient centred approach in this group of patients - that is, those with a high prevalence of psychosocial problems - supports previous work that patients presenting with psychosocial problems are more likely to be satisfied with a patient centred consultation style. A similar pattern was found for those strongly wanting partnership and health promotion.

This work supports general evidence about what patients want from their consultation and contradicts evidence from other settings that a considerable minority of patients want a doctor centred approach, although the latter discrepancy may be explained by the very different nature of the problem (for example, cancer care). The current study is likely to be more representative of patients' views in primary care.

Evidence regarding relationships in psychotherapy

As with doctor/patient relationships, the evidence clearly indicates that the quality of relationships between psychotherapists and their clients is important for outcomes (Ahn & Wampold, 2001; Horvath, 2001; Karver et al., 2006; Shirk & Karver, 2003). In a review of studies of outcomes in psychotherapy, Orlinsky and Howard (1986) found that factors related to the quality of the emotional connection between the patient and the therapist were far more important than the theoretical orientation of the therapist. This conclusion is supported by analyses of the efficacy literature (Campbell, 2002) which have found that the client's relationship with the therapist typically accounted for around 30% of the effectiveness of particular therapies, whereas the therapeutic model and/or technique used only accounted for around 15%. More specifically, the factors typically accounting for the effectiveness of psychotherapy are as follows:

- *Extra-therapeutic factors.* These are any and all aspects of the client *and* his or her environment that facilitate recovery, regardless of formal participation in therapy. These include the client's strengths and resources, world view, existing social supports, and any fortuitous events in their lives. These factors account for around 40% of the effectiveness of particular therapies.
- *Relationship with the therapist.* This includes the therapists' personal qualities, their ability to relate effectively to the client, and to establish a therapeutic alliance with the client. These factors account for around 30% of the effectiveness of particular therapies.

- *Placebo, hope, and/or expectancy.* This includes the client's awareness of receiving treatment and any positive or hopeful expectations that accompany the use of a given method or approach. These factors account for around 15% of the effectiveness of particular therapies.
- *Structure, model, and/or technique.* These include the particular theoretical models and techniques used by the therapist. These factors account for around 15% of the effectiveness of particular therapies.

Ahn & Wampold (2001) address the question of whether the proven beneficial effects of counseling and psychotherapy are due to the specific ingredients of the treatments or to the factors common in all therapies. On one side are the advocates of empirically supported treatments who claim that counselling and psychotherapy treatments function in the same way as medical treatments in that their efficacy depends upon specific ingredients or techniques. On the other side are the advocates of models that stipulate that the common factors, such as the healing context, the working alliance, and belief in the rationale for treatment and in the treatment itself, are the important therapeutic aspects of counseling and psychotherapy.

Ahn and Wampold (2001) conclude that the preponderance of the research evidence suggests that the benefits of treatments are probably due to the pathways common to all bona fide psychological treatments, such as the healing context, the belief in the rationale for and the efficacy of therapy by the client and by the therapist, the therapeutic alliance, therapeutic procedures consistent with the client's understanding of his or her problems, and the development of increased self-efficacy to solve one's problems.

One important aspect of this relationship is the quality of the alliance (or therapeutic alliance) formed between the therapist and client (Alexander & Dore, 1999; Elvins & Green 2008; Horvath, 2001; Horvath & Bedi, 2002; Kazdin et al., 2006; Muran & Barber, 2010; Shirk et al., 2011). According to Horvath and Bedi (2002), the alliance refers to the quality and strength of the collaborative relationship between client and therapist in therapy. This concept is inclusive of:

- positive affective bonds between client and therapist, such as mutual trust, liking, respect, and caring;
- consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached; and
- a sense of partnership in therapy between therapist and client, in which each participant is actively committed to their specific and appropriate responsibilities in therapy, and believes the other is likewise enthusiastically engaged in the process.

Horvath (2001) reviewed the evidence regarding the role of the therapeutic alliance in therapy. This evidence suggests the following:

- The qualities of a good therapeutic alliance and the significant contribution it makes to positive outcome are remarkably stable and robust across a broad range of variables.
- The magnitude of this relation appears to be independent of the type of therapy and whether the outcome is assessed from the perspective of the therapist, client, or observer.
- Developing the alliance takes precedence over technical interventions in the beginning of therapy. Although the strength of the connection between alliance and therapy outcome appears to be relatively uniform throughout therapy, the client's report of the early alliance may be the most clinically useful indicator. In successful treatments, the therapist's and client's assessments of the alliance tend to converge over time.

Evidence from reviews of family-centred practice and family-centred care

There is strong evidence to support the effectiveness of family-centred practice and care approaches. Recent literature reviews and meta-analyses of research across a wide range of medical and early intervention service sectors have consistently shown that family-centered practices have positive effects in a diverse array of child and family domains, such as more efficient use of services, decreased health care costs, family satisfaction with services, family well-being, building child and family strengths, parenting practices, and improved health or developmental outcomes for children (American Academy of Pediatrics, 2012; Bailey et al., 2007; Dempsey & Keen, 2008; Dunst et al., 2007, 2008; Dunst & Trivette, 2009; Gooding et al., 2011; Kuhlthau et al., 2011; McBroom & Enriquez, 2009; Piotrowski et al., 2009; Raspa et al., 2010; Rosenbaum et al., 1998). In addition, there are benefits for professionals in the form of stronger alliances with families, improved clinical decision-making, improved follow-through, greater understanding of the family's strengths and caregiving capacities, more efficient and effective use of professional time and health care resources, greater professional satisfaction, and greater child and family satisfaction (American Academy of Pediatrics, 2012).

There is evidence, however, that, despite the almost universal recommendation for a family-centred approach and the evidence of its effectiveness, implementing family-centred practice consistently and reliably is a challenge (Brorson, 2005; Bruder, 2000; Gooding et al., 2011; Hanna & Rodger, 2002; Kuo et al., 2012; Litchfield & MacDougall, 2002; Perrin et al., 2007). In professionals' direct dealings with families, there appears to be a gap between the rhetoric of family-centred practice and the reality. In part, this appears to reflect natural tensions between the policy of family-centred practice and the push for evidence-based practice. However, there are a number of other contributing factors. Litchfield and

MacDougall (2002) suggest that while family-centred practice is supported by the literature and by professional bodies, significant policy and professional issues need to be addressed before such practice can be fully adopted.

The implications of these different accounts of parent-professional relationships is that how early childhood intervention services are delivered is as important as what is delivered (Davis & Day, 2010; Dunst et al., 1988; Pawl & St. John, 1998). Thus, as Davis and Day (2010) suggest, 'Outcomes are not simply the result of advice (e.g. take drug X or play with your child) but are determined also by the ways in which advice is given'. And, as Dunst and Trivette (2009) have noted, the manner in which support is provided, offered, or procured influences whether the support has positive, neutral, or negative consequences. For instance, providing social support to parents in response to an indicated need for help is associated with positive consequences, whereas providing social support in the absence of an indicated need for help has negative consequences (Affleck et al., 1989).

Having established that process features of services delivery make a difference to the efficacy and effectiveness of services, the following discussion explores what process features of service delivery are important for effective service delivery.

4.2 What process features of service delivery are important for effective service delivery?

In this section, the focus is on what is known about the qualities of effective professional/parent relationships and effective help-giving, the qualities of effective helpers, the skills involved in effective help-giving, and how to train and support professionals.

Effective professional/parent relationships and help-giving

Several studies have described the characteristics of effective parent/professional relationships and of effective help-giving (e.g. Barnes, 2003; Barnes & Freude-Lagevardi, 2003; Blue-Banning et al., 2004; Braun et al., 2006; Davis & Day, 2010; Dunst et al., 2007; Stewart et al., 1999; Moore & Larkin, 2006). This evidence is discussed below.

Evidence regarding effective professional/parent relationships

According to Braun et al. (2006), the evidence suggests that the most effective relationship is a partnership. They identify the following characteristics of an effective partnership for helping:

- *Working closely together with active participation and involvement* - this is critical because without mutual participation the rest of the helping process cannot be activated.

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- *Shared decision-making power* - to be most effective, parents and helpers should work collaboratively, contributing equally to decisions. Parents have power and acknowledging this is of benefit to parents, since it enables parental self-efficacy and self-advocacy.
- *Complementary expertise* – professional expertise and specialist knowledge are important, but it is only of benefit if it adds to and builds on the expertise of the parent and can only be effective in combination with information provided by parents.
- *Agreeing aims and process* – partnership can only exist if the aims are mutually agreed, as well as the means by which the aims are to be achieved.
- *Mutual trust and respect.*
- *Openness and honesty.*
- *Clear communication.*
- *Understanding and flexibility* – allowing the partners to, on occasion, take more or less equal roles, such as when the helper moves to a ‘one-down’ position in order to encourage the parent to become the expert, so that their position as such is acknowledged.
- *Negotiation of all aspects of helping, including the relationship* – this has to be continuous, to ensure agreement, especially where there is disagreement or potential conflict.

A review by Stewart et al. (1999) concluded that the key features of effective communication between doctors and patients involve

- providing the patient with clear information;
- reaching agreement on goals and expectations;
- encouraging the patient to play an active role; and
- providing positive affect, empathy and support.

According to Brown et al. (1995), the main domains of patient-centred care are:

- exploring the experience of disease and illness - patients' ideas about the problem, feelings, expectations for the visit, and effects on function;
- understanding the whole person - personal and developmental issues (for example, feeling emotionally understood) and the context (the family and how life has been affected);
- finding common ground (partnership) - problems, priorities, goals of treatment, and roles of doctor and patient;
- focusing on health promotion - health enhancement, risk reduction, early detection of disease; and

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- enhancing the doctor-patient relationship - sharing power, the caring and healing relationship.

Wensing et al. (1998) conducted a systematic literature review of studies on patient priorities with regard to primary health care. From patients' perspectives, the most important aspects of care were *humaneness*, followed by *competence/accuracy*, *patients' involvement in decisions*, and *time for care*.

Coulter (2005) summarises the evidence regarding what British patients and the public want from primary medical care services. Patients want primary care professionals who are good communicators and have sound, up to date clinical knowledge and skills. They also want professionals who are interested and sympathetic, involve them in decisions, give them sufficient time and attention, and provide advice on health promotion and self care (Little et al., 2001). Many patients have their own ideas about what is wrong and what may have caused it, but they do not always articulate these. Failure to engage with the patient's agenda can lead to misunderstandings, dissatisfaction, and poor outcomes.

Partnerships are an essential feature of family-centred practice and family-centred care. On the basis of a review of the literature on family-centred practice, Moore & Larkin (2006) identify the key family-centred practices, including the following:

- Families and family members are treated with dignity and respect at all times.
- Services are sensitive and responsive to family cultural, ethnic, and socio-economic diversity.
- Services are based on the needs and priorities of families.
- Services are provided in a flexible fashion according to the evolving needs and circumstances of particular families.
- Service providers acknowledge and respect the family's expert knowledge of the child and the family circumstances as complementing their own professional expertise.
- Parents are given opportunities to participate fully in the planning and delivery of services, and service providers support and respect the choices they make.

Hilton Davis and colleagues in the UK have developed a Family Partnership Model based on many of the same principles and processes (Davis et al., 2002; Davis and Day, 2010). They note that all parents may require help at various times, but this must be more than simple advice giving, which they suggest is notoriously variable in outcome:

To be effective, help must take account of parents as individual people within their unique family and social contexts. It must involve a relationship that enables parents to express their concerns freely and that enhances their self-

belief and therefore their ability to be effective and to manage in the long-term. Within this context, professional information and advice is of value, but only if it is tailored to explicit need, derives from negotiation that fully involves the expertise of the parents, and does not interfere with their contribution to the management of their problems (Davis & Day, 2010).

Ultimately developing and sustaining positive partnerships with parents may be more an art than a science. In the words of two recent researchers (de Boer & Coady, 2006) in this area:

... we wish to stress that the results of this research are not reducible to a list of 'dos and don'ts'. Our findings suggest that good helping relationships are more ways-of-being than they are about strategies and techniques. If the effort a worker avails in establishing a positive relationship with clients is prescriptive and technique driven, it is likely to fail. Workers' relationship and engagement skills can only blossom when they are rooted in genuine care and respect for the clients they serve. Specific techniques can augment an empathic, supportive, and collaborative approach, but they cannot substitute for this.

Evidence regarding effective help-giving

On the basis of their research over 20 years, Dunst and Trivette (2009) identify twelve principles of effective help-giving. Help-giving is more likely to be effective when:

- It is both positive and proactive and conveys a sincere sense of help giver warmth, caring, and encouragement.
- It is offered in response to an indicated need for assistance.
- It engages the help receiver in choice and decisions about the options best suited for obtaining desired supports and resources.
- It is normative and typical of the help receivers' culture and values and is similar to how others would obtain assistance to meet similar needs.
- It is congruent with how the help receiver views the appropriateness of the supports and resources for meeting needs.
- The response-costs for seeking and accepting help do not outweigh the benefits.
- It includes opportunities for reciprocating and the ability to limit indebtedness.
- It bolsters the self-esteem of the help receiver by making resource and support procurement immediately successful.
- It promotes, to the extent possible, the use of informal supports and resources for meeting needs.
- It is provided in the context of help giver-help receiver collaboration.

- It promotes the acquisition of effective behaviour that decreases the need for the same type of help for the same kind of supports and resources.
- It actively involves the help receiver in obtaining desired resource supports in ways bolstering his or her self-efficacy beliefs.

Translating these principles into practice, effective help-giving involves three components, each with two elements (Dunst et al., 2007):

- *Technical quality* includes the knowledge, skills, and competence one possesses as a professional and the expression of this expertise as part of practicing one's craft.
- *Relational practices* include behaviours typically associated with effective help-giving (active listening, compassion, empathy, etc.) and positive practitioner attributions about help-receiver capabilities. Relational practices also include help giver beliefs about existing family member strengths and their capacity to become more competent.
- *Participatory practices* include behaviours that involve *help-receiver choice* and decision making, and which meaningfully involve participants in actively procuring or obtaining desired resources or supports or achieving desired life goals. Participatory practices also include *help giver responsiveness* to a family's situation and changing life circumstances, and *help giver flexibility* to these situations and circumstances.

All three elements need to be present for help-giving to be truly effective. Thus, there is evidence that family-centred programs incorporating participatory help-giving practices are more effective in empowering families (i.e. in supporting and strengthening family competencies and problem solving abilities) (Judge, 1997; King, et al., 1999; Thompson et al., 1997; Trivette et al., 1996).

Meta-analyses of multiple studies have shown that family-centred help-giving has the strongest effect on the most proximal variables, namely parental satisfaction with service received, parental self-efficacy beliefs, and, to a lesser extent, how helpful the parents judged the supports and resources provided by the help-giver and their programs (Dunst et al., 2007, 2008). Outcomes measures that are more distal to family-centred help-giving (parental ratings of child behaviour and functioning, personal/ family well-being, and parenting behaviour) were also affected by family-centred help-giving, but not nearly as strongly.

These results indicate that the ways in which help givers interact and treat families influences, to some degree, judgments of their own behaviour, that of their family, and their children's behaviour. Relational helping practices are more closely linked to satisfaction measures, whereas participatory helping practices are more closely related to self-efficacy beliefs and parental perceptions of child behaviour and their own parenting.

Thus, family-centred practices produce direct beneficial effects for families but indirect beneficial effects for child development. This is because family-centred practices have empowerment type effects (e.g., strengthened efficacy beliefs), and parents who feel empowered about their parenting capabilities are more likely to provide their children development-enhancing learning opportunities. However, as Dunst et al. (2007) note,

There is no reason to believe or expect that family-centred practices would be directly related to child development outcomes. Child focused or parent/child-focused interventions are what is done and family-centred practices are how the interventions are implemented. The latter is expected to influence the ways in which the former is carried out.

The most recent analyses by Dunst and colleagues (Trivette et al., 2010) show how this process works. Family-centred help-giving practices have a direct impact on parental self-efficacy beliefs, which in turn influence parent well-being. The combination of more positive self-efficacy beliefs and well-being leads to improved parent-child interactions which then shape the child's development. In other words, the impact on child development is indirect – positive help-giving had direct impacts on parental self-efficacy beliefs and well-being, which in turn led to direct impacts on child behaviour and functioning.

Family-centred practices are only one of a number of factors that would be expected to contribute to improved child, parent, and family behaviour and functioning. In particular, there is a third element of effective help-giving – technical competence – that is essential for help-giving to be fully effective in promoting change in children's development and functioning (Trivette & Dunst, 2007).

The relationship between technical competence and the other two characteristics is discussed. A thorough review of the evidence regarding interventions relevant to the prevention of mental health problems of infants and toddlers (Barnes, 2003; Barnes & Freude-Lagevardi, 2003) throws some light on this question. This review concludes that, to be optimally effective, programs must address simultaneously:

- the *representational level*, i.e. the psychological needs of the parents (especially their sense of mastery and competence);
- the *behavioural level*, i.e. child behaviours as well as parental behaviours that influence maternal, foetal and infant development; and
- the *situational stresses and social supports* that can either interfere with or promote their adaptation to pregnancy, birth, and early care of the child.

Barnes (2003) and Barnes & Freude-Lagevardi (2003) conclude that there appears to be a number of necessary, but not sufficient, factors associated with enhanced early intervention outcomes. They can be divided into primary

(threshold) factors that function in an all-or-nothing manner and secondary factors (fine-tuning).

There are six primary factors:

- shared decision-making between parent and therapist/intervenor;
- quality of relationship between the parent and the intervenor;
- non-stigmatising presentation of intervention;
- cultural awareness/sensitivity;
- flexible settings/hours; and
- crisis help prior to other intervention aims.

The secondary factors include:

- choice of theoretical model;
- choice of timing of intervention;
- choice of location to offer intervention—home, clinic, community location; and
- choice of intervenor—professional, paraprofessional.

As Barnes & Freude-Lagevardi (2003) explain,

.... if a reasonably satisfying therapeutic relationship cannot be established between intervenor and client, then the duration or intensity of an intervention program may be of little consequence. The same applies if the intervention model fails to match the client's needs, when the client is not involved in the decision-making or disagrees with any prescribed program goals/outcomes, when the program is experienced as stigmatising/labelling, when the cultural background of the participant is ignored, when the parent is so overwhelmed by urgent and basic needs that this crisis prevents any focus/engagement with the program content, or simply, when they are prevented from participation due to time and/or location barriers. It appears that these primary factors are predominantly factors of participant perceptions/beliefs, and it is these which may need to be ascertained and addressed when planning or executing any early intervention programs.

A telling illustration of the importance of combining technical, relational and participatory skills comes from a study by Hebbeler and Gerlach-Downie (2002). This took the form of an in-depth analysis of a program that provided monthly home visits to mothers over the first 3 years of the child's life. The study looked at the content of the home visits and the nature of the interaction between the home visitor and the mother in order to understand precisely how the program improved developmental outcomes for children or, alternatively, to explain why it did not.

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In fact, the program was not very effective: there were small and inconsistent effects of participation in the home visiting program on parent knowledge, attitude and behaviour but no overall gains in child development or health. This is despite the fact that the parents were overwhelmingly positive about the program and spoke highly of their relationships with the home visitors.

Analyses of the home visitors' theories of change (i.e. how they understood the program produced results) showed that they saw their prime responsibility as being the provision of social support, and, although they recognised the importance of parent-child relationships, they did little to model or teach the parents better ways of interacting with the children. Even when they did so, the parents did not recognise what they were doing and thought the home visitor was trying to teach the child something. Many parents did not see the importance of duplicating the types of home visitor-child interactions and activities they observed.

The key lesson from Hebbeler and Gerlach-Downie's (2002) study is that, if the goal is to improve outcomes for children, it is not sufficient to provide good relational support to the parents – one must also give the parents actual skills and strategies that will have a direct effect on their children's functioning and participation. And to do this, professionals need both technical skills and participatory skills in addition to relational skills.

Qualities of effective helpers

Another way of understanding professional-parent relationships is in terms of the key qualities needed by professionals to relate well to parents (Blue-Banning et al., 2004; Braun et al., 2006; Davis & Day, 2010; de Boer & Coady, 2007; Gomby, 2005; Horvath, 2001; Scott et al., 2007).

Gomby (2005) makes the case for the importance of the personal qualities of the home visitors themselves in home visiting services:

The success of a home visiting program rides on the shoulders of its home visitors. From the point of view of families, home visitors are the program. They draw families to the program, and they deliver the curriculum. Home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the home visiting curriculum while still responding to family crises that may arise, the problem-solving skills to be able to address issues that families present in the moment when they are presented, and the cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if programs are to be successful.

Selecting the right home visitor is crucial for program success. However, research can provide only limited advice on who makes the best home visitors, and most researchers believe it is not possible at this time to conclude that individuals from

a particular professional or educational discipline are better home visitors than others (Gomby, 2005).

According to Hilton Davis and colleagues (Davis & Day, 2010), the following qualities are needed for effective helping:

- *Respect.* This is the foremost attitude, and refers to the helper trying to suspend judgemental thinking; valuing parents as individuals; thinking positively about them without imposing conditions, and regardless of their problems, status, nationality, values all other personal characteristics.
- *Genuineness.* This involves being open to experience, perceiving it accurately, and not distorting it with defences, personal prejudices and one's own problems. People who are genuine are not acting a part or pretending, deliberately or otherwise. They are real in appearing to be what they are, and are flexible and prepared to change.
- *Humility.* This is closely related to both respect and genuineness. It involves the helper not having an inflated sense of his/her own importance in relation to parents.
- *Empathy.* This refers to a general attempt by the helper to understand the world from the viewpoint of the parents. What is particularly important is that helpers demonstrate their understanding to parents.
- *Personal integrity.* This refers to the capacity of the helper to be strong enough to support those who are vulnerable, to tolerate the anxieties of the helping situation, and take a reasonably independent viewpoint.
- *Quiet enthusiasm.* This involves taking pride in what one does and enjoying that the attempt to do it well for the benefit of parents.
- *Technical knowledge and expertise.* This includes technical or specialist knowledge, service knowledge, and an understanding of the helping process.

Similar qualities appear in the list of indicators of professional behaviour that Blue-Banning et al. (2004) have identified as facilitating collaborative partnerships with parents:

- *Communication:* The quality of communication is positive, understandable, and respectful among all members at all levels of the partnership. The quantity of communication is also at a level to enable efficient and effective coordination and understanding among all members.
- *Commitment:* The members of the partnership share a sense of assurance about (a) each other's devotion and loyalty to the child and family, and (b) each other's belief in the importance of the goals being pursued on behalf of the child and family.

- *Equality*: The members of the partnership feel a sense of equity in decision making and service implementation, and actively work to ensure that all other members of the partnership feel equally powerful in their ability to influence outcomes for children and families
- *Skills*: Members of the partnership perceive that others on the team demonstrate competence, including service providers' ability to fulfil their roles and to demonstrate recommended practice approaches to working with children and families.
- *Trust*: The members of the partnership share a sense of assurance about the reliability or dependability of the character, ability, strength, or truth of the other members of the partnership.
- *Respect*: The members of the partnership regard each other with esteem and demonstrate that esteem in their communications with one another. There is also evidence about what skills and personal factors in therapists influence the likelihood of developing a good therapeutic alliance with the client, leading to improved outcomes (Horvath, 2001). These are:
 - *Communication skills* have a positive impact, e.g. the therapist's ability to convey understanding or the appreciation of the client's phenomenological perspective.
 - *Empathy, openness, and flexibility* are all important, especially in early phases of treatment. When therapists take charge of sessions, the alliance is undermined.
 - *Experience and training* - although research shows that the relationship between the therapist's level of training is not consistently related to the quality of the alliance, it is likely that more highly trained therapists are able to form better alliances with severely impaired clients.
 - *Collaboration* is one of the key features of the alliance concept, and there is some preliminary evidence linking collaboration and better alliance.

Summing up, Horvath (2001) says

The value of an open, flexible stance as opposed to relational control or rigid expectations on the part of the therapist is a consistent theme across much of the literature. The therapists who can complement the client's relational style and are able to demonstrate a capacity to collaborate (e.g., adopt the client's ideas, 'leapfrog' using the client's ideas or expressions) seem to have a better chance of building good alliances. On the other hand, therapists who were seen by clients as rigid or 'cold' were rated as less effective and had poorer alliances.

Scott et al. (2007) reviewed the evidence regarding the elements of effective partnerships with parents, and concluded that the key elements in effective working relationships are the practitioner's empathy, respect, genuineness and optimism (ERGO). Drawing on research on doctor-patient relationships, de Boer &

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Coady (2007) conclude that a good helping relationship is commonly characterized by mutual respect, acceptance, trust, warmth, liking, understanding and collaboration.

Drawing on the evidence from neuroscience and psychotherapy, Cozolino (2002) concludes that the following are important factors in effective psychotherapy:

- *A safe and empathic relationship* establishes an emotional and neurobiological context conducive to the work of neural reorganisation. It serves as a buffer and scaffolding within which a client can better tolerate the stress required for neural reorganisation.
- *Emotion and stress* are important in the process of change because they stimulate the biochemical environment for neural plasticity. Optimal levels of arousal and stress result in increased production of neurotransmitters and neural growth hormones that enhance long-term potentiation, learning, and cortical reorganisation.
- *Language* is important because it allows us to create autobiographical narratives that bridge processing from various neural networks into a cohesive and integrated story of the self. Narratives allow us to combine, in conscious memory, our knowledge, sensations, feelings, and behaviours supporting underlying neural network integration.

Another finding from the psychotherapy field comes from Miller et al. (2008) who identify two features that distinguish highly effective therapists from those who are less effective: they work harder at improving their performance than others, and they constantly seek feedback. What helps them get accurate feedback is a keen 'situational awareness': they are observant, alert and attentive. They compare new information constantly with what they already know, are 'exquisitely attuned to the vicissitudes of client engagement', and are more likely to ask for, and receive negative feedback from clients about the quality of the work and their contribution to the alliance.

All therapists experience incisive moments in their work with clients; times when they are acutely insightful, discerning, even wise. However, such experiences are actually of little consequence in separating the good from the great. Instead, superior performance is found in the margins— the small but consistent difference in the number of times corrective feedback is sought, successfully obtained, and then acted on (Miller et al., 2008).

Most therapists, when asked, report that they routinely seek feedback from their clients, but the evidence suggests that they overestimate or misrepresent how often they really do so. Highly effective therapists, on the other hand, consistently seek client feedback about how the client feels about them and their work together (Miller et al, 2008).

Skills needed for effective helping

There are numerous accounts of what skills are required for professionals to develop effective relationships with parents (e.g. Braun et al., 2006; Davis & Day, 2010; Gilkerson & Ritzler, 2005; Moore & Larkin, 2006). A general account of the skills and practices needed by home visitors has been provided by Klass (2008). Specific accounts of how to work with families of children with additional needs can be found in Cook and Sparks (2008) and McWilliam (2010), while Landy and Menna (2006) describe how to work with vulnerable families.

The draft *National Framework for Universal Child and Family Health Services* (Allen Consulting Group, 2009b) identifies the common core skills and knowledge for those working in this sector as follows:

- Effective communication and engagement with children, young people, their families and carers:
 - skills: listening and building empathy; summarising and explaining; consultation and negotiation;
 - knowledge: how communication works; confidentiality and ethics and; how to engage and work in partnership with communities.
- Child and young person development:
 - skills: observation and judgement, empathy and understanding; and screening, referral , assessment, brief interventions;
 - knowledge: understand context; understand how babies, children and young people develop (that is knowledge of early brain development, the cumulative effects of multiple risk and protective factors and the developmental implications of the interaction between them and knowledge of environmental and resource *factors* that support or undermine the capacity of families to rear young children as they (and society) would wish).
- Safeguarding and promoting the welfare of the child:
 - skills: relate, recognise and take considered action; communication, recording and reporting; personal skills;
 - knowledge: legal and procedural frameworks; wider context of issues; understanding the legal rights of children and families, and the ethical considerations that may arise in working with them.
- Supporting transitions:
 - skills: identify transitions; provide support;
 - knowledge: how children and young people respond; when and how to intervene.

- Multi-agency working:
 - skills: communication and teamwork; assertiveness;
 - knowledge: your role and remit; know how to make queries; procedures and working methods; the law, policies and procedures.
- Sharing information:
 - skills: information handling; clear communication; engagement;
 - knowledge: importance of information sharing; role and responsibilities; awareness of complexities; awareness of legislation.
- Self-knowledge: Understanding one's own personal values, attitudes, qualities and philosophical views and how these impact on work with families and young children.

Gilkerson & Ritzler (2005) propose that the core practice skills needed for effective work with families and others include: the capacity to listen carefully, demonstrate concern and empathy, promote reflection, observe and highlight the parent/child relationship, respect role boundaries, respond thoughtfully in emotionally intense interactions, and understand, regulate, and use one's own feelings. Similarly, Braun et al. (2006) identify the core communication skills of helpers as follows:

- *Active listening/concentration/being attentive* - being able to concentrate completely on the person seeking help is crucial at all stages. It is the basis of actively listening, which involves attempting to understand what the person means, using all our senses.
- *Prompting and exploration* - are the means by which the helper enables the person to talk about the issues that are important to them, and to explore their situation thoroughly. These skills include, for example, asking open questions, not interrupting, and reflecting back what the person is saying.
- *Empathic responding and summarising* - the means by which the helper attempts to show an understanding of what the parent feels, means, or thinks. These are also the ways in which the process of change can be initiated and followed up.
- *Assessing the limits of competence and involvement* - helpers need to be aware of their limits and the limits of their working situation and of their level of involvement.
- *Purpose stating* - consciously making a point of stating the intentions of the helper and making a clear offer of help.
- *Identifying the main message* – listening for the main theme of what is shared in the dialogue, the central message from the parent.

- *Enabling change* - these involve a set of skills that help parents change the ways that they look at situations. This might include providing new information or a different way of looking at the situation. However, attempting to change people may be threatening and therefore one needs to do so in ways that ask permission, endorse the parents' strengths, and invites them to consider situations differently.
- *Negotiating* - these skills must be used explicitly throughout the process to ensure that the parent is in agreement with what is happening, and to resolve potential conflicts. They include beginning with the parent's position, and presenting alternatives with clear explanation.
- *Problem solving* - these skills include prioritising, goal setting, and creatively generating options to be evaluated with the parent.

Based on a synthesis of the best statements of family-centred principles and practice (Moore & Larkin, 2006), the core skills needed to implement family-centred practice effectively are as follows:

- Service providers need well-developed listening and communication skills.
- Service providers need skills to establish and maintain good collaborative relationships with families.
- Service providers need skills in helping parents determine their priorities and clarify their goals.
- Service providers need skills in recognising, acknowledging and helping families build upon their strengths and competencies.
- Service providers need skills in identifying and mobilising social support networks and community resources.
- Service providers need skills in establishing and maintaining good collaborative relationships with other mainstream and specialist child and family services.

There are many direct correspondences between these different accounts. One of the less obvious but nevertheless important elements of effective helping is being able to challenge the person being helped when necessary. According to Heron (1990), confronting others can cause anxiety in the confronter. This anxiety can distort behaviour in two ways, leading either to 'pussyfooting' or 'clobbering', neither of which enable the person being challenged to hear the message. In a similar vein, Furlong (2001) talks about the potential conflict between 'colluding' and 'colliding', that is, between either accepting the world view of clients too easily, or confronting them too fiercely. Effective help-giving involves striking a balance between these extremes and, when appropriate, challenging the client in ways that promote growth.

The skill levels of those working with vulnerable families are also important considerations. Australian reviews of the competencies of nurse home visitors suggest that they do not have all the skills needed for the work they are doing. A review of the Victorian Maternal and Child Health (MCH) Service (KPMG, 2006) found that, at that time, the MCH Service operated in an environment where practice standards were outdated and in need of 'contemporising'. Another review of the competencies of nurses involved in sustained home visiting (Kemp et al., 2005) suggested that they need to develop competencies in three areas:

- enhanced knowledge of child development, social determinants of health, and broader outcomes for individuals and populations;
- advanced skills in fine observation, anticipatory guidance, negotiating, modelling and experimentation, holistic case management, and working in interdisciplinary teams; and
- attitudinal competency for working 'with' and supporting risk taking.

Kemp et al. (2005) also reviewed published statements of Australian child and family nursing competencies and concluded that these do not encompass the different and advanced competencies needed to support the delivery of a comprehensive biopsychosocial model of sustained nurse home visiting for vulnerable and at-risk families.

Training issues

Clearly, working with families is a highly complex process demanding particular personal qualities and considerable skills and there are important implications for staff selection and training.

Gomby (2005) suggests that higher levels of training are probably needed to serve families who are facing multiple, complex issues, or to work in programs with multiple, broad goals or with a curriculum that allows a great deal of flexibility.

Parry (2008) conducted a systematic review of direct evidence about effects of interventions to improve communication performance amongst allied health professionals. Five reports of interventions for these professionals were identified, all of which reported positive effects of training. Interventions based on strong conceptual and empirical foundations and targeting specific areas of practice appeared more effective. Strongest evidence is for performance-based training for clinicians already working with clients.

In the UK, Hilton Davis and colleagues (Davis et al., 2002; Davis and Day, 2010) have developed a training model and program – the Family Partnership Model – for those working with families of children at risk. This training is now widely available in Australia.

In essence, the Family Partnership Model states that:

The outcomes of helping are determined by a set of tasks (the helping process) undertaken together by the client and practitioner in the context of a relationship that is most effective if it is a defined partnership. The process, and hence the outcomes, are determined by the interpersonal skills and personal qualities of the helpers, various client characteristics and their family context, the nature of the service context, and the construction processes that determine the psychological adaptation of all those involved in the helping situation (e.g. clients, family members, practitioners, managers/supervisors) (Davis and Day, 2010).

In this model, practitioner and family must work together to achieve outcomes. This is done by:

- working closely together with active participation and involvement;
- sharing decision-making and recognising each others' expertise;
- sharing and agreeing goals;
- discussing how disagreement will be overcome;
- trusting and respecting each other;
- displaying openness and honesty; and
- communicating clearly.

The Family Partnership Model provides the vehicle for the more effective implementation of the expertise of all practitioners because it takes account of the psychological and social processes involved, as well as the technical solutions. By addressing the psychosocial processes explicitly, the Family Partnership Model enables practitioners to engage parents more effectively, and in so doing provides holistic, family-centred support that promotes their well-being generally and puts them in a much better position to nurture their children.

Supervisory and organisational support

Schmied et al. (2008) argue that in order to enable child and family health nurses to increase their engagement with vulnerable families, additional and ongoing support and consultation will be required. No matter what their skill level, close supervision is needed to help home visitors deal with the emotional stresses of the job and maintain objectivity, prevent drift from program protocols, and provide an opportunity for reflection and professional growth (Gomby et al., 1999).

In the Family Partnership Training model (Davis & Day, 2010), the priority is providing for the development of a relationship, so all aspects of the model – including staff selection and training – are geared towards the development of basic qualities and interpersonal skills. Staff must be supervised in ways that

support them and facilitate their work in order for them to be as effective as possible with parents and to continue to develop (Davis, 2009).

What does effective supervision entail? According to Landy and Menna (2006), there are four main components:

- Supervision is available regularly, relatively frequently and without interruption.
- It is collaborative and supportive and occurs in a respectful interpersonal climate that encourages open discussion of difficult feelings and frustrations.
- It has a sound theoretical base that is accepted and understood within the agency.
- It is reflective and allows staff members supportive opportunities to think about their cases and the ways they are working and to consider other possible approaches.

Organisational support is also important. Scott et al. (2007) reviewed the evidence regarding the elements of effective partnerships with parents, and noted that the worker-parent relationship is embedded within an organisational context which influences the relationship through the nature of the physical setting, its resources, the service role and mandate, and agency climate and morale. Organisations can enhance positive worker-parent partnerships through creating a culture of inquiry and reflection, selecting the right staff, supporting staff through good supervision and training, and giving staff enough time to develop relationships. The worker-parent relationship and the organisation are also embedded in a broader social environment which can facilitate and/or inhibit the potential for positive partnerships. In this respect, culture and class are important dimensions and rural settings have particular challenges and opportunities.

4.3 Implications for service delivery

Given the importance of professional parent relationships, there is a strong case for using a relationship-based approach to service delivery. This approach, originally developed within the infant mental health field (Heffron, 2000; Weston et al., 1997), has increasingly been applied in other services as well, including social work (Ruch, 2005; Ruch et al., 2010) and early childhood intervention (Edelman, 2004; Gilkerson & Ritzler, 2005; King, 2009; Wilcox & Weber, 2001). According to Heffron (2000),

... relationship-based preventive intervention is a way of delivering a variety of services to infants, toddlers, and families that includes a focus on the importance of parent-child interaction, knowledge of how parallel process or how the staff-family relationship influences the family-child relationships, and the deliberate use of the intervenor's self awareness in working with infants and families where relationships are at risk.

This approach seeks to integrate a focus on the parent-child relationship and a focus on the professional-parent relationship. Thus, Ruch (2005) sees the central premise of relationship-based practice as being:

... the emphasis placed on the professional relationship as the medium through which the practitioner can engage with the complexity of an individual's internal and external worlds and intervene. The practitioner-client relationship is recognized to be an important source of information for the practitioner to understand how best to help, and simultaneously this relationship is the means by which any help or intervention is offered.

In a similar vein, Wilcox and Weber (2001) see the primary goal of a relationship-based model for early intervention services as being

... to facilitate optimal parent-child interactions by focusing on individualized parent-professional relationships as the practitioner mirrors the attributes and attitudes that need to be fostered between parent and child. Therefore, early interventionists using this approach should demonstrate more family-centered behaviours and attitudes and in turn, their families should feel more confident and comfortable in supporting their children's development.

This approach builds upon family-centred and strength-based approaches, with the key focus being *responsive caregiving*: 'It is important to remember that we are not in the home to meet the needs of the baby himself; instead we are in the home to try to assure that the baby's needs are met' (Trout, 1987)

Weston et al. (1997) suggest that making relationships central to all that early childhood intervention services do, constitutes a paradigm shift in how such services work, moving us beyond what they call 'additive models of service'. The centrality of relationships acts as a 'unifying principle for theory, service models, program evaluation, and efficacy research' (p. 10). Similarly, Norman-Murch (2005) suggests that there is an emerging understanding of the core knowledge, principles, and practices that are shared by a broad range of professionals who work with young children and their families. This understanding is based on an awareness of the critical importance of early social and emotional development as an organizer of overall development, and on the tremendous impact that caregiver-child relationships have on child development. There is also a growing appreciation of the ways in which the caregiver-professional relationships can either support or interfere with effective service delivery and the ways in which that relationship functions as a form of intervention.

Based upon some of these formulations, Gilkerson and Ritzler (2005) identify the following principles as being central to relationship-based practice:

- Centrality of relationships is reflected in all aspects of the effort.
- Process is as important as content in intervention.
- The development of a respectful, collaborative alliance with families is central.

- Relationships are seen as the organizer of early development, and so focus is placed on supporting parent-child relationship and paying attention to both the parent's experience of the child and child's social-emotional world.
- Knowledge of parallel process-how relationships affect relationships-is essential: how management-staff relationships affect staff-family relationships, how staff-family relationships influence the family-child relationships, etc.
- Development of self-awareness is a professional competency.
- Reflection is encouraged at all levels.

What skills are needed to work in this way? According to Wilcox and Weber (2001), the skills required for relationship-based approaches to early intervention service delivery build upon family-centred and strength-based approaches, and are based upon five practitioner abilities:

- the ability to observe ecologically;
- the ability to form a therapeutic alliance with the family on behalf of the child;
- the ability to be aware of your own values/attitudes and the impact of your interactions with a family;
- the ability to be reflective and strengths-based; and
- the ability to contract and clarify.

Relationship-based practice needs to be distinguished from relationship-focused practice, i.e. services that treat the infant-caregiver relationship as the principle focus of intervention. There is a strong tradition of relationship-focused interventions within the infant mental health and family support fields (e.g. Heinicke et al., 2000, 2001; McDonough, 2004). However, relationship-based practice is a broader concept that recognizes the importance of parent-child interaction, but also takes into account how the relationship between the service provider and the family influences the family-child relationship.

A good example of this approach is the relational goal-oriented model of service delivery to children with physical or mental health difficulties and their families developed by Gillian King (2009). This highlights the importance of six major elements of quality care and management: overarching goals; desired outcomes; fundamental needs; relational processes; approaches, worldviews, and priorities; and strategies by which to bring about desired outcomes. The focus of this model is on *how* services are delivered, rather than the *why* or *what* of service delivery. The core of this approach is an emphasis on relationship and goal orientation: King stresses the role played by supportive and nonjudgmental client-practitioner relationships in enhancing clients' hope, control, and feeling of empowerment over their situations and in fostering the mutuality and cooperation required to achieve client goals. King also highlights the role played by a supportive

organization in maximising practitioners' ability to provide the best quality services.

4.4 Summary and conclusions

This section has focused on the process features of service delivery, addressing two specific questions: do process features of services delivery matter? And, if so, what process features of service delivery are important for effective service delivery?

The key conclusions regarding whether process features of service delivery matter are as follows:

- In general, there is evidence that the *manner* in which support is provided, offered, or obtained influences whether the support has positive, neutral or negative consequences.
- The relationship between practitioners and service users has consistently been identified as a major factor influencing the engagement of parents in mainstream services. The benefits of program services will not be fully realised unless the participant is genuinely engaged. The importance of building an effective relationship with parents is greatest in the case of the most vulnerable families.
- Effective relational practices have the strongest effects on parental satisfaction and parental self-efficacy beliefs, with weaker indirect effects on parental behaviour. Thus, building effective relationships constitutes a necessary but not sufficient condition for changing parenting practices. Services that only deliver relational support do not lead to significant changes in parental care and stimulation of the child.
- Delivering effective services is not enough to ensure attendance and engagement by the neediest parents. Barriers experienced by parents include personal life factors (beliefs, lifestyles and limited resources) and program-specific factors (delivery, content and support arrangements). Unless these are addressed at the same time as direct relationship-based support services are provided, the benefits of the support services will not be sustained.
- Services delivered using principles of family-centred practice and family-centred care have been shown to be effective in increasing parents' sense of parenting confidence and competence, and their empowerment and control over important aspects of their lives. This relationship holds true for families from many cultural backgrounds and for families with a wide variety of demographic characteristics.
- Participatory family-centered help-giving practices that actively involve parents in deciding what knowledge is important to them and how they want

to acquire the information they need, have the greatest positive effect on parents' sense of competence and confidence.

- Services based upon family-strengthening principles and practices have been found to have a range of beneficial outcomes, including positively changing the family environment, improving parent-child relationships, increasing parental support for children's learning at home and at school, and improving outcomes for children and youth.

Conclusions regarding what key process features are central to effective service delivery are as follows:

- Providing social support to parents in response to an indicated need for help is associated with positive consequences, whereas providing social support in the absence of an indicated need for help has negative consequences.
- Key practitioner qualities needed for effective working relationships have been identified. These include empathy, respect, genuineness, humility, personal integrity, optimism, and knowledge.
- Key features of effective working relationships have also been identified. These include working closely together with active participation and involvement, shared decision-making power, complementary expertise, agreement regarding aims and process, mutual trust and respect, openness and honesty, clear communication, understanding and flexibility, and negotiation of all aspects of helping (including the relationship).
- Three elements of effective help-giving/family-centred practice have been identified:
 - *Relational help-giving* includes both help giver interpersonal skills with help receivers, and help giver attitudes about help receivers' capability to become more competent.
 - *Participatory help-giving* includes both help receiver choice and action and help giver responsiveness and flexibility.
 - *Technical quality* includes the knowledge, skills, and competence one possesses as a professional and the expression of this expertise as part of practicing one's craft.
- There appears to be a number of necessary, but not sufficient, factors associated with enhanced early intervention outcomes. They can be divided into primary (threshold) factors that function in an all-or-nothing manner and secondary factors (fine-tuning).
 - Primary factors include: shared decision-making between parent and professional; quality of relationship between the parent and professional; non-stigmatising presentation of intervention; cultural

awareness/sensitivity; flexible settings/hours; and crisis help prior to other intervention aims.

- Secondary factors include: choice of theoretical model; choice of timing of intervention; choice of location to offer intervention—home, clinic, community location; and choice of intervenor—professional, paraprofessional.
- Features of intervention practices known to be essential for effective work with parents have been identified. They include:
 - The relationship between parents and professionals is the most critical factor in determining the success of an intervention.
 - These relationships need to be family-centered, that is, based on a partnership between parents and professionals, with parents making the final decisions regarding the focus of the work and the methods used.
 - Effective service delivery involves the use of capacity-building help-giving practices, whereby the professional helps the parents master and use the behaviours and skills that will benefit their child.
 - Effective services are also non-stigmatising, and demonstrate cultural awareness and sensitivity.
 - Effective services are responsive to family needs and circumstances, and they begin by providing crisis help prior to other intervention aims.

5. Working with vulnerable families

This section draws largely on a number of recent reviews and policy briefs prepared by the Centre for Community Child Health (CCCH, 2010, 2011; Moore, 2009, 2010; Moore & Fry, 2011; Moore, Fry et al., 2011; Moore, Keyes & Sanjeevan, 2011; Moore & Sanjeevan, 2011).

The section begins by summarising changing ideas about disadvantaged and 'hard-to-reach' families, and then explores what makes families vulnerable. The relationships between families and services is considered next: what use vulnerable families make of services, what barriers prevent them from making more use, and what families want from services and service providers. Effective ways of engaging and retaining vulnerable families are described, as are the specific needs of different ethnic and cultural groups, families with complex needs, and families involved with child protection services. Finally, some promising approaches and programs for working vulnerable families are identified.

5.1 Changing ideas about disadvantaged and vulnerable populations

Among those who are the focus of social inclusion initiatives are families who make limited use of available services, sometimes referred to as 'hard to reach' families. Increasingly, the validity of this term has been challenged (Boag-Munroe & Evangelou, 2012; Brackertz & Meredyth, 2008; Landy & Menna, 2006; Slee, 2006; Webster-Stratton, 1998). One problem with the term is the lack of clarity about exactly who or what it refers to (Boag-Munroe & Evangelou, 2012). The term is employed inconsistently, sometimes referring to minority groups (such as the homeless) or to 'hidden populations' (those who do not wish to be found or contacted, such as illicit drug users or gang members). In the service context, 'hard to reach' often refers to the 'underserved', those slipping through the net, who are not known to services or do not wish to use services.

Another problem with the term 'hard to reach' is that it implies that the problem exists in the 'hard to reach' themselves, rather than in the services provided for them (Boag-Munroe & Evangelou, 2012; Landy & Menna, 2006; Slee, 2006; Webster-Stratton, 1998). There is a growing consensus that, rather than thinking about certain sections of the community as being hard to reach, it is more useful to think of them as being people whom services find difficult to engage and retain in their services. As Slee (2006) argues,

In order to achieve improved outcomes for families at risk, a paradigm shift is required, so that unequal outcomes are seen as social injustices, rather than as products of individual dysfunction or deficit.

Similarly, Landy and Menna (2006) suggest that,

... working effectively with families who might be labelled 'hard-to-reach' involves a shift from perceiving the family as being hard-to-reach to thinking about what makes the service that is being offered hard to accept for a particular family' and that working with such families 'involves a shift from providing information to listening and knowing how to respond to particular behaviours.

This new perspective shifts the burden of responsibility from being totally that of those who do not make use of the services available to those who provide the services. Instead of marginalised families being seen as at fault for failing to make full use of the early childhood services that are available, the services themselves might be held to account for failing to reach out to and engage such families effectively. Adopting this perspective is challenging for all parties involved: those seeking to involve marginalised families need to overcome their own prejudices about the people they wish to contact, while at the same time having to work to address the prejudices and preconceptions (often misconceptions) of the families themselves (Brackertz, 2007).

An alternative way of framing the 'disinterest' or 'lack of motivation' often attributed to marginalised groups is to emphasise differences rather than deficits, that is, to act on the assumption that when people are motivated to acquire information and that information is functional in their lives, they will make use of it (Brackertz, 2007).

5.2 What makes families vulnerable

The dramatic economic and social changes that have occurred in developed nations over the past 50 years have significantly altered the conditions under which families are raising young children (Hayes et al., 2010; Moore, 2008; Moore & Skinner, 2010; Richardson & Prior, 2005; Trask, 2010). Many of the recent social and economic changes have been beneficial for most families, but have been accompanied by a widening gap between the rich and the poor. It is this gap, rather than absolute levels of poverty, that is damaging: outcomes for children and families are worse in societies that have steeper social gradients, even when the poorest members of society are above a basic subsistence level (Social Exclusion Task Force, 2007; Friedli, 2009; Wilkinson, 2005; Wilkinson & Pickett, 2009).

For families, the result of the recent social and economic changes has been a widening gap between those who are benefitting and those who are not: families who are relatively well-resourced are better able to meet the challenges posed by changed social conditions, whereas poorly-resourced families can find the heightened demands of contemporary living and parenting overwhelming (Barnes et al., 2006; Gallo & Mathews, 2003).

Gaps in family functioning are cumulative: the more advantaged families are initially, the better they are able to capitalise and build on the enhanced opportunities available, so that the gap between them and those unable to do so progressively widens (Rigney, 2010; Social Exclusion Task Force, 2007). The result is that there has been an increase in the numbers of families with complex needs, and more pockets of intergenerational disadvantage, underachievement and poor health and developmental outcomes (Bromfield et al., 2010).

Why should we be concerned about children and families who are vulnerable? As Landy and Menna (2006) point out, although vulnerable families may only constitute about 8%-10% of all families, children who are members of these families are thought to compose 70% of all children who have mental health problems and adjustment difficulties. A significant percentage of children, as high as 65% in some studies, who have severe difficulties in the early years and do not receive intervention will continue to have ongoing problems in later years. These children and families consume a highly disproportionate percentage of the costs and resources designated for mental health, education services, criminal justice and welfare services.

As with vulnerabilities in children, the usual approach has been to identify families who are vulnerable in terms of risk and protective factors: the more risk factors and the fewer protective factors, the more vulnerable the family, i.e. the more likely the family is to have children with social-emotional and developmental problems.

The factors that make families vulnerable fall into three groups: factors within the parent or parents, factors within the family, and factors in the wider community and society. Based on a range of studies and analyses – including Ghate & Hazel (2002), Jack & Gill (2003), Landy & Menna (2006) and Slee (2006) – the following table summarises the factors that contribute to poor outcomes in families.

Table 3: Types of risk factors that contribute to poor outcome in families

Factors within the parent(s)	Factors within the family	Community, and societal factors
Low level of education	Single teenage parent	Lack of social support/ isolation
Parental mental illness, character disorder, or depression	Low income/food insecurity	Neighbourhood problems and community violence
Parental chronic medical condition	Chronic unemployment	Lack of public transport
Parental intellectual disability	Insecure or inadequate housing	Non-family friendly urban environment
Parental criminal record	Frequent moves	Lack of family-friendly recreational and other facilities
Alcohol and drug abuse	Severe family dysfunction and/or instability	Difficulties in accessing child and family services
Parental background of severe abuse, neglect, or loss in childhood that is unresolved	Violence reported in the family	
Recent life stresses (death, job loss, immigration)	Large family	
Other loss or trauma		

A UK study (Ghate & Hazel, 2002) focused on parents living in poor neighbourhoods and the stressors that made parenting more difficult to cope with. Stressors were grouped at the level of the individual, the family and the community. Many of the stressors were found to occur with much higher frequency for adults in poor neighbourhoods than for adults in the general population, and so point to particular challenges for bringing up children in these environments. Stressors at the level of individual parents and children included: parents with long-term physical health difficulties, parents with emotional and

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mental health problems, and having a child with a long-term physical health problem. Stressors at the level of the family included: having a very low income, having low or no qualifications, having no adult in paid work, poor quality of housing, having a large family, being a lone parent, and having an unsupportive or abusive partner.

Ghate and Hazel also looked at which problems had the greatest impact on coping with parenting. They identified a number of 'priority need' groups – that is, parents whose problems coping suggested they are a particular priority in terms of targeted support – as follows: parents living in the very poorest neighbourhoods, parents on the lowest incomes, lone parents, parents with significant emotional and mental health problems, parents with high levels of current problems, parents with 'difficult' children, parents with accommodation problems, and parents with large families.

It is the cumulative effect of multiple environmental stressors and risks that make families more vulnerable. At all three levels (individual, family and community), parents' problems were multiple, overlapping, and cumulative. So, if parents had problems in one area they almost certainly had problems in other areas of their life, further compounding parenting difficulties. The greater the number of stress factors that were reported by parents, the less likely they were to be 'coping' with parenting.

The key point regarding the factors that make families vulnerable is that the ability of parents to care for their children can be undermined by a whole range of parental, familial and social factors (Ghate & Hazel, 2002; Jack & Gill, 2003; Landy & Menna, 2006; Slee, 2006). The evidence indicates that if these are not addressed, then efforts to help parents with the problems they experience as a result of these factors – such as their inadequate care of their children – are likely to be only partially effective or short-lived.

What is clear is that the capacity of parents to raise their children in ways that they (and we) would wish is compromised by factors beyond their control. Parents do not set out to do a poor job of raising their children, but some end up doing so because of external factors beyond their control. For many of them, these externalities – housing, finances, family violence etc. – are more salient and more stressful than the care and parenting needs of their children (Carbone et al., 2004). A major focus of work with parents, therefore, is to seek to remove (or at least manage and stabilise) these barriers to family functioning and parenting.

5.3 Vulnerable families' use of services

While most families of young children are well supported socially and make good use of services, some do not (Carbone et al., 2004; Moran & Ghate, 2005;

Winkworth et al., 2010). As noted previously, many of these are marginalised and vulnerable families who are receiving little support in their family and parenting roles either from personal support networks or from early childhood and family support services. Children from families who have poor social supports and make limited or no use of early child and family services are at increased risk of poor health and developmental outcomes.

Social support plays an important role in helping parents access services. Usually, parents only access community services such as family centres when they have a recommendation from people in their informal networks, and they are unlikely to go along unless they know someone who is already involved (Barnes et al., 2006). When services are improved through specific initiatives designed to target the most disadvantaged families, it is the relatively well-off who hear about the services and have the resources to actually access them (Katz et al., 2007). Vulnerable families are less likely to use services that they perceive are dominated by more affluent, assertive and confident families (Anning et al., 2007; National Evaluation of Sure Start, 2004; Tunstill et al., 2005).

There are particular challenges faced by some families on low incomes who do not have access to the range of complex and rich social networks enjoyed by more affluent families. The family and neighbourhood networks of financially disadvantaged families, for example, can be conflicted as well as supportive; some studies have shown they may actually undermine access to external social support such as home visitation programs (Barnes et al., 2006). Furthermore, networks of support work best when parents can “reciprocate” the small favours that bind informal social support networks. Parents who do not have sufficient “human capital” to do this tend to be isolated from both formal and informal support and the social capital that is known to aid parents cope with the stresses and demands of raising young children.

The parents in most need tend to be the ones who are least likely to access support (Fram, 2003; Ghate & Hazel, 2002; Offord, 1987). These include families with low incomes, young parent families, sole parent families, Indigenous families, families from culturally and linguistically diverse communities, families with a parent who has a disability, and families experiencing problems with housing, domestic violence, substance abuse, mental health or child protection (Carbone et al., 2004). Many marginalised families experience more than one of these problems.

5.4 Barriers to families using services

The research evidence regarding marginalised and vulnerable families and how best to meet their needs is limited. This is partly because most studies of effective interventions and support services have focused only on their effectiveness for those who actually used them. There are few studies of those who did not make use of services or who dropped out of programs, and we do not

know much about the relative merits of different methods of engaging vulnerable families (Katz et al., 2007).

While research identifies some parental issues that stop them from making use of services, the vast majority of barriers are not of parents' making: parents generally want to receive help if it is appropriate to their needs. In most cases, it appears that retaining families on service rather than them accessing the service in the first place is the key issue: most parents make contact with services, but some then cease attendance, attend infrequently, or do not become fully involved (Carbone et al., 2004).

There are three types of barriers to families making use of services: service level barriers, family level barriers, and interpersonal or relational barriers.

- **Service level (or structural) barriers** include lack of publicity about services, cost of services, limited availability, failure to provide services that meet parents' felt needs, inability of services to respond promptly to requests for help, rigid eligibility criteria, inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, lack of affordable child care, poor coordination between services, and not having an outreach capacity (Attride-Stirling et al., 2001; Carbone et al., 2004; Barlow et al., 2005; Anning et al., 2007; Winkworth et al., 2009).
- **Family level barriers** include limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and beliefs about the necessity and value of services, physical or mental health issues or disability and day-to-day stress (Carbone et al., 2004). Vulnerable parents have to balance competing needs, and sometimes 'survival' needs take priority over attendance at a service.
- **Relational or interpersonal barriers** include beliefs, attitudes and skills that can compromise the ability of service providers to engage families successfully or the ability of parents to seek out and make use of support services (Attride-Stirling et al., 2001; Barlow et al., 2005; Carbone et al., 2004). In the case of service providers, relational barriers include insensitive or judgmental attitudes and behaviours, lack of awareness of cultural sensitivities, poor listening and helping skills, inability to put parents at ease, and failure to acknowledge and build on family strengths and to engage families as partners (Anning et al., 2007; Attride-Stirling et al., 2001; Barlow et al., 2005; Carbone et al., 2004; Watson, 2005; Winkworth et al., 2009).

In the case of parents, relational barriers include lack of trust in services, fear of child protection services, misperceptions of what services offer, lack of the social skills and confidence to negotiate with professionals, and being easily intimidated or put off by perceived attitudes of staff or other parents (Anning et al., 2007; Attride-Stirling et al., 2001; Barlow et al., 2005; Jack et al., 2005; Landy & Menna, 2006; Winkworth et al., 2009).

The formal service system has a culture of its own, and for parents to make good use of it requires them to master the language, roles and values of that culture (Sobo et al., 2006). Most families learn these skills from their parents, but many do not.

Families that move often can find it difficult to access the services they need and maintain continuity of health care (Healy et al., 2009). This has adverse consequences for the development and wellbeing of their children (Jelleyman & Spencer, 2008).

Vulnerable parents have to overcome numerous obstacles and balance competing needs. It is likely that at times, 'survival' needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit) or barriers collectively become overwhelming. Without appropriate advocacy and practical support, some parents will remain unaware of services or unable to use services to their benefit.

5.5 What families want from services

A number of studies have looked at what families want from services and what qualities they value in service providers (e.g. Attridge-Stirling et al., 2001; Ghate & Hazel, 2002; Winkworth et al., 2009).

In a UK study of parents' experiences of the support services available to them, Attridge-Stirling et al. (2001) found that parents wanted to be simultaneously cared for and enabled in their role as parents, and to receive services characterised by empathy, competence and functionality:

- *Empathy.* One of the parents' principal concerns was to feel valued and understood. Parents reported feeling insecure because they did not know what the problem was, what might be the cause of it, or whether they were imagining it or blowing it out of proportion. This uncertainty caused much anxiety which led the parents to doubt their own judgment. As a result, parents perceived a deep need for reassurance that they were not imagining things and that their distress was justified. What parents wanted was an opportunity to talk to a professional who could provide guidance and advice, and who would listen to them and show empathy for their situation.
- *Competence.* Parents wanted to feel capable, competent and empowered. They wanted to overcome the impotence caused by their inability to cope, to learn new ways of managing the difficulties, and to be treated with dignity.
- *Functionality.* Parents wanted services to be both effective and easy to access. They wanted effective and efficient help that would produce positive outcomes and real results, and they wanted competent professionals who knew what they were doing and could provide support and guidance that

actually helped alleviate the difficulties. They also wanted services that were easy to find out about, and physically and procedurally easy to access.

An Australian study by Winkworth et al. (2009) of services to vulnerable families found that they can be important sources of social support if they are respectful, flexible and honest. The study confirms the important role that positive relationships with service providers can play in assisting isolated parents with very young children:

Parents said they engage with services that are 'humanising' – that is, relationships which have respect for their inherent human dignity at their core; they are responsive to people's needs, rather than prescriptive, and they are honest. These qualities are not only the tangible provision of practical assistance, they are also an orientation – a broad minded attitude to service delivery that is genuinely collaborative with the parent. Parents identified a number of practitioners who work this way (Winkworth et al., 2009).

Ghate and Hazel (2002) report a large scale study of parents' experiences of parenting in objectively defined 'poor parenting environments' in the UK. When parents were asked how they wanted family support services delivered, three main themes emerged:

- *Services that allowed parents to feel in control.* Parents defined 'good' support as 'help that nevertheless allowed them to feel "in control" of decisions and what happened to them and their families'. The fear of loss of autonomy was a strong theme, whether parents were discussing informal or organised support, and there is clearly a delicate balance to be struck between 'help' that genuinely supports (or as some would term it, 'empowers') and help that in fact undermines, disempowers and de-skills.
- *Practical, useful services to meet parents' self-defined needs.* Parents set great store by the practical value of services, but often only insofar as they met their own self-defined needs. The implication is that it is important that family support services pay more attention to parents' perception of the support they provide in terms of the manner in which the support is delivered and parents' feelings about how useful and appropriate the service is.
- *Timely service.* Another key principle is that what parents want from support is help when *they* feel they need it, not weeks, months or even years later. (Ghate & Hazel, 2002)

An Australian study of women's expectations and experiences of infant feeding support provided by health professionals in the first six weeks after birth (Sheehan et al., 2009) found that many women found breastfeeding more difficult than they had expected. They reported that the information they received about breastfeeding prior to birth did not prepare them totally for the actual experience, and they looked to the health nurses for support as they learned to breastfeed. From these mothers' perspectives, what appeared to be most

important was that the support they received increased their confidence, whereas poor professional support appeared to contribute to decreasing the women's confidence to breastfeed.

The specific qualities these mothers wanted from professionals were:

- *Acknowledgement and approval.* Mothers wanted their own experiences acknowledged and approved.
- *Honesty.* The majority of women recognised that infant feeding was very individual and that feeding a baby was different for everyone. In contrast to this individuality, many believed breastfeeding was presented by professionals as being the same or parallel for all women that 'it is easy', 'doable' and problems are 'fixable'. Breastfeeding experiences however, were individual. For some women, breastfeeding was relatively straightforward, while for others it was painful and difficult, even traumatic. The effect of not having breastfeeding presented in a realistic and honest way was that they felt it was their fault when things went wrong. The women wanted the reality and variety of breastfeeding experiences to be better explicated.
- *Not being judged.* The mothers did not want to be judged for their difficulties in breastfeeding. Currently, policies and practices appear to be entrenched in the concept that 'breast is best' and focus on the needs of the infant and less on the needs of the women. (Sheehan et al., 2009)

Other findings suggest that parents also want

- *Continuity of care.* The sense of security that comes from having a long-term relationship with the same health practitioner can be highly valued by patients (von Bültzingslöwen et al., 2006). Mothers express lower levels of trust in situations where there is no continuous relationship with any one provider (Sheppard et al., 2004).

Further evidence regarding what forms of support are valued by breastfeeding mothers comes from two metasyntheses of research by McInnes and Chambers (2008) and Schmied et al. (2011).

In the first study (McInnes & Chambers, 2008), one of the key themes that emerged was the importance of relationship between the mother and the health professional. Building a good relationship was important to mothers and the foundation on which postnatal support rests. Mothers were clearly able to identify the supportive health professional as non-judgmental, encouraging, reassuring, sympathetic, patient and understanding. Helpful professionals praised the mother while building her confidence, cared whether or not she breastfed successfully and/or had time to watch and listen. By contrast, unhelpful professionals were described as bossy, judgmental, inaccessible and uncaring, and might project a lack of belief in the mother's ability to breastfeed successfully. They approached

care in a more directive or authoritarian manner, for example, by taking over caring for the baby, giving 'standardized' or prescriptive advice or attributing problems to the mother's anxiety or child's personality. Such a professional may give lots of encouragement to breastfeed without actually providing any practical advice or emotional support. (McInnes & Chambers, 2008)

In the second study, Schmied et al. (2011) conducted a metasynthesis of studies of women's perceptions and experiences of breastfeeding support, either professional or peer, to identify those aspects of support they found supportive. Their synthesis found four major categories forming two continua:

- In one continuum, support for breastfeeding varied from authentic presence at one end, which the parents experienced as effective support, to disconnected encounters at the other, experienced by parents as ineffective or even discouraging and counterproductive. *Authentic presence* involves a trusting relationship or connectedness and rapport between the woman and her caregiver, supporter, or both. Providing an authentic presence helps to ensure that support given is appropriate to the woman's needs and enhances its perceived effectiveness. At the other end of the continuum are *disconnected encounters*, characterized by limited or no relationship and a lack of rapport. This approach seems to inhibit learning, leading to women lacking confidence, and being less likely to sustain breastfeeding.
- In the second continuum, support varied from a facilitative approach (which was experienced as helpful) to a reductionist approach (experienced as unhelpful). A *facilitative style* is a helping approach that helps people draw on a range of information and experience and learn for themselves. The manner in which information, help, and support are offered is critical: the approach is similar to partnership models and to adult-learning or learner-centered approach to learning, and is strongly associated with an authentic presence. Contrary to a facilitative style is a *reductionist approach* or style, which involves a tendency to analyse things into simpler parts or organized systems, and to explain complex things in overly simple ways. When a reductionist approach is used, information and advice tend to be given in a dogmatic or didactic style, and is associated with disconnected encounters. (Schmied et al., 2011)

There is a clear convergence of evidence from these various studies, with the importance of positive relationships between parents and professionals repeatedly emerging as a key theme.

5.6 Effective strategies for engaging and retaining vulnerable families

In reviewing the efficacy of parenting support programs, Moran et al. (2004) note that even the best-designed services may fall at any one of a number of key implementation hurdles:

- the first hurdle is 'getting' parents (persuading parents to attend the service in the first place);
- the second is 'keeping' them (persuading them to attend sessions regularly and complete the course); and
- the third is 'engaging' parents: making it possible for them to engage actively with what the service has to offer (listening, taking part in interactive elements, completing 'home-work' assignments, reading supporting materials etc).

Clearing each of these hurdles requires considerable effort and strategic planning on the part of service providers, yet it is clear that in fact, quite often much more effort and thought goes into designing the content of the intervention than in planning how to deal with implementation challenges. In most cases, it appears 'keeping' the parents on service is the problem, rather than 'getting' them there in the first place, particularly within Maternal and Child Health services, kindergarten and primary schools. Most parents make contact with services, but some might then cease attendance, attend infrequently, or not become fully involved in the services' activities. This failure to retain families on service is a major issue to be addressed.

Based upon analyses of the effective features of community-based intervention services (e.g. CCCH, 2007), a set of best characteristics for working with vulnerable families of various types is described below. There is a general consensus that best practices in engaging vulnerable families include the following features:

- they use strength-based approaches,
- they use solution-focused strategies,
- they use family-centred practices,
- they are culturally responsive,
- they are relationship-based, and
- they provide accessible and family-friendly environments.

As well as the evidence regarding evidence-based programs and evidence-based practices for working directly with parents, there is evidence about effective general strategies for supporting families. These have been summarised by Moran

et al. (2004), Carbone et al. (2004), Ghate & Hazel (2002), Barnes & Freude-Lagevardi (2003), Caspe & Lopez (2006), Sheppard et al. (2004) and Soriano et al. (2008).

Briggs (2006) notes the importance of the personal qualities that the child and family health nurse is required to bring to the relationship with the parent and family. Briggs labelled the phases of the relationship as follows:

- *Entry work.* Entry work is the process of obtaining access to the client and the home. Facilitating factors include the nurse having met the mother antenatally, addressing identified needs or problems and previous positive client experiences with health visitors. Blocking factors included clients' perceptions that the visiting service was not required or if they did not value the service provided.
- *Getting to know the client.* This opens the interaction between the client and the nurse. The aim is for the nurse to identify the position and base beliefs of the client so that suggestions made are compatible with the perceptions and values of the client. Nurses' tolerance of diversity in their clients, acceptance of individual client values and receptiveness to a broad range of perceived needs were important in establishing a relationship.
- *Settling in the relationship.* Three conditions are central to the process of setting up the relationship: (1) legitimacy (convincing the client that the service is of value to them in order to warrant continuing contact); (2) normalcy (compatible views on basic principles and values between the nurse and client); and (3) activity (agreement on how the actions will proceed). The establishment of trust also enables the client to open up and express their needs.
- *Developing mutual trust and creating connectedness.* Jack et al. (2005) found that mothers judged a nurses' trustworthiness according to whether they perceived the nurse as reliable, whether they maintained their confidentiality and were accepting. Those who did not possess the aforementioned qualities were perceived as not interested, bureaucratic or judgmental. Mothers felt more connected when they felt the nurse had experienced similar personal situations to themselves. (Briggs, 2006)

A US study with low-income women (Sheppard et al., 2004) focused on the qualities of patient-provider relationships that were related to the development of trust and adherence to certain protective health behaviours. Factors related to greater trust, specific to patient-provider relationships, were: continuity of the patient-provider relationship, effective communication, demonstration of caring and perceived competence. Women with less trust in their physicians reported an unwillingness to follow his/her advice.

In a Victorian study, Carbone et al. (2004) explored how antenatal and universal early childhood services (MCH services, kindergartens and primary schools) could be made more inclusive. Drawing on the limited empirical evidence and 'practice wisdom', inclusive services need to:

- be affordable and well publicised;
- be geographically accessible;
- provide outreach and support with transport;
- provide a family-friendly and culturally inclusive physical environment;
- employ skilled and responsive staff working from a family-centred, culturally sensitive perspective;
- promote social connectedness through informal supports; and
- establish strong reciprocal links with other relevant services (universal and specialist).

Among the most critical factors is workers' ability to:

- establish a positive, non-judgmental relationship with all children and parents; and
- proactively engage and sensitively follow up vulnerable children and parents who are at risk of 'dropping out'. (Carbone et al., 2004)

Ghate and Hazel's (2002) aforementioned large-scale study of parents' experiences of parenting in objectively defined 'poor parenting environments' in the UK drew a number of conclusions about how services can be most helpful to vulnerable families, including the following:

- *Diversity of forms of support.* There is a need to preserve a diversity of support because people use informal, semi-formal and formal services for different reasons.
- *Role of formal services.* The formal service sector has continuing relevance especially to very vulnerable families.
- *Need for multi-level interventions.* Multiple risk factor situations mean that strategies to address these accumulated and complex situations need to be multi-level to be effective. Support to families in poor environments needs to operate on a number of dimensions, tackling stressors simultaneously at the individual, the family and the community level.
- *Danger of 'negative' support.* The concept of 'negative support' may be very useful in understanding why parents do and do not access different sorts of help and support in parenting. There were strong indications that 'support' is not always perceived in an entirely positive light; there is a fine dividing line between help and interference. Losing control over one's life (and one's

children) was perceived by parents to be a possible consequence of asking for help or support.

- *Helping parents to feel in control.* The best way to support parents in poor environments is to ensure that parents feel in control of the type of support they receive and the way in which it is delivered. External support that appears to undermine parents' autonomy and which steps over the fine line that divides 'help' from 'interference' can end up being experienced as negative rather than positive and may simply add to, rather than relieve, stress. (Ghate & Hazel, 2002)

On the basis of a thorough review of the evidence regarding interventions relevant to the prevention of mental health problems of infants and toddlers, Barnes and Freude-Lagevardi (2003) identify the following strategies and recommendations to optimise engagement of vulnerable families:

Strategies to recruit and re-engage participants

- do not unduly pressure into participation, but offer program entry at a later stage if possible;
- aim for a high profile of the offered/advertised program services in the local community;
- for research trials, make participants aware of the different experimental and control conditions prior to randomisation and offer choices if feasible;
- conduct initial assessments in person, if possible in the participant's home;
- follow-up each failed appointment by reminders in form of telephone, letter, or personal contact to ascertain reasons, to pass on homework and relevant information, and to convey the desire and expectation of meeting the participant at the next session; and
- note down as many contact addresses/telephone numbers as possible, as participants (e.g. teenage mothers) may have mobile living arrangements (e.g. home, relatives' and friends' addresses, shelters, etc).

Strategies to minimise perceptual barriers to participation

- establish a therapeutic alliance, conveying trustworthiness, commitment, confidentiality, empathy, partnership, etc;
- avoid any changes, especially frequent changes, of the assigned personal intervener/therapist as this undermines the formation of a trusting relationship;
- do not mislead/disappoint participants by promises you cannot keep;
- involve the participants in decision-making relating to therapeutic aims/goals etc. (e.g. find out what participants want, need, expect, and understand);

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- and adopt a non-judgemental, non-threatening, non-expert approach (e.g. avoid the “I know what’s best for you” stance) by acknowledging that parents are the experts of their own life and children and have coped to their best ability; however, note that some clients may prefer a confident, directive style, if they feel too overwhelmed to make any contributions of their own or if they perceive self-participation as weakness or incompetence on behalf of the therapist;
- consider the cognitive ability of the participant when communicating (e.g. style of language, terminology, repetitions, rephrasing);
- examine whether program advertising and attendance is stigmatising in the eyes of participants or the local community;
- adopt a culturally and ethnically aware approach in terms of issues, customs, ethnic background of interveners and communication (e.g. interpreters);
- provide a coherent and transparent case-management approach that links therapeutic, health, social and educational services, thereby minimising bureaucracy, confusion and communication failures or lengthy waiting times; an
- train, support and supervise interveners and researchers sufficiently to be able to cope safely and effectively with the client problems and resistance they encounter.

Strategies to minimise structural barriers to participation

- reward participants in form of money, gifts, vouchers etc. for attendance of sessions or research assessments;
- provide free transport to sessions or ensure that the therapeutic base is in a central, convenient location;
- provide flexible timetables or opening hours (e.g. including evenings and weekends) that also enable working parents and fathers to attend;
- conduct home visits for participants’ convenience or to gain further insights into the clients’ life circumstances;
- provide an inviting, comfortable environment;
- provide childcare facilities if the child(ren) or siblings are not to be involved in the sessions;
- provide attractive meals and snacks on the premises or other useful services (e.g. laundry or nearly new toys, furniture and clothes exchange facilities); and

- provide crisis intervention, e.g. referral or backup services related to housing, health, financial difficulties, partner violence or other problems. (Barnes & Freude-Lagevardi, 2003)

Caspe and Lopez (2006) examined a sample of family-strengthening intervention programs that provide support to parents and seek to change family behaviours and environments to encourage healthy child development. The programs reviewed had a positive impact on four main parenting processes: family environment, parent-child relationships, parenting, and family involvement in learning in the home and at school. In addition, family-strengthening programs, as part of larger comprehensive intervention programs, were shown to improve child outcomes.

Soriano et al (2008) analysed 57 Australian intervention programs that had been designated as demonstrating 'promising practice'. While the programs varied in terms of objectives, duration and intensity, and were delivered through a variety of program modalities, a number of common, transferable features appear to have worked in a variety of contexts and for a wide spectrum of target populations:

- *Safe, comfortable, non-stigmatising venues.* Programs repeatedly highlighted the importance of a welcoming, informal and safe environment.
- *Multiple, intensive, targeted recruitment and retention strategies for hard-to-reach populations.* Multiple recruitment strategies are needed to engage hard-to-reach populations, such as CALD individuals and families, young parents, fathers, Indigenous families and families with complex and multiple needs. The recruitment practices targeting hard-to-reach populations in this collection are a combination of both formal (e.g. approaching community leaders, other community organisations, advertising in local newspapers) and informal methods (e.g. door knocks, distributing flyers at shopping centres, chemists, community events, advertising in shopfronts, etc.).
- For practices dealing with young parents, intensive and targeted recruitment processes are employed, involving home visits, personal approach, follow-up and individual, one-to-one support. Using peer educators and experienced/mature mentors are also effective in retaining young parents in the programs, together with using less structured programs and welcoming spaces (which also works with Indigenous and socially isolated families).
- Among the socially excluded (young parents, parents with multiple needs and parents from highly disadvantaged communities), a facilitation approach that gives clients a voice in program activities and outcomes, empowers the parents and enhances program commitment. This approach ensures that the activities within the program respond to the needs and priorities of the families. Responding to the multiple needs of parents (in particular young parents) through parent education, home visiting and support, and connecting

families to services (e.g., child care, education, etc.) produces positive outcomes.

- *Soft entry points.* Universal services are widely used to provide an important soft entry point of first contact, where parents can access support to more specialised services. Attaching targeted services to other, universally available services – such as schools, maternal and child health centres, churches, libraries and health clinics – is effective in engaging and working with hard-to-reach populations.
- *Culturally specific approaches.* In order to be responsive to the needs of CALD and Indigenous families, service users are matched with staff/volunteers from similar cultural backgrounds.
- *Interagency and intersectoral collaboration and cooperation.* A whole-of-community approach that builds on existing services within the local community optimises the use of institutional and human resources within the community.
- *Active assistance with access.* Lack of access to services imposed by distance and lack of transport is addressed by some programs through outreach services, using multimedia technologies to meet the needs of children with additional needs living in rural and remote areas, providing transport, implementing a hub-and-spoke approach to service delivery and through the establishment of learning hubs to deliver more specialised services.
- *Building relationships and establishing trust.* A recurring theme was the importance of relationship-building and rapport between workers and clients, which is thought to emanate from a strengths-based practice approach. An integral component of relationship building is trust. The cultivation of trust was acknowledged to be one (if not the key) ingredient to program effectiveness across the programs. Offering practical support that responds to parents' most immediate needs is essential in winning and establishing trust and retaining contact with these families. Individual support offered during home visits is an essential ingredient in trust-building, particularly for Indigenous young mothers.
- *Mentoring.* Several programs show how mentoring helps to achieve positive outcomes with various client groups, such as “at-risk” youth, young parents and isolated parents.
- *A graduated approach.* A graduated approach to intervention that increases demands and expectations appears to work well to engage and retain involvement among hard-to-reach groups. While the initial focus may be practical issues (e.g., budgeting, hobbies, cooking, nutrition) or providing social activities and establishing formal and informal support networks, more sensitive or intractable issues such as child disability or developmental delay,

parent mental health problems and reengagement in education or the workforce, are addressed at a later stage.

- *Involving the wider community.* The local community is a fount of potential resources to be tapped, enhanced or developed. Practices show that local business leaders, school teachers, police officers, other workers and the “grey force” can be tapped as mentors, and parents can be trained and skilled up as volunteers or peer mentors.
- *Trained, committed and reflective staff.* Client feedback suggests that a committed worker is absolutely essential for retaining program participants and in achieving program objectives. Organisational practices that use explicit action/reflection processes – as well as training and ongoing professional development initiatives that enhance the capacities of their workers – are essential to keep staff focused on the program vision. (Soriano et al., 2008)

The importance of early childhood services being both accessible and family-friendly is well recognised (Katz et al., 2007; Moore, 2001; Weeks, 2004). A review of the barriers to families accessing mainstream services by Katz et al. (2007) found there were both physical and practical barriers. These included lack of knowledge of local services and how they could help, problems in physically accessing services (because of lack of safe and affordable transport), and services whose geographical location precludes easy access by some families (some disadvantaged areas do not have local services).

Another review (Weeks, 2004) focused on the importance of the physical environment in service delivery, and what it can teach us about creating services that are comfortable, safe, friendly and attractive for people who are facing family difficulties to attend. On the basis of this review, Weeks proposed the following nine principles as a basis for achieving user-friendly services:

- *Accessibility.* First, location is a key factor in making family services accessible. Accessibility is a key principle and includes geographical, physical and psychological accessibility. *Geographic access* refers to locations which are readily reached, for example, through proximity to public transport. *Physical access* refers to the capacity to enter the building, for example, in a wheelchair, or if aged or disabled and walking with a stick. This implies the unsuitability of stairs and steps, and also requires wheelchair accessible curbs around the building and toilets and rooms internally. *Psychological access* refers to an absence of features which might stimulate stigma or, as in the case of security guards, a sense of fear about the entry.
- *A 'neutral' doorway.* Second is the provision of a 'neutral' doorway. The term 'neutral' means an entry which is non-stigmatising. The overall principle refers to the physical way a service is presented and located within the community.

- *A welcoming entry.* Third is a principle of providing welcoming entry. A 'neutral doorway' is one step in a 'welcoming entry', however, a welcoming entry is put forward as a separate principle because it refers to the full experience of entry: ease of access; presentation of the waiting room; and practices of reception. The reception or waiting area is often the first point of contact and is as important as the telephone manner for first-contact telephone calls.
- *The provision of information.* Fourth is the principle of provision of information on services and resources, which might be readily available in the waiting area. This can be more or less developed, depending on the service delivery philosophy.
- *Cultural diversity.* Fifth is a principle of cultural diversity in environmental design. Racism and ignorance about the cultural practices of others is reflected and embedded in individual workers' practices, as well as systemic arrangements. This principle can refer to minority ethnic groups' experiences, as well as indigenous experience.
- *Availability of outdoor space.* Sixth, the availability of outdoor space is considered to be an important principle, following from the research on the effect of the physical environment. Finding beautiful and peaceful outdoor areas can promote a sense of well-being and welcoming. Aboriginal people particularly value outdoor space, and a sitting area with trees and shrubs is used by people waiting, having a smoke, or just sitting in the beauty of the garden area. Family and women's services might include an outdoor children's playground, to assist young family members to have fun and feel at home.
- *Safety.* Seventh, safety is an issue which provides a challenge if one is not to resort to security guards and electronic barriers. One entry gate and door is necessary, and reception staff require a mechanism, such as a counter bell or buzzer, to alert others to assist in the event of a violent incident. Reception staff may need a call system to local police as extra protection. Services also need a safe place for locked records.
- *Community and group work space.* The eighth element is available community and group work space. Associated with the principle of service user participation, services need meeting space and open space for activity sessions, community meetings and lunches, and space in which to run groups. Opportunities for community food sharing can assist participation. Using the service as a site for community meetings increases community ownership, an essential precursor to citizens feeling that this service belongs to them.
- *Co-location of services.* The ninth principle, co-location, is not necessary for the welcoming and friendly nature of services, but is an essential element of

the framework proposed. Co-location of interrelated services can be a very useful resource to service users, without the difficulties of amalgamation of services. It is particularly relevant for family services. To maximise the availability and accessibility of such knowledge to service users, this collected knowledge and experience can be made available at one site. (Weeks, 2004)

The building of a relationship with the parent is of great importance in the case of the most vulnerable families. Such parents feel particularly vulnerable and powerless when they allow service providers into their home. Jack et al. (2005) suggest that these parents engage with public health nurses and family visitors through a basic social process of limiting family vulnerability, which has three phases: overcoming fear, building trust, and seeking mutuality. The personal characteristics, values, experiences and actions of the nurse and the mother determine the time it takes to negotiate each phase and ultimately to develop a connected relationship. Given the importance that mothers place on the development of an interpersonal relationship, it is important for home visitors continually to assess the quality of their relationships with clients.

5.7 Needs of different ethnic and cultural groups

Indigenous children and their families

First and foremost, it is noted that the needs and expectations of Indigenous children and families vary widely according to their community of origin and their current circumstances.

A recent review of research evidence regarding the school readiness of Indigenous Australian children (McTurk et al., 2008) found no research evidence specifically concerned with defining components of the readiness of services for schooling of Indigenous children. The sources summarised below represent evidence-informed expert opinion on what can be done to engage Indigenous children and families in early childhood services.

Shepherd and Walker (2008) discuss what is known about how to engage Indigenous families in preparing children for school. They report that there are high levels of vulnerability in the Indigenous population across a range of areas of development, and that these are evident from the early years of life. For many of these children, this early vulnerability will compromise their ability to do well at school and their opportunities later in life. At the same time, there is evidence that the many strengths in Indigenous children, parents, extended families and communities are often ignored by inappropriate interventions and by inexperienced (albeit well intentioned) practitioners.

Shepherd and Walker identify a number of guiding principles to implementation of effective programs, services and policies:

- Ensure Indigenous participation and consultation in all stages of a program or intervention.
- Build the capacity of parents and families wherever possible.
- Acknowledge and respect different learning styles.
- Recognise and respect Indigenous peoples and cultures.

In addition, practitioners need to systematically record the outcomes and process to identify what program elements are working and why. The practice wisdom identifies that some of the key elements of strategies to engage Indigenous families include:

- guiding relationships;
- strengths-based approaches as opposed to focusing on needs or problems;
- building in time for evaluation, to measure how effective programs have been in achieving outcomes;
- producing high quality programs requires staff with training and qualifications in Early Child Development and cross cultural competence;
- incorporating early learning and literacy programs that simultaneously target both parents and children (facilitating dual or trans-generational and community learning); and
- providing a culturally inclusive space, where possible. (Shepherd & Walker, 2008)

Daly and Smith (2003) propose an 'asset model' that emphasises the importance of 'Indigenous children's inclusion and participation within their own culturally-based family, social and economic systems.' This is based on the idea that social or economic exclusion may actively undermine Indigenous families' own capacity to reproduce culturally valued relationships and roles. If that is the case, social and cultural wellbeing may be linked to breaking the cycle of inter-generational welfare dependency and economic exclusion. For early childhood services, this highlights the importance of supporting for culturally valued relationships and roles.

Sims et al. (2008) argue that services have the potential to make a huge impact on our society and that Indigenous children need services that support a strong cultural identity to enable them to move into the schooling system and experience success. Services need to be accessible to, and reflect the needs of local communities, families and children. The emphasis is on engagement with the local community to reflect the communities' unique culture in program planning and this means that services in different communities will look quite different.

Sims et al provide case studies of culturally targeted services that share common characteristics to achieve success for their local communities, these include:

- The services are holistic, addressing a range of needs including health and wellbeing, education, employment and training, housing, social security and cultural heritage.
- The services include parents and offer play, learning and health opportunities.
- The services are delivered by carers with high levels of trust with families – the most effective carers are often embedded within the community.
- In order to embed services in communities, members of the community are involved in service governance.

Culturally and Linguistically Diverse (CALD) families

Several accounts of how to engage families from CALD backgrounds effectively have been developed, both in the US (Barrera et al., 2003; Kalyanpur & Harry, 1999; Ontai & Mastergeorge, 2006), and in Australia (Hayden et al., 2004; Sawrikar & Katz, 2008).

According to Barrera et al. (2003), in interactions across diverse cultural parameters, three qualities are central to determining whether interactions can be described as skilled or unskilled: respect, reciprocity, and responsiveness.

- *Respect* refers to an acknowledgment and acceptance of the boundaries that exist between persons.
- *Reciprocity* refers to the balance of power between persons in dialogue, and is based on the recognition that each person in an interaction is equally capable.
- *Responsiveness* involves a deep respect for the uniqueness of others, and an openness to allowing them to be who they are, rather than shaping them into who we want or need them to be.

Barrera et al describe a model – Skilled Dialogue - for interacting with others that helps practitioners better approach the challenges posed by cultural diversity and improve their relationships with families. Two skills are essential to using Skilled Dialogue:

- *anchored understanding of diversity* - the understanding of differences that is both experiential (stemming from personal interactions and hands-on experiences) and cognitive (others behaviours make as much sense as one's own); and
- *3rd Space* - creatively reframing contradictions into paradoxes, to adopt a mindset that integrates the complementary aspects of diverse values, behaviours, and beliefs into a new whole. (Barrera et al., 2003)

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Another account of how to engage CALD families is provided by Kalyanpur and Harry (1999). They maintain that cultural awareness needs to go beyond the mere acknowledgment of what is often no more than stereotypical characteristics about particular communities. Instead, it requires professionals to go through a process of introspection and inquiry about their underlying assumptions, and to confront the contradictions between their values and practices:

Awareness of cultural differences provides merely the scaffolding for building collaborative relationships. Knowledge of the underlying belief and value that bring about the difference in perspective provides the reinforcing strength to the relationship.

Kalyanpur and Harry propose that there are three levels of cultural awareness:

- *Overt awareness* is the awareness of obvious differences, such as language or manner of dress. These differences are usually easy to recognise and therefore make allowances for. However, this does not necessarily allow for families' varying levels of acculturation, nor does it empower the families involved.
- *Covert awareness* involves an awareness of differences that cannot be recognized by outward signs, such as parameters of status or interpersonal communicative styles that require sustained contact or observation before becoming apparent. Although this level of understanding can help professionals become more sensitive to and accepting of differences, the effect is still limited because professionals may either not seek an explanation for the behaviour, or may find an explanation that makes sense to them but does not make sense to the families.
- *Subtle awareness* involves the recognition of embedded values and beliefs that underlie our actions and the awareness that these beliefs, which we have hitherto taken for granted and assumed to be universal, are, in fact, specific to our culture.

To promote this level of understanding, Kalyanpur and Harry recommend adopting 'a posture of cultural reciprocity'. Key features of the posture of cultural reciprocity:

- It goes beyond awareness of differences in self-awareness, requiring a constant awareness of self and others, and a nonjudgmental attitude towards others' worldviews.
- It aims for subtle levels of awareness of difference, not simply awareness of obvious cultural differences.
- It has universal applicability in that the basic underlying construct – that communication involves listening to and respecting both perspectives – applies to all interactions.

- It avoids stereotyping, instead treating each situation and encounter as unique.
- It ensures that parents and professionals are both empowered, enabling both parties to engage in a dialogue whereby each learns from the other.

Kalyanpur and Harry identify four steps of the posture of cultural reciprocity:

1. Identify the cultural values that are embedded in the professional interpretation of child's difficulties or the recommended course of action.
2. Find out whether the family being served recognizes and values these assumptions and, if not, how their view differs from that of the professional.
3. Acknowledge and give explicit respect to any cultural differences identified, and fully explain the cultural basis of the professional assumption.
4. Through discussion and elaboration, set about determining the most effective way of adapting professional interpretations or recommendations to the value system of this family.

Implementing the posture of cultural reciprocity is not easy, with the biggest barrier being time. However, time must be made:

The posture of cultural reciprocity cannot be seen as a bag of tricks to be pulled out during situations of conflict or in emergencies but almost as a value that is internalized and applied to all contexts. If we seek to understand ourselves and the families whom we serve at every interaction, however small, then the task will seem less onerous. (Kalyanpur & Harry, 1999)

These same authors suggest that another barrier is the mistaken belief that only professionals from minority cultures can work with families from minority cultures. There is no evidence that professionals who do belong to the same culture as their clients are any more successful at accomplishing collaborative relationships than those who do not. On the contrary, there is evidence that the best examples of collaborative relationships can occur with professionals who have little or no affiliation with culture of the families:

The issue is not that we must have the same experiences in terms of culture, ethnic background, race, socioeconomic status, or gender as the families we serve – because we cannot – but that we have the willingness to learn about and understand their experiences, that we are willing to understand their experiences, that we are willing to understand how our own experiences have shaped us, and that we respect and accept these differences in our various experiences. (Kalyanpur and Harry, 1999)

Ontai and Mastergeorge (2006) have developed a guide for practitioners to evaluate the cultural sensitivity of programs and services they offer to families, and to provide guidance on how to make a parenting program more culturally sensitive. Child-rearing topics covered include: communication, discipline, parent-child emotional bonding, family structures and roles, gender role development,

play, and sleeping arrangements. The guide provides research findings, tips for professionals, and a cultural sensitivity checklist for each topic.

An Australian resource to promote culturally sensitive practice has been developed by Hayden et al. (2004). This takes the form of a handbook to assist staff in early childhood services facilitate partnerships, networks, goodwill and trust relationships for both staff and families from CALD backgrounds. All strategies in this handbook were developed and tested with CALD families in early childhood services in the South West region of Sydney. Several noteworthy findings emerged from this work:

- *Many CALD families would like to participate in early childhood services but may be unclear about how to do this.* Some CALD families believe that they are not welcome as participants in the service and some families reported that they lacked the confidence to offer their skills to the service. When families understood their role and the expectations of the early childhood service, CALD families were very pleased to share their skills, knowledge base and time with the service.
- *Translating information into home languages is usually an effective means for communicating with families from CALD backgrounds, but some caution is advised.* Even with nationally accredited translations, it is sometimes difficult to develop documents with the correct tone and wording for families. A trusted individual who knows the language (perhaps a family member from the service) should check all translated documents before they are handed out to families. Other important points regarding translation are as follows:
 - Some home spoken languages are not the same languages which are used for reading and writing. Services should check with families to find out what language they read or write.
 - Some CALD families actually prefer to receive their written information in English. This should be checked before handing out translated documents.
 - CALD families often appreciate the effort made when staff or a service client is used as a translator/interpreter. Access to this service through the early childhood setting, rather than through external agencies, is appreciated and tends to facilitate increased communication on a regular basis.
- Despite the common assumption that families from CALD backgrounds have a lot of support from extended families and/or from their communities, many CALD families do not have support from relatives and/or close friends. Many CALD families are in Australia without relatives and close friends. Also, CALD families report that it is common for one family member to be working very long hours while the 'stay at home' family member (usually the mother) is left

to make decisions about their children with little input or opportunity for discussion.

Hayden et al identify five steps for facilitating partnerships and networks with CALD families. The steps are:

1. plan: identify goals for facilitating partnerships, communication and networking;
2. recruit a 'Family Representative';
3. assess current communication strategies in the service;
4. develop and implement 'Action Plans'; and
5. assess the program and re-commence the planning cycle (Hayden et al., 2004)

Sawrikar and Katz (2008) have developed a practice and policy framework that can be used to help overcome inequities in access to or culturally inappropriate service delivery of family relationship services for CALD families in Australia. They begin by identifying a number of barriers to equal access and use of services that may be perceived or experienced by ethnic minority families. These can be divided into three types:

- Cultural barriers
 - language barriers: English proficiency, professional jargon and misinterpretation of body language;
 - cultural norms that prohibit seeking extra-familial support, especially for women and children;
 - traditional gender roles that prevent men from engaging with services or discussing family difficulties; and
 - fear of authorities, such as child protection, police, courts, taxation, immigration and housing departments (although not strictly speaking a cultural barrier, it is a barrier that CALD families may face).
- Structural barriers
 - practical barriers accessing services; and
 - lack of knowledge or understanding of services that are available.
- Service-related barriers
 - model of service is culturally inappropriate;
 - service not perceived as relevant due to lack of cultural diversity in the workforce and marketing of services;

- service choice perceived as limited due to lack of cultural diversity in the workforce; and
- reluctance to engage with services because of concern they will not be understood, or that they will be stereotyped or judged.

In addition to the barriers experienced by CALD families themselves, there are also various barriers to equal access and use of services that may be perceived or experienced by service providers and practitioners who deliver services to CALD families. These include:

- lack of awareness or confidence to address the needs of CALD families;
- practice that is not culturally competent;
- lack of adequate resources;
- institutional racism; and
- lack of awareness and partnering with CALD-focused organisations in the local community. (Sawrikar & Katz, 2008)

Based on the barriers outlined above and drawing on an earlier analysis of service barriers by Katz et al. (2007), Sawrikar and Katz make a number of recommendations for enhancing service accessibility and delivery to CALD families have been identified.

- *Improve the overall quality of the service.* High-quality, well-resourced services with dedicated, well-trained and well-supported staff are the basic ingredients for accessible services. Practices that encourage diversity, client participation and good worker–client relationships will benefit *all* clients, not only CALD families. Indeed, the Australian-born population is itself very diverse, and these policies and practices will impact equally on them.
- *Implement equal employment opportunity and multicultural policies to increase recruitment of CALD staff.* If possible, recruitment should reflect the local ethnic mix in the community.
- *Collect data on factors that measure or assess culture,* such as the country of birth of family members, their year of arrival in Australia, main language(s) spoken at home, and their self-rated cultural identity. This will allow the service outlet to monitor the size of (in)equity of access to and use of services, especially across the different types of services that the outlet offers.
- *Market and promote services to increase awareness of them, and their perceived relevance, to CALD and ethnic minority families.* This can occur through local community networks, such as newsletters, local businesses, religious and community groups, and should be translated or indicate that translated versions are available. The cultural diversity of the staff profile

should be indicated and pictures of ethnic minority families should be included.

- *Service providers and practitioners in the outlet should receive training in cultural competency* to become aware of:
 - cultural norms, values, beliefs and practices typical of a CALD group;
 - the need to pay attention to individual variation within a cultural group in order to avoid stereotyping or homogenising the needs of all ethnic minority families and misattributing problematic behaviours to culture or culture to problematic behaviours; and
 - differences in cultural norms between themselves and their client family to avoid judging behaviours as deviations from their own cultural norms rather than as deviations from the cultural norms of the CALD family.
- *Consider practical issues*, such as the physical locality of the service, the layout of the rooms, opening times, staff profile and links between different services. This may be relevant for enhancing service accessibility and delivery to *all* families, not just those from a CALD background.
- *Partner with other CALD-focused centres or organisations in the local community* to receive support through networks; advice and consultation on appropriate service delivery; clear referral pathways for CALD families; language services; cultural awareness training; and provision of more holistic support for CALD families by building the CALD capacity of the service outlet; that is, the service outlet will be better able to respond to the needs of their CALD families because of the collective knowledge, experience and support of a culturally diverse and competent workforce. (Sawrikar & Katz, 2008)

Refugee families

Refugee families face all of the problems that other CALD families face, but are particularly vulnerable in other ways, including:

- **loss or trauma:** a significant proportion of people from a refugee background have experienced severe trauma (Arney & Scott, 2010; NSW Refugee Health Service & STARTTS, 2004). Parents who are victims of or witnesses to acts of violence can find it difficult to be emotionally available and responsive to their children (Jackson, 2006).
- **severe family instability:** Families may have been separated. A parent (or parents) or siblings may be in another country or their location unknown (Arney & Scott, 2010).

- low income/food insecurity: many recent humanitarian arrival families experience poverty in Australia (Lewig et al, 2009).
- violence reported in the family: domestic violence has been identified as one of the leading type of incidents leading to child protection notifications amongst refugee families in South Australia. This suggests that for those refugee families where child abuse is occurring, family violence is a common feature (Lewig et al, 2009).
- chronic unemployment: newly arrived refugees in Australia have higher unemployment rates than the community average (Australian Childhood Foundation, 2011). Recently arrive refugees are often employed in low-paid, low status positions such as cleaning and labouring (Arney & Scott, 2010).
- difficulties in accessing child and family services: the barriers that make it difficult for vulnerable families to engage with services may be especially prominent amongst refugee families. For example, refugee families may be especially wary of government services as a result of persecution in their home country (NSW Refugee Health Service & STARTTS, 2004; Arney & Scott, 2010).
- social isolation: recently arrived refugee families are especially vulnerable to social isolation because of the severing of family ties as a result of war, persecution and forced migration (NSW Refugee Health Service & STARTTS, 2004; Arney & Scott, 2010). Adding to the impacts of separation from family, when they are in Australia refugee families may be less likely to form supportive social relationships because they have difficulties trusting people (NSW Refugee Health Service & STARTTS, 2004).

Although recent humanitarian arrivals to Australia are likely to be experiencing multiple risk factors, some families from a refugee background will adapt relatively quickly to life in Australia. Lewig et al (2009) notes that refugees from middle-class backgrounds and urban environments are more likely to have the skills to navigate an urban environment, deal with bureaucracies and obtain employment.

There is a lack of published literature regarding best practice for professionals who work with children and families from refugee backgrounds as a means of strengthening family functioning (Arney & Scott, 2010). However, some specific issues that are important to consider in regards to engaging recently arrived refugee families are:

- trust: families from refugee backgrounds may fear government authorities (or any other service they view as an 'authority') hence it is important for service providers to explain to these families that they are there to help (Arney & Scott, 2010; NSW Refugee Health Service & STARTTS, 2004).

- interpreters: families may be reluctant to trust interpreters, especially interpreters from their own community. It is important to ask families if they have any preferences in regards to interpreters, such as gender, ethnicity or religion (NSW Refugee Health Service & STARTTS, 2004).
- consultation: Families from refugee backgrounds may have had poor experiences of consultation, where no change occurred as a result of consultation, which may make them reluctant to become involved in consultation processes in Australia. They may be sceptical about the concept of consultation and believe that no change will occur (Australian Childhood Foundation, 2011).
- confidentiality: families from refugee backgrounds may be unfamiliar with the concept of confidentiality and this may need to be explained. It is important to note that publicly identifying refugees could put any family members who remain in their home country in danger therefore service providers need to ask for permission before any identifiable information about refugees is made available publicly (NSW Refugee Service & STARTTS, 2004).
- sensitivity to circumstances: Service providers should avoid asking refugees to repeat traumatic stories (NSW Refugee Service & STARTTS, 2004). Form filling should be undertaken sensitively and gradually otherwise families may experience the process as interrogator). It is important to be sensitive when asking about family composition – husbands, wives and partners may have been separated by war, parents may have more biological children than those currently living in Australia).
- background: refugees may not want to identify as such hence service providers need to be aware of the countries where recently arrived refugees are coming from so they can ask about families' circumstances in a sensitive way (NSW Refugee Service and STARTTS, 2004).
- vicarious trauma and burn-out: service providers who work with refugees may be especially vulnerable to vicarious trauma and burn-out. It is important that appropriate support and supervision is in place for practitioners who work with refugees (NSW Refugee Service & STARTTS, 2004).
- the service environment: service providers should not make clients from refugee backgrounds wait for extended periods of time as this is a tactic used by torturers to intimidate and unsettle people. Similarly, service providers should avoid the use of small, closed-in spaces or rooms with barred windows (NSW Refugee Service & STARTTS, 2004, 2004).
- the changed role of children: recently arrived refugees may have different views and experiences of the role of children in the family. In their country of origin, there may be an expectation that children will remain at home until they get married and will not challenge or question their parents decisions.

Parents may experience the changed role of children in their families as a loss, representing a break from cultural traditions (Arney & Scott, 2010).

- confusion regarding the role of parents: recently arrived refugees may be confused about Australian laws and cultural norms about parenting. Parents may feel as if their rights as parents are undermined by schools because of the focus within Australian schools upon encouraging independence (Arney & Scott, 2010).

5.8 Families with multiple and complex needs

The concepts of 'complex' and 'multiple' needs are used by various disciplines and service sectors in a variety of ways (Rosengard et al. (2007). According to Rankin and Regan (2004), complex needs can be best understood as involving both *breadth of need* (more than one need, with multiple needs interconnected) and *depth of need* (profound, severe, serious or intense needs). Additionally, they suggest that the term 'complex needs' can be used as 'a framework for understanding multiple, interlocking needs that span health and social issues'.

A very wide range of people were identified as having multiple and complex needs (Rosengard et al., 2007). These included people:

- with mental health problems, including 'severe and lasting' problems;
- disadvantaged by age and transitions – young and older people;
- fleeing abuse and violence – mainly women and refugees;
- who are culturally and circumstantially disadvantaged or excluded – minority ethnic groups; travelling people;
- with a disability, including profound, severe or long term impairment or disability and those with sensory disabilities with 'additional needs';
- who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods;
- who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations which mean they are distant from services;
- who are 'marginal, high risk and hard to reach', who may be involved in substance misuse, offending and at risk of exclusion; and
- who have a 'dual diagnosis' of mental ill health and substance misuse, or of other combinations of medically defined conditions.

As noted previously, studies of families living in poor environments have identified a number of stressors that made parenting more difficult to cope with.

Parents who appear to have particular problems coping with parenting and therefore appear to be a particular priority in terms of targeted support include:

- parents living in the very poorest neighbourhoods;
- parents on the lowest incomes;
- lone parents;
- parents with significant emotional and mental health problems;
- parents with high levels of current problems;
- parents with 'difficult' children;
- parents with accommodation problems; and
- parents with large families.

We do not know how many families or what percentage of families can be considered vulnerable, and therefore would benefit from additional support and services. We have data on the numbers of children who fall into particular risk categories, such as poverty, but not on how many children and families are exposed to multiple risk factors, or whether the number of such families has increased.

From a service system perspective, it would be valuable to know how many families or what percentage of families can be considered vulnerable, and therefore would benefit from additional support and services. However, there is no available data that allows us to calculate these numbers. Data is available on the numbers of children who fall into particular risk categories, such as poverty. But there is no data on how many children and families are exposed to multiple risk factors, or whether the number of such families has increased.

Making a positive difference for families with complex problems has proved to be challenging. Shonkoff (2010) sums up the evidence thus:

- First, there is marked variability in the quality of implementation of successful programs as they are taken to scale.
- Second, increasing evidence indicates that the most effective interventions for children living in poverty produce positive outcomes, but the magnitude of their impacts is typically modest in size.
- Third, large numbers of young children and families who are at greatest risk, particularly those experiencing toxic stress associated with persistent poverty complicated by child maltreatment, maternal depression, parental substance abuse, and/or interpersonal violence, do not appear to benefit significantly from existing programs. Highly disorganized parents are less likely to seek services and more likely to drop out of programs when they do enrol. When they are successfully engaged, the needs of families facing exceedingly

complex social and economic disruptions typically overwhelm conventional early childhood program staff whose expertise is restricted to child development and parenting education. Consequently, the evaluation literature on interventions for children in highly distressed families, such as programs for children who have been victims of abuse or neglect, reveals relatively limited evidence of success (MacMillan et al., 2007, 2009).

5.9 Families involved with child protection services

Social workers and other professionals who are working with parents where there is a possibility of child abuse or other types of harm face a number of problems and dilemmas (Forrester et al., 2012; Platt & Turney, 2012). Challenges include:

- *Tension between the needs of the child and those of the parent(s)* (Platt and Turney, 2012). The welfare of the *child* is the fundamental concern, and yet attention must often be given to eliciting the *parents'* engagement with professional interventions in order for access to the child to be achieved. Practitioners must grapple with the need to keep the child at the heart of practice, whilst at the same time giving due attention to the concerns of the parents – who themselves may be very vulnerable.
- *Parental resistance* (Fauth et al., 2010; Forrester et al., 2012; Platt & Turney, 2012; Shemmings et al., 2012). According to Forrester et al. (2012), parental resistance has two main types of cause: resistance created by the social context of the social work encounter (triggered by the very different role the social worker has compared with a therapist; or by the social worker's behaviour), and resistance linked to the individual or family dynamics (prompted by shame, ambivalence, or lack of confidence in the ability to change). Parents who strongly resist attempts to develop co-operative relationships may be displaying anxiety because of the seriousness of the accusations or they may be reacting to professionals' anxieties, especially if their practice lacks compassion (Fauth et al., 2010). Only a small proportion of parents set out to be awkward or aggressive but that they can quickly feel alienated early on if accused unfairly or treated as if they are lying or being deceitful (Fauth et al., 2010).

Resistance may take the form of open hostility and aggressive or even violence towards social workers and other professionals. Hostility towards workers was more likely to be manifest as 'indirect' aggression, as opposed to actual violence, and occurred most often when key decisions were being made, such as in child protection conferences or court hearings and reports (Fauth et al., 2010). Resistance can also take the form of disguised compliance, in which parents appear to 'cooperate' with services, but, at worst, may be actively undermining the efforts to help them (Platt & Turney, 2012). This can be hard to detect (Fauth et al., 2010).

- *Danger of collusion* (Platt & Turney, 2012). It is well-established, particularly in social work research, that where professional relationships are too close to parents, they can become collusive, can obscure the needs of the child, and can even lead to tragic consequences. On the other hand, organisational pressures, to maintain the child as the central focus, may inadvertently militate against professionals forming good working relationships with parents, particularly in Anglophone child protection systems.

What skills and qualities do social workers and others need to successfully engage with vulnerable families under these circumstances? As in work with non-child protection cases, the evidence indicates that the client–social worker relationship is critical, with the key qualities being sensitivity, honesty and openness about social work procedures (Platt, 2008). Good listening and conveying that workers have correctly understood their clients' narratives is particularly important (Platt, 2007), and one of the major barriers to a client's engagement is when social workers do not ask the parent what their views and opinions are on their own situation, whether they are entirely believed or not (Platt, 2008).

These findings are confirmed in a recent systematic knowledge review of research for the Centre for Excellence in Outcomes for Children and Families (C4EO) on 'highly resistant families' (Fauth et al., 2010). This concentrated on families who do not engage with services or do not demonstrate positive change despite intervention, as evidenced by further abuse, or those whose child is subject to a serious case review.

One of the most consistent findings of Fauth et al.'s (2010) study was that child protection work is best conducted within the context of supportive relationships embodying Rogerian qualities of empathy, active listening, demonstrable genuineness and respect. However, these relational qualities are necessary but not sufficient conditions of effective and lasting change when working with reluctant or resistant families as they need 'to be balanced with an eyes-wide-open, boundaried, authoritative approach aimed at containing anxiety and ensuring that the child's needs and outcomes stay in sharp focus' (Fauth et al., 2010). Furthermore, the ability for workers to be 'human', to treat family members fairly, to demonstrate sensitivity and respect, and to show compassion and genuineness were all viewed as important by family members.

5.10 Models for working with vulnerable families

The previous literature review identified a number of manualised home visiting packages that have been shown to be modestly effective.

There are a number of other more flexible models for working with vulnerable families that are more consistent with process features and therefore might service as models for the current project. These include:

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- Dishion, T.J. and Stormshak, E.A. (2007). *Intervening in Children's Lives: An Ecological, Family-Centered Approach to Mental Health Care*. Washington, DC: American Psychological Association.
- Dishion, T. J., Stormshak, E. A., & Kavanagh, K. (2011). *Everyday parenting: A professional's guide to building family management skills*. Champaign, Illinois: Research Press.
- Landy, S. and Menna, R. (2006). *Early Intervention with Multi-Risk Families: An Integrative Approach*. Baltimore, Maryland: Paul H. Brookes.
- Roggman, L.A., Boyce, L.K. and Innocenti, M.S. (2008). *Developmental Parenting: A Guide for Early Childhood Practitioners*. Baltimore, Maryland: Paul H. Brookes.

5.11 Service implications

Sustained home visiting programs are specifically designed for families who are experiencing stress as a result of various factors in their lives. One of the challenges in delivering a service that focuses on providing parenting support is how to deal with the external factors that are creating stress for the families.

One way of thinking about these issues is in terms of *foreground* and *background* factors and services.

- *Foreground factors* in people's lives are the problems they present with – e.g. with parenting and care of children. These are the problems that are most salient to professionals. Foreground services are those that address these problems and seek to remedy them directly. These include universal services (such as maternal and child health services), secondary/targeted services (such as sustained home visiting services), and tertiary/treatment services.
- *Background factors* are the underlying causes of the foreground/presenting problems and may either be internal (personal factors in the parent) or external (circumstances in which families are living) or a combination of both. Background services are those that seek to address specific background factors – e.g. housing, family violence, drug and alcohol use.

The evidence indicates that, if these background factors are not addressed, then the impact of direct foreground services is weakened – either they do not work at all (because the parent is too preoccupied with other issues) or they are effective in the short term only.

In terms of their salience for parents, the balance between background and foreground factors varies. In some cases, the background factors are minimal (because the parent's personal circumstances are stable and supportive) and the foreground factors (such as concerns about parenting or the child's development) are uppermost in the parent's minds. In these cases, programs that address the

parental concerns directly are more likely to be effective. In other cases, the background factors are so overwhelming that the parent is unable to focus on the foreground issues (e.g. parenting concerns). In such cases, programs that only address the parenting issues directly are unlikely to be beneficial.

Vulnerable families, by definition, are those with background factors that are likely to compromise their parenting, and direct efforts to help them with their parenting struggle to make a lasting positive difference as a result. For these services to be effective, the background factors that are resulting in the parenting problems (and that will continue to undermine any direct efforts to improve parenting) need to be addressed directly.

In working with vulnerable parents living in chaotic or dangerous circumstances, a major task is to stabilise their situation, put them in a safe place. As Forehand and Kotchick (2002) have noted, parents cannot fully engage in parent training until their other basic needs have been adequately addressed. In the case of parents in insecure housing or violent relationships, a safe place can be a physical location, while in the case of people with troubled personal histories, the safe place can be provided through supportive long-term relationships (either with partners or friends, or with professionals). However, crucial as they are, efforts to stabilise parental circumstances should not take total precedence over efforts to improve parenting - a dual approach is required in which foreground and background factors are addressed simultaneously.

The balance of foreground and background intervention efforts will vary according to family circumstances - in cases where families are in unsafe or chaotic circumstances, background interventions to stabilise the situation will predominate, while foreground interventions to support parenting may be minimal, focusing on a few key issues or behaviours that are of most concern to the parent rather than seeking to address all the issues that are of concern to professionals through a comprehensive intervention program.

As noted previously, evidence indicates that vulnerable parents value practical support that addresses their self-defined needs, rather than those identified by professionals. Providing such support early in a relationship helps build trust that the professional and the service system they represent are going to listen to what the parent's needs are and respond to them.

In addressing foreground factors with parents with disruptive or chaotic backgrounds, care must be taken not to overwhelm them with demands - even though there may be many aspects of the parent's care for the child that are of concern or are not optimal, the parents must be allowed to control the pace at which they try to adopt new practices. If this is not done, then the parent/professional alliance can be compromised and the effectiveness of the professional's support undermined

This discussion highlights the importance of adopting a dual approach in supporting vulnerable families:

- providing 'foreground' services in the form of sustained home visiting focusing on parenting issues and designed to build parenting competencies.
- providing brokerage support to coordinate parental access to 'background' services that address relevant background factors as well as to services that address their parenting needs.

5.12 Summary and conclusions

Changing ideas about disadvantaged and vulnerable populations

- There has been a change in the way that vulnerable and marginalised families are perceived. Previously seen as 'hard-to-reach' (in the sense of failing to make use of services), such families are now more likely to be seen as facing many barriers to accessing and using services.
- This new perspective shifts the burden of responsibility from being totally that of those who do not make use of the available services to those who provide the services. Instead of marginalised families being seen as at fault for failing to make full use of the early childhood services that are available, the services themselves might be held to account for failing to reach out to and engage such families effectively.

What makes families vulnerable?

- The dramatic economic and social changes that have occurred in developed nations over the past 50 years have significantly altered the conditions under which families are raising young children. Many of the recent social and economic changes have been beneficial for most families, but have been accompanied by a widening gap between the rich and the poor. It is this gap, rather than absolute levels of poverty, that is damaging.
- For families, the result has been a widening of the gap between those who are benefitting and those who are not. Families who are relatively well-resourced are better able to meet the challenges posed by changed social conditions, whereas poorly-resourced families can find the heightened demands of contemporary living and parenting overwhelming.
- Gaps in family functioning are cumulative: the more advantaged families are initially, the better they are able to capitalise and build on the enhanced opportunities available, so that the gap between them and those unable to do so progressively widens. The result is that there has been an increase in the numbers of families with complex needs, and more pockets of

intergenerational disadvantage, underachievement and poor health and developmental outcomes.

- Although they represent only a small minority, these families and their children subsequently account for a highly disproportionate percentage of the costs and resources for mental health, education services and welfare services. Part of the reason for these high costs is that families at risk often access services and support that are crisis-led, and are focused on the immediate presenting issue. This narrow approach fails to help those families who have multiple needs and require simultaneous support from a range of services.
- The factors that make families vulnerable fall into three groups: factors within the parent or parents, factors within the family, and factors in the wider community and society.
 - *Factors within the parent or parents* include low levels of education, parental mental illness or depression, parental chronic medical condition, parental intellectual disability, parental criminal record, alcohol and drug abuse, recent life stresses (death, job loss, immigration), and a parental background of severe abuse, neglect, or loss in childhood that is unresolved.
 - *Factors within the family* include single teenage parent, low income/food insecurity, chronic unemployment, insecure or inadequate housing, frequent moves, severe family dysfunction and/or instability and family violence.
 - *Factors within the wider community* include lack of social support/isolation, neighbourhood problems and community violence, lack of public transport, difficulties in accessing child and family services, non-family friendly urban environment, and lack of family-friendly recreational and other facilities.
- It is clear is that the capacity of parents to raise their children in ways that they (and we) would wish is compromised by factors beyond their control. A major focus of work with parents, therefore, is to seek to remove (or at least manage and stabilise) these barriers to family functioning and parenting.

Vulnerable families' use of services

- While most families of young children are well supported socially and make good use of services, some do not.
- For a variety of reasons, the children and families who are most in need of support are those least likely to access or receive it.

- Children from families who have poor social supports and make limited or no use of early child and family services are at increased risk of poor health and developmental outcomes.

Barriers to families using services

- Barriers to families making use of services include service level (or structural) barriers, family level barriers, and interpersonal or relational barriers:
 - *Service level (or structural) barriers* include lack of publicity about services, cost of services, limited availability, failure to provide services that meet parents' felt needs, inability of services to respond promptly to requests for help, rigid eligibility criteria, inaccessible locations, lack of public transport, limited hours of operation, inflexible appointment systems, lack of affordable child care, poor coordination between services, and not having an outreach capacity.
 - *Family level barriers* include limited income, lack of social support, lack of private transport, unstable housing or homelessness, low literacy levels, large family size, personal preferences and beliefs about the necessity and value of services, physical or mental health issues or disability and day-to-day stress. Vulnerable parents have to balance competing needs, and sometimes 'survival' needs take priority over attendance at a service.
 - *Relational or interpersonal barriers* include beliefs, attitudes and skills that can compromise the ability of service providers to engage families successfully or the ability of parents to seek out and make use of support services.

In the case of service providers, relational barriers include insensitive or judgmental attitudes and behaviours, lack of awareness of cultural sensitivities, poor listening and helping skills, inability to put parents at ease, and failure to acknowledge and build on family strengths and to engage families as partners.

In the case of parents, relational barriers include lack of trust in services, fear of child protection services, misperceptions of what services offer, lack of the social skills and confidence to negotiate with professionals, and being easily intimidated or put off by perceived attitudes of staff or other parents.

Effective strategies for engaging vulnerable families

- *Ways of effectively engaging and empowering marginalised families* have been identified. Studies of what vulnerable families want from support

services have identified a number of key features that affect the extent to which they use and trust the services, as well as their 'take-up' of the help provided.

- These features include: services that help them feel valued and understood, and that are non-judgmental and honest; services that are 'humanising' – that is, relationships that have respect for their inherent human dignity, and are responsive to their needs, rather than prescriptive; services that allow them to feel in control and help them feel capable, competent and empowered; services that are practical and help them meet their self-defined needs; services that are timely, providing help when they feel they need it, not weeks, months or even years later; and services that provide continuity of care – parents value the sense of security that comes from having a long-term relationship with the same service provider.

Needs of specific 'at-risk' populations (ATSI, CALD, refugee groups)

In general, the need for services to vulnerable families be culturally sensitive is repeatedly highlighted in the research literature. The needs of three specific groups are considered.

Aboriginal and Torres Strait Islanders

- The needs and expectations of Indigenous children and families vary widely according to their community of origin and their current circumstances, and it is important to avoid homogenising indigenous Australians into a collective 'they';
- Several studies show that many of the strengths of Indigenous children, parents, extended families and communities are often overlooked and diminished by inappropriate interventions, unintended outcomes of policy decisions and inexperienced (albeit well intentioned) practitioners.
- Some of the key elements of strategies to engage Indigenous families include: building relationships; use of strengths-based approaches as opposed to focusing on needs or problems; building in time for evaluation to measure how effective programs have been in achieving outcomes; having well-qualified staff with training in cross cultural competence; and incorporating early learning and literacy programs that simultaneously target both parents and children.

Families from culturally and linguistically different backgrounds

- Respect for diversity and difference and the use of culturally responsive practices are widely recognised as essential features of effective services for young children and their families.

- Strategies for addressing the cultural issues and challenges presented by CALD families include: valuing diversity; understanding the dynamics of difference; making cultural adaptations; conducting ongoing cultural self-assessment; and institutionalising cultural knowledge.

Refugee families

- Refugee families face all of the problems that other CALD families face, but are particularly vulnerable in other ways, including loss or trauma, severe family instability and low income/food insecurity.
- There is a lack of published literature regarding best practice for professionals who work with children and families from refugee backgrounds as a means of strengthening family functioning (Arney & Scott, 2010). However, some specific issues that are important to consider in regards to engaging recently arrived refugee families include: trust (e.g. fear of government authorities or any agency that is seen to represent an authority), interpreters (e.g. families may be reluctant to trust interpreters) and consultation (e.g. families may have had a poor experience of consultation).

Families with multiple and complex needs

- The concepts of ‘complex’ and ‘multiple’ needs are used by various disciplines and service sectors in a variety of ways. However, the essence of complex needs as implying both *breadth of need* (more than one need, with multiple needs interconnected) and *depth of need* (profound, severe, serious or intense needs). Additionally, they use the term ‘complex needs’ as “a framework for understanding multiple, interlocking needs that span health and social issues”.
- A very wide range of people have been identified as having multiple and complex needs. These include: people with mental health problems, including ‘severe and lasting’ problems; those fleeing abuse and violence – mainly women and refugees; those culturally and circumstantially disadvantaged or excluded; people with disabilities: people who present challenging behaviours to services; people who are multiply disadvantaged by poverty, poor housing, poor environments or rural locations; and people who are involved in substance misuse, offending and are at risk of exclusion.
- Studies of families living in poor environments have identified a number of stressors that made parenting more difficult to cope with. Stressors were grouped at the level of the individual, the family and the community. Many of the stressors were found to occur with much higher frequency than for adults in the general population, and so point to particular challenges for bringing up children in poor environments.

- Stressors at the level of individual parents and children include parents with long-term physical health difficulties, parents with emotional and mental health problems, and having a child with a long-term physical health problem.
- Stressors at the level of the family include: having a very low income, having low or no qualifications, having no adult in paid work, poor quality of housing, having a large family, being a lone parent, and having an unsupportive or abusive partner.
- Parents whose problems coping suggest they are a particular priority in terms of targeted support include: parents living in the very poorest neighbourhoods, parents on the lowest incomes, lone parents, parents with significant emotional and mental health problems, parents with high levels of current problems, parents with 'difficult' children, parents with accommodation problems, and parents with large families.
- It is the cumulative effect of multiple environmental stressors and risks that make families more vulnerable. At all three levels (individual, family and community), parents' problems are likely to be multiple, overlapping, and cumulative. If parents have problems in one area they almost certainly had problems in other areas of their life, further compounding parenting difficulties. The greater the number of stress factors that were reported by parents, the less likely they were to be 'coping' with parenting.
- We do not know how many families or what percentage of families can be considered vulnerable, and therefore would benefit from additional support and services. We have data on the numbers of children who fall into particular risk categories, such as poverty, but not on how many children and families are exposed to multiple risk factors, or whether the number of such families has increased.

Models for working with vulnerable families

- The previous literature review (CCCH, 2012) identified a number of manualised home visiting packages that have been shown to be modestly effective.
- The present review has identified a number of more flexible models for working with vulnerable families that are more consistent with process features and therefore might service as models for the current project.

1. PART B: SERVICES FOR FAMILIES WITH MULTIPLE PROBLEMS

This section reviews three different types of services/models of service delivery/service processes for families with multiple problems. The following services are reviewed:

- multi-systemic therapy (MST);
- wraparound models of service delivery; and
- key worker and transdisciplinary models.

Each of these sections concludes with a summary of key issues and recommendations.

6. Multi-systemic therapy (MST)

6.1 Background and description of MST

The body of MST literature is relatively small and much of it has been conducted by MST creators with US samples. MST is a commercial entity – earning around \$500 for each youth served – so the data may be complicated by a conflict of interest (Littell 2006).

This document summarises the main findings from:

- (a) Recent systematic reviews and a meta-analysis of MST efficacy and effectiveness (Curtis et al. 2004; Littell et al. 2005; Schmied et al. 2006; Shepperd et al. 2009), and
- (b) MST studies conducted since 2006 that are not included in the recent reviews.

6.1 What is MST?

MST is a family- and community-based therapy originally designed to reduce anti-social behaviour in juvenile offenders. Developed by Henggeler and colleagues in the 1980s, MST is based on:

- (a) Family Systems Theory: understanding that the family is a system of interconnected individuals and it is not possible to understand an individual without understanding the system;
- (b) Social Ecology Theory: understanding the reciprocal relationship between an individual and their environment; and
- (c) Research on the predictors and correlates of antisocial behaviour (Henggeler et al., 1999).

MST has also been used with young people in out-of-home placement and with drug addition, psychiatric inpatients, sexual offenders,(Schmied et al., 2006) and young people with obesity and poorly-controlled Type I diabetes (Ellis et al., 2010; Ellis et al., 2007; Naar-King et al., 2007).

MST typically lasts 3-6 months and is intensive. The therapist is available to the individual and family 24 hours, 7 days a week (Littell 2005). Therapists commonly have masters/doctoral-level mental health qualifications, and are supported by a treatment team that may include crisis workers and clinical psychologists and psychiatrists. Therapists have small caseloads, i.e. no more than 5 families (Littell 2005).

6.2 MST principles and goals

MST delivered according to family preservation model of service delivery and operates on 9 principles (see <http://www.mstservices.com/index.php>):

1. Understanding how the identified problem 'fits' in the context of the young person's environment
2. Focusing on families' positives and strengths
3. Increasing family members' responsibility for their own behaviour
4. Focusing on the present, defining issues clearly and identifying ways to act now to improve the problem
5. Identifying and targeting sequences of behaviour in the young person's life that contribute to and maintain the problem
6. Is developmentally appropriate
7. Requires daily or weekly effort by family members
8. Involves continuous evaluation of effectiveness from multiple perspectives
9. Designed to generalize to individuals' and families' lives after the intervention ends

MST assumes that a young person's problem behaviour can be traced back to a family problem or dysfunction; it is not considered an individual problem. The problem behaviour is considered to be created and maintained by a number of systems, e.g. family, school, peer relationships, community. Therapy addresses these multiple factors (hence 'multisystemic') to provide consistency in the change being implemented (Curtis et al. 2004).

Therapists use a range of treatment models depending on the family and problem(s) being addressed. Initial assessments evaluate the child's development, and the family's interactions with each other, peers and community. MST aims to empower parents to change their child's environment and behaviour. The family and therapist define clear treatment goals together. Goals are broken into smaller tasks and assigned to family members. The family's

progress toward achieving the goals is assessed via family meetings held in the family home at least once a week (Littell 2005). Treatment ends when treatment goals are achieved.

6.3 Evidence for program content

Evidence from systematic reviews

The evidence of MST effectiveness for severe antisocial and conduct behaviour is controversial. A systematic review conducted by MST creators identified 7 eligible intervention trials (all US) involving 708 participants (median 116 per study, range 16-176, 70% male) and 35 MST therapists (Curtis et al. 2004). The authors reported that MST has moderate effects on individual and family relations and interactions, and criminal activity, but less effect on peer relations, which may be due to the reduced focus of MST on the latter. In clinical efficacy studies (those conducted by the MST creators), the mean effect size was large ($d=0.81$). In community-based studies (not conducted by MST creators) the mean effect size was small ($d=0.26$). The overall sample had low power (57%) to detect differences at the population level.

Littell (2005) – who is independent of MST – argued that the review by Curtis et al., (2004) was poorly conducted and overestimated the quality of the existing research, leading to an unfounded conclusion that MST is a robust evidence-based intervention. Littell (2005) conducted a Campbell review to assess MST efficacy. Of the 8 eligible studies she identified, Littell argued that only one randomised controlled trial (RCT) conducted a rigorous evaluation of MST. It was also the largest trial, and found no evidence of MST effectiveness. Examples of bias in the less rigorous trials included per-protocol rather than intention-to-treat analyses, and lack of blinding. While these poorer-quality studies suggest some evidence of efficacy, the findings are not consistent across outcomes. Littell concluded that MST is yet to be established as effective.

A Cochrane review of alternatives to inpatient mental health care for young people with psychiatric disorders gave a similar conclusion. Shepperd et al., (2009) identified two RCTs that evaluated the efficacy of MST. There was no evidence for group differences for the majority of statistical tests. One study reported small immediate improvements in youth (self- but not teacher-reported) mental health, family cohesion, days out of school, alcohol use, and treatment satisfaction, but several of these effects faded at the 4 month follow-up. MST had no effect on marijuana use or arrests. The second study, which had high attrition and fidelity issues, reported that MST was associated with reduced risk behaviour, delinquency and days in out-of-home placement. There was no evidence that MST affected child mental health, family cohesion or drug use (Shepperd et al. 2009).

Evidence from studies conducted since 2006

Sustained home visiting for vulnerable families and children: A literature review of effective processes and strategies

Timmons-Mitchell et al., (2006) were the first MST-independent researchers to test the effectiveness of MST in the US setting. In a sample of 93 youth appearing before county family court for a felony charge (mean age 15.1 years, SD 1.3 years; 78% male), the authors examined whether MST reduced re-arrests and improved youth functioning up to 18 months post-treatment, compared with treatment as usual (TAU). The authors found that MST led to fewer re-arrests (67% vs. 87%) although proportions were still high; and fewer new offences (mean 1.4 (SD 1.5) vs. 2.3 (1.5)). Youths offered TAU were 3.2 times more likely to be re-arrested than those offered MST. There was no evidence that the time to re-arrest was different between groups (MST mean 135 days, TAU mean 117 days). Measures of functioning in the home, school/work and community were improved, as was the young person's mood. There was no evidence for reduced substance abuse (Timmons-Mitchell et al. 2006).

In contrast with these findings, a Swedish trial with 156 youths with conduct disorder (mean age 15 years, SD 1.4 years; 61% male) reported that MST did not improve outcomes compared with TAU. In both trial arms mental health and parenting skills (self- but not youth-reported) improved, delinquent behaviours and school attendance decreased, and there was no change over time in substance use (Sundell et al. 2008)

Butler et al., (2011) conducted a RCT examining MST efficacy compared with UK usual care (Youth Offending Teams) in reducing offending and out-of-home placement in 108 juveniles aged 13-17 years. Therapists visited families an average of 3 times per week, and intervention length ranged from 11-30 weeks (mean 20 weeks). The authors reported that both interventions reduced subsequent offences, but MST showed a greater reduction in non-violent offending and youth/parent-reported aggressive and delinquent behaviour 18 months later (Butler et al. 2011).

In a pre-post study, Tolman et al., (2008) investigated whether MST improved child functioning in 254 children (64% male; mean age 14.8 (SD 2) years) with a history of 'wilful misconduct'. MST was delivered by Hawaii's Child and Adolescent Mental Health Division (CAMHD), with functioning measured by CAFAS and CALOCUS¹ in a subgroup of n=122 youth who represented the full sample on demographics. Unlike standard MST which specifies an age range of 12-17 years, 10% of participants were <12 years (as young as 7 years). Approx 70% of goals (mean 4 goals per family) were met by the end of therapy. 48% of cases were classed as 'successful' and 36% as 'partially successful'. 'Successful' cases showed lower impairment and service needs, 'partially successful' showed no difference in functioning, and 'unsuccessful' cases showed poorer individual

¹ CAFAS: Child and Adolescent Functional Assessment Scale; CALOCUS: Child and Adolescent Level of Care Utilization System

functioning and increased service need by study end. Compared with RCTs conducted by MST creators, Tolman et al., (2008) found that effect sizes for their CAMHD MST pre-post changes were within-range but toward the smaller end. As the outcomes were not tested via RCT, however, it is not clear whether MST improved outcomes compared with usual care.

6.4 Evidence for process components

MST licensing requires that programs undergo intense quality assurance procedures. According to Schmied et al., (2006), "training and commitment of therapists, adherence to principles, commitment to the strategy by young people and their families, cooperation within and among relevant staff, positive involvement with peers and community or neighbourhood" increase MST effectiveness, as shown by the reduction in effect size when the MST is transported from clinical efficacy to effectiveness trials (Curtis et al. 2004).

Evidence from studies conducted since 2006

The published MST research tends to focus more on overall program effectiveness than the influence of process components.

Tolman et al., (2008) found that 'successful' MST cases were not predicted by the young person's age, gender or problem behaviour investigated, but were more likely for individuals with more than 1 diagnosis and for those who received longer treatment. Specifically, 'successful' and 'partially successful' cases had a mean treatment length of 4.8 and 4.6 months, respectively (no statistical difference between the two), while 'unsuccessful' cases received a mean of 3.5 months.

In the Swedish effectiveness trial, neither site differences nor program maturity were responsible for the null findings (Sundell et al. 2008). Treatment adherence was associated with similar proportions of improved and poorer outcomes. Treatment conditions did not vary according to youths' sociodemographic or clinical backgrounds. However, treatment fidelity was lower than reported in comparable trials, leading the authors to question whether MST was implemented effectively, and the validity of the treatment adherence model in the Swedish context.

Ellis et al., (2010) examined caregiver characteristics that predicted therapy adherence (from the MST Therapy Adherence Measure) in 82 school children (mean age 14.6 years, SD 1.3 years) from the intervention arm of trial aiming to reduce conduct problems. There was variation between families as to initial adherence/engagement but no evidence that the levels reported by participants changed over time. Parent factors like "psychopathology, motivation, expectations about treatment outcomes, and level of functional involvement in

child-rearing practices all were related to parents' perceptions of how well MST therapists adhered to MST principles", and "family cohesiveness,...ability to adjust to family stressors, and parental motivation for change and therapy" with an enhanced working relationship. Engaging the client appeared to relate more to the "session-by-session activities that lead to treatment goals and the client's evaluation of therapy sessions". The authors suggest that, to build a successful working relationship, therapists begin at an easy starting point (Ellis et al. 2010).

Butler et al., (2011) found that more adherent treatments were not associated with the outcome (i.e. reduced offences). Tighe et al., (2012) examined parents' experiences of MST in this UK sample (n=19). The authors identified 10 themes that could be categorised into two domains: (a) aspects that helped families engage and facilitated the initial process of change, and (b) the complexity of child and family functioning outcomes. Aspects contributing to the former include offering MST at the family's convenience; taking a holistic approach – working within systems around the family; using a solution-focused and practical approach; a strong, person-focused, relationship with the therapist; and having the therapist as a source of support. Aspects contributing to the latter include increased parental confidence and skills; the parent-child relationship improving as therapy progresses; the young person choosing a new future (particularly related to education); the young person's behaviour improving; and the fact that, while most families said their situation was better post-intervention than pre, not all goals were met and sometimes the situation deteriorated after MST ended (Tighe et al. 2012).

Related studies that may be of interest:

- The Fast Track intervention (<http://www.fasttrackproject.org>) is an ongoing, intensive, multiple-program school-based intervention designed to improve academic achievement, social skills and behaviour regulation in children who enter school poorly-equipped to manage the 'social, emotional, and cognitive demands' encountered. Foster et al., (2006) suggests that the intervention, which they tested for preventing aggressive behaviour in school-aged children (from 1st to 9th grade), was comparable to multisystemic therapy (Foster et al. 2006).
- Carstens et al., (2009) examined the factors that influenced systems of care (i.e. coordinated networks of behavioural health care providers) to decide whether or not to adopt MST in 13 Ohio communities (Carstens et al. 2009).
- Asscher et al., (2007) report the implementation issues encountered when trying to conduct an efficacy RCT of MST through the Dutch juvenile justice system (Asscher et al. 2007).

6.5 Conclusion

The conclusion regarding MST program effectiveness is similar to that proposed by Schmied et al. (2006) 6 years ago: MST may be effective for juveniles in the criminal justice system, but the efficacy and effectiveness of MST is unknown for (a) younger primary-school age children, and (b) Australian families. Furthermore, while MST may be cost-effective for adolescents in the criminal justice setting, it is unclear whether the intensive therapy would remain cost-effective when offered to the younger ages targeted by the sustained nurse home visiting trial. Families value therapists' commitment and the person-centred approach. To effectively implement MST, families need to be motivated to change and committed to the program, be engaged with their therapist and build a good working relationship.

7. Wraparound models of service delivery

This section provides summative findings of wraparound models of service delivery. The wraparound model of service delivery is defined, followed by a discussion regarding for whom it was developed. The four phases of the wraparound process and the ten principles that inform the wraparound approach are then described. This is followed by a brief summary of the challenges surrounding its fidelity, and a discussion of evidence of the effectiveness of a wraparound approach.

7.1 What is the wraparound model of service delivery?

According to Burns et al. (2000), wraparound is 'a philosophy of care that includes a definable planning process involving the child and family and results in a unique set of community services and natural supports that are individualized for the child and family to achieve a positive set of outcomes.' (p. 295). This process is described by Walker and Bruns (2003) thus:

A team is formed around a child and family who are struggling to stay safe, stay together, and maintain everyday life and functioning. Included on the team are people who have a stake in seeing the family succeed: family members, service providers, and members of the family's natural and community support networks. These people come together to create, implement, and monitor a plan that will help the family realise its vision for a better life. The plan that is produced, as well as the planning process itself, is culturally competent and community and strengths based.

Wraparound is an approach to treatment that developed as an attempt to overcome the fragmented, uncoordinated way in which services traditionally were provided to youth with multiple problems who received services from multiple child-serving agencies (Farmer et al., 2004). Wraparound programs are organized to coordinate services across multiple human service sectors in the community. The objective of this coordination is to improve the effectiveness and efficiency of

services in order to bring about improved outcomes for children and families in the home, school, and community environments (Bruns et al., 2006). This aspect of the wraparound approach aligns with evidence regarding effective service delivery, as noted by Schmeid et al. (2004):

... effective approaches to service coordination and integration is a key component of any successful service system or intervention being provided for the young people with multiple and complex needs and their families.

Unlike other evidence-based practices, wraparound services are not delivered by a single person or agency, but aim to establish and utilise strong links between the family, service providers, and members of the family's social network. As such, services and supports are 'wrapped around' the child/young person (Burchard & Clarke, 1990; Burns et al., 2000).

Who is the wraparound model designed for?

The wraparound model is designed for children and young people with significant emotional and behavioural problems and multiple, complex needs and their families (Schmied et al., 2006). Wraparound is also intended to work with young people and their families, whose needs cannot be sufficiently met by a single intervention/service or who are involved with multiple agencies (Bruns et al., 2006). Target populations include children in the mental health, education, juvenile justice, and child welfare sectors.

While the wraparound approach has mostly been used with children and adolescents who have significant emotional and behavioural problems (Schmied et al., 2006), they are also being utilised increasingly with children at risk of developing such problems, even at the preschool level (Burns et al., 2000). Adults with severe mental health problems, and young people with severe disabilities have also been shown to benefit from wraparound models of service delivery (Burns et al., 2000).

Principles and phases of the wraparound process

The philosophical principles underlying the wraparound approach are based on an ecological/social environmental approach which is founded upon the idea that 'children and young people function best when the larger service system surrounding them is coordinated efficiently with the micro-system of the immediate home and family environment.' (Burns et al., 2000, p. 296).

Ten practice principles, developed by Goldman (1999) and Bruns et al. (2004) are essential to understanding the wraparound process:

1. *Family voice and choice*: family and youth/child perspectives are sought and prioritised during all phases of the process and opportunities for family members to articulate their perspectives of the process are provided so that the program reflects the family's values and preferences.

2. *Team based*: the members that comprise the team must have a strong commitment to the family's well being and consist of individuals agreed upon by the family.
3. *Natural supports*: the team actively seeks out and promotes the full participation of team members drawn from family members' networks of interpersonal and community relationships. These sources of informal support are viewed as sustainable (i.e. available for the youth/child and family after wraparound and formal services have ended).
4. *Collaboration*: each team member must be dedicated to the team, the team's goals, and the wraparound plan. The plan reflects a merger of team members' perspectives and resources.
5. *Community-based*: the team implements service and support strategies that are accessible to the family and located within the community that the family live in. Teams work to ensure that family members receiving wraparound have greatest possible access to the range of activities and environments that are available.
6. *Culturally competent*: the wraparound process respects the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
7. *Individualized*: the plan is tailored to the needs and wants of the child and family.
8. *Strengths based*: the process and the plan hone on in and build upon the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
9. *Persistence*: there is a commitment to achieving the goals set out despite challenges. The team persists in working toward the goals included in the wraparound plan until the team agree that a formal wraparound process is no longer warranted.
10. *Outcome based*: outcomes must be determined and measured for each goal established with the child and family as well as for those goals established at the program and system levels (Bruns et al, 2004).²

The wraparound model of service delivery consists of four phases (Walker et al, 2004) and ten underlying practice principles (Goldman, 1999; Bruns et al., 2004). These phases and principles provide further insight into the way in which the wraparound model operates.

The four phases of the wraparound process are as follows:

² Description of the principles have been adapted from Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten principles of the wraparound process*. Portland Research and Training Center on Family Support and Children's Mental Health, Portland State University.

1. *Engagement and team preparation*: the facilitator works closely with those involved to build trust and ownership and a shared vision is created. During this phase the family is encouraged to articulate their – and their child's – strengths needs and experiences.
2. *Initial plan development*: the facilitator guides the team through the initial plan and there is a shift towards team meetings and action planning. During this phase the tasks and roles of all team members are clarified.
3. *Ongoing plan implementation*: the plan is put into practice and progress is continually monitored and used to review initial plans and revise interventions. This phase is repeated/continued until goals are achieved and it is deemed that the wraparound efforts are no longer needed.
4. *Refinement and transition from wraparound*: the final phase of the wraparound process marks the point whereby the formal wraparound process is no longer necessary. During this phase, accomplishments are reviewed and a transition plan is developed (Walker et al., 2004).³

Challenges of wraparound

According to Walker and Bruns (2003), the Wraparound approach can be difficult to implement in practice. Professionals have to learn to work together in ways that are sometimes radically different from their usual practice, and agencies must also become more collaborative and flexible (Walker and Koroloff, 2007). High-quality wraparound teamwork is characterized by collaboration and blending of perspectives, creative problem solving, and respect for each team member's expertise and background (Walker, 2008).

Schmied et al. (2006) identify a number of challenges exist to implementing and evaluating Wraparound. These include:

- inconsistent adherence to its elements and principles such as not engaging important individuals on the child and family team, especially school personnel, friends and family advocates
- limited involvement of the young person in community activities and activities the young person does well
- limited use of family and community strengths to plan services
- limited flexible funds to implement innovative ideas generated from team planning, and inconsistent measurement of consumer satisfaction
- flexible funding (programs remain hampered by traditional reimbursement procedures and agencies that continue to operate in isolation)

³ Description of the phases have been adapted from Walker, J. S., Bruns, E. J., VanDenBerg, J. D., Rast, J., Osher, T. W., Miles, P., Adams, J., & National Wraparound Initiative Advisory Group (2004). *Phases and activities of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

- ensuring a clear understanding of family-centred, community-based principles and strategies
- providing intensive and ongoing training, supervision and administrative support

Another difficulty is that there is no definitive set of guidelines for best practice (Walker and Bruns, 2003).

A further difficulty is the time involved. Establishing links between services and people is often time consuming and thus wraparound is usually a long-term intervention and can take up to months to implement, especially when working with vulnerable families (Schmied et al., 2006). Barriers to the implementation of a wraparound model include organisational, policy and funding constraints (Bruns et al., 2004).

7.3 What is the evidence for effectiveness?

Because Wraparound is a flexible process rather than a fixed program, evaluating its effectiveness is not a simple matter. There are no randomised control trials to show whether wraparound works any better than regular services such as individualised therapies (Burns et al., 2000). As Schmied et al. (2006) note, the growth in wraparound's popularity has been driven primarily by the appeal of its underlying philosophy rather than by its empirical evidence for effectiveness.

Effectiveness studies summarised by Burns et al. (2000) provide preliminary evidence only of the benefits of the wraparound process. The research designs used were largely uncontrolled (either case study or pre-post) and potentially subject to problems such as ensuring the validity of the implementation. More conclusive studies depend upon the developing a better definition of wraparound, formal training curricula, standards, and measurement of fidelity (Burns et al., 2000).

Farmer et al. (2004) reviewed the evidence base for community-based interventions (including wraparound services) for young people with mental health problems from a systems of care perspective. Currently, the evidence base for wraparound seems to fall on the weak side of 'promising'. Some research shows positive gains, while other work shows equal gains with usual care at an increased cost for wraparound.

Breault et al. (2005) conducted a study of parent experiences of wraparound program for children and youth with severe emotional disturbance in Massachusetts. Four themes emerged from the analysis of the data: encouragement to participate in treatment planning; support during the wraparound process; focus on child and family strengths; and concerns surrounding discharge.

- *Caregivers were encouraged to participate in the treatment planning process.* Caregivers reported that teams listened to their ideas and didn't make decisions without them.
- *Caregivers felt supported.* Caregivers described receiving generous amounts of concrete and emotional support.
- *Wraparound teams focus on the strengths of children and families.* Caregivers reported that wraparound teams maintained a focus on the strengths of their children and the family, and that identifying and focusing on strengths helped caregivers feel hopeful about the future.
- *Caregivers were concerned about discharge planning.* Some caregivers expressed concerns about discharge planning; many caregivers wanted the program to continue after their child met graduation goals.

7.4 Summary and conclusions

- Overall, there are benefits to children and young people with high needs from wraparound models. Common outcomes reported for children and young people receiving the services and interventions are: improved social, emotional, psychological and behavioural functioning; improved school performance; and reduction in the number of days and level of restrictiveness of placement.
- The limitations of wraparound is that its 'flexible' and 'individualised' nature and grassroots development may result in an 'any service will do' approach; and there is limited evidence to suggest it works any better than regular services.
- At a broader systems level, expected outcomes include: the establishment of new and improved systems and partnerships; improvements in accessibility, quality and quantity of services; and communication among services, in order to achieve improvements in child and family outcomes.
- There are several common principles that underpin the models of service delivery and interventions discussed, including: a sound theoretical and conceptual basis; emphasis on the multiple needs of children and young people and their families; well-trained, skilled staff who are well supported; active involvement of the family, and maintaining community connections for children and young people; and provision of transitional and after care services.

8. Key workers and transdisciplinary models

This section looks at the evidence regarding three strategies for supporting vulnerable families and children:

- key worker models,
- transdisciplinary teamwork, and
- Team Around the Child models.

8.1 Key worker models

According to Drennan et al. (2005), an issue repeatedly highlighted in the literature is the need for effective care coordination for families of children with special care needs. It has been shown that the more health or development problems a child has, the more services they receive; this in turn is correlated with the number of sources of service, which in turn is related to a greater diversity of locations from which those services are provided.

Not surprisingly, parents report that in these circumstances (i.e. high number of services, sources of service, diversity of locations) services are less family-centred (Drennan et al., 2005). Studies also show that in these circumstances there are high levels of unmet needs for information, help with child's development, respite, aids, equipment, and financial help (Greco et al., 2007). Parents report a constant battle to access information and services, and these battles increase parents' stress, which in turn impacts on their child's development. Numerous research studies have also reported that parents want a single point of contact with services and an effective, trusted person to support them to get what they need (eg. Sloper, 1999).

The 'key worker' model is a method of service delivery involving a person who works in a guide role with families (Drennan et al., 2005). This person acts as a single point of contact for a family, helping the family to coordinate their care, not only within the healthcare system, but also across systems (education, social services, financial resources, recreation, transportation, etc). The main concept of the key worker's role is to empower parents by providing them with support, resources and information tailored to meet their individual needs.

This activity is accomplished by a variety of means which may include:

- being available on a regular basis, and also when required by the family;
- helping parents understand the system(s) and, if required, helping them navigate the system(s);
- being present at various meetings/appointments if requested by parents;

- assisting with the interpretation of assessment results, or outcomes of meetings; and
- supporting the family's skills, and providing parents with additional skills or tools to facilitate empowerment.

Drennan et al. (2005) have identified general principles to guide the implementation of a key worker model of service delivery. According to these, the key worker service should:

- be family-centred rather than child-centred;
- be needs-led rather than service-led;
- entail a flexible, individualized approach;
- be a formalized program so it is recognized by professionals/practitioners across all agencies;
- be evaluated, monitored, and able to adjust to meet needs;
- include an overall Service Coordinator (i.e., to coordinate key worker services);
- be supported by a multi-agency steering committee; and
- have buy-in and ownership from management for longevity and maintenance of the program.

To support and empower key workers appropriately, their role should include:

- clearly defined job descriptions outlining roles, responsibilities, and limitations;
- protected time for the service, regardless of whether it is full-time or otherwise; and
- adequate support and training.

Key workers should be accountable to the family, not perceived as working for an agency; and be a single contact, able to work across agencies.

The key working model has its limitations, including the following:

- Although parents with a key worker are more likely to report a positive relationship with professionals than those without such a relationship, the availability of a key worker may not minimize the number of problems they experience with services. Such problems are often related to inter-agency collaboration and availability of services.
- Some key workers feel dissatisfied and frustrated with their prescribed role, as they are not able to provide direct care utilizing their skills and expertise.

- The effectiveness of this model is not well documented. The evidence is generally of a low level in terms of the research methods by which it has been gathered. The evidence is frequently in the form of satisfaction surveys and information gathered from qualitative studies including focus groups. (Drennan et al., 2005)

Evidence of efficacy of key worker model

A literature review by Liabo et al. (2001) found that the main function of key worker systems is to enable professionals to respond flexibly to parents' and children's needs, rather than focusing on the needs of services. The key research findings were:

- If a key worker system is in place, the overall quality of life of families with disabled children is improved.
- Specific outcomes are better relationships with services, better and quicker access to statutory and discretionary benefits (both financial and environmental) and reduced levels of stress.
- Families with disabled children identify a lack of money as their greatest overall concern. They believe that key worker systems can have an impact on this and there is some supporting evidence to support this claim.
- Good personal relationships between key workers and parents are reported as an important factor by parents, and of value in itself.
- There is no evidence that key worker systems result in variations in quality of medical or paramedical care.
- Key workers report a high degree of satisfaction with the role, even when organizational difficulties have been encountered, and believe that it makes a positive difference to the lives of both children and parents.
- While a key worker in the role of an independent advocate can be effective, a key worker who works for a service appears more able to exercise the degree of leverage necessary to meet families' needs.
- Organisational obstacles are seen by many agencies as greater than the perceived benefits of the model – restricting its use.
- The key worker model is available to only one third of families with disabled children.
- Statutory services are often of high quality, but a consistent finding is lack of flexibility and poor co-ordination between agencies. Key working aims to overcome this.
- Due to their wide reaching base, key worker systems are vulnerable to wasting away. The following core requirements guard against this: a multi-

agency steering group and supporters at a senior level, dedicated administrative support and both individual and joint training.

- While reports are continually positive, robust studies of key worker systems are lacking.
- The focus of the literature is on parental needs and we cannot assume that the needs of children will in all cases be congruent with these.

Liabo et al conclude that the current research strongly supports the key worker approach. Services should take this on board and offer all families with disabled children the *opportunity* to access such a system. When establishing a system a clear model is needed, including mechanisms to identify and allow change. During the key worker appointment process certain personal characteristics should be considered due to the particular emotional and practical relationship required with the family.

According to Sloper et al. (2006), research has shown that families of disabled children who have a key worker benefit from this service. UK evidence also suggests that parents of children with disabilities prefer working with a key service provider to working with different team members or services (Sloper, 1999).

Recent policy initiatives emphasize the importance of key worker service models (Sloper et al., 2006). However, research is lacking on which characteristics of key worker schemes for disabled children are related to better outcomes for families. To explore this question, Sloper and colleagues a postal questionnaire completed by 189 parents with disabled children who were receiving a service in seven key worker schemes in England and Wales. Path analysis was used to investigate associations between characteristics of the services and outcomes for families (satisfaction with the service, impact of key worker on quality of life, parent unmet need, child unmet need).

The four path models showed that better outcomes for families were achieved when:

- key workers carried out more aspects of the key worker role (provision of emotional support, information about services and the child's condition, advice, identifying and addressing needs of all family members, speaking on behalf of the family when dealing with services, co-ordinating care, and improving access to services and provision of support in a crisis);
- families had appropriate amounts of contact with key workers;
- there was regular training, had supervision and peer support for key workers; and
- there was a dedicated service manager and a clear job description for key workers.

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Greco et al. (2007) report the findings from interviews with parents of disabled children who are users of key worker schemes in England and Wales. The findings from this study have implications for policy and practice, for example, the necessity of protected time for key workers, the necessity of conveying clear information about the key worker's role, the importance of access to training and information for the key worker, the need for key workers to be proactive, and for their involvement in care plan and review meetings.

Principles of effective key worker service delivery

According to Drennan et al. (2005), the following general principles should guide the key worker model of service delivery:

Service-specific principles: the key worker service should:

- be family-centred rather than child-centred;
- be needs-led rather than service-led;
- entail a flexible, individualized approach;
- be a formalized program so it is recognized by professionals/practitioners across all agencies;
- be evaluated, monitored, and able to adjust to meet needs;
- include an overall Service Coordinator (i.e., to coordinate key worker services);
- be supported by a multi-agency steering committee; and
- have buy-in and ownership from management for longevity and maintenance of the program.

Role-specific principles: to support and empower key workers appropriately, the role should include:

- clearly defined job descriptions outlining roles, responsibilities, and limitations;
- protected time for the service, regardless of whether it is full-time or otherwise; and
- adequate support and training.
- Furthermore, key workers should: be accountable to the family, not perceived as working for an agency; and be a single contact, able to work across agencies.

The characteristics of effective key workers were identified by Greco et al. (2007) from interviews with parents of disabled children who were users of key worker schemes in the UK. Parents identified the following characteristics of a good key worker:

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- *Knowledge:* The key worker is knowledgeable, informed and knows where to find the information necessary about local services; and knows what it is like to have a child with a disability
- *Skills:* The key worker is organised; able to chair a meeting and speak on parents' behalf at meetings; able to liaise between different services, agencies; able to communicate information at different levels to families and to professionals; and is good with the disabled child
- *Professional characteristics:* The key worker Includes the whole family; is available at the other end of a phone; treats all that is said as confidential; is respected by other professionals; contacts the family regularly; is persistent; and treats the family like experts on their child
- *Personal characteristics:* The key worker is friendly and approachable; compassionate, caring and enthusiastic; has tact and diplomacy; listens and is not judgmental; and is respectful of the family.

8.2 Transdisciplinary teamwork

Transdisciplinary teamwork models were originally developed in early childhood intervention services for young children with disabilities. Such children often require the services of several different professionals, which could create additional stress for the family. To prevent such unintended effects, early intervention teams developed the transdisciplinary approach. This approach is designed to reduce fragmentation in services, reduce the likelihood of conflicting and confusing reports and communications with families, and enhance service coordination (King et al., 2009).

Woodruff and Sheldon (2006) define a transdisciplinary team service delivery model as:

one in which a team that is composed of professionals from different disciplines and the family come together to develop an integrated service plan for the child and family that is primarily carried out by one member of the team known as the primary service provider and the family' (p. 85).

King et al. (2009) define transdisciplinary service as 'the sharing of roles across disciplinary boundaries so that communication, interaction, and cooperation are maximized among team members'. The transdisciplinary team is characterized by the commitment of its members to teach, learn, and work together to implement coordinated services.

Transdisciplinary teamwork is one of four forms of teamwork which differ in the degree to which the team members act in an integrated fashion (Briggs, 1997):

- *Unidisciplinary teamwork:* one professional or one professional discipline attempts to serve all the needs of the family and child;

- *Multidisciplinary teamwork*: several professionals or professional disciplines work in parallel to meet the needs of the child and family, with limited interaction and exchange of information and expertise;
- *Interdisciplinary teamwork*: several professionals or professional disciplines , coordinate their services to the child and family, but with limited crossing of disciplinary boundaries; and
- *Transdisciplinary teamwork*: several professionals or professional disciplines , provide an integrated service to the child and family, with one professional acting as a conduit of services for the team.

Transdisciplinary teamwork is now seen a best practice in early childhood intervention services (Bruder, 2000; Kilgo et al., 2003; McWilliam, 2000).

Guidelines for interdisciplinary/transdisciplinary practice

In the US, the Council for Exceptional Children's Division of Early Childhood (DEC) has recommended guidelines for interdisciplinary practice (McWilliam, 2000). Four principles underpin the recommended practices in interdisciplinary services:

- *Collective responsibility and teamwork*: The first principle is that early intervention involves collective responsibility, meaning that teamwork is needed. The notion is that different perspectives make for better decision-making and that no one can do everything. The team consists of the individuals needed to conduct assessment, as well as the individuals involved in providing services. The children's parents or guardians are always central team members.
- *Transdisciplinary*: The second principle is that a transdisciplinary model of service delivery is recommended. It is important to avoid fracturing services along disciplinary lines. There should be an exchange of competencies between team members. This not only makes the intervention more holistic and complete, but enhances team members' abilities.
- *Functionality*: The third principle is that intervention should be functional. Interventions should be those that are necessary for the child's engagement, independence, and social relationships in the context in which he or she lives, and those that are immediately useful to the child. Functionality is necessary to avoid practices that serve the apparent need to some professionals to use their favourite interventions, regardless of the usefulness to the child or the impact on caregivers.
- *Practicality and parsimony for regular caregivers*. The fourth principle is that interdisciplinary services should be practical for regular caregivers and should be the simplest possible to implement. This is based on the belief that young children learn through ongoing interactions with the natural environment, rather than isolated lessons or sessions. Therefore, it is not the consultant

who has the direct impact on the child; it is the child's natural caregivers. (McWilliam, 2000)

Key components of the transdisciplinary model

Key components of the transdisciplinary model are as follows (Briggs, 1997):

- *Many disciplines are involved in the service delivery:* flexible boundaries and interchangeable roles and responsibilities encouraged the exchange of information, knowledge, and skills.
- *Collaboration and consensus decision-making* characterise the team members' interactions and problem-solving methods. Although all members may not be involved in direct service delivery for every family, all members are involved in the planning and monitoring aspects of intervention. All members are committed to teaching and learning from each other.
- *Families are integral members of the team,* involved to whatever extent they desire in the assessment, planning, implementation, and evaluation of treatment. Although all team members participate equally, the family holds ultimate warranty and decision-making power.
- *One person is designated as coordinator of care* to reduce the number of individuals working with the child and the intrusion into family life. The role of the coordinator of care is to incorporate team decisions and integrate other disciplines goals into a treatment program. (Briggs, 1997)

In transdisciplinary teamwork, all team members have to expand their traditional roles. This involves a sharing and exchange of certain roles and responsibilities, as well as a sharing of information and training. Team members continue to be recognised as the authority and resource for their own primary discipline (Briggs, 1997). A key feature of this way of working is *role release*:

The team becomes truly transdisciplinary in practice when members give up or "release" intervention strategies from their disciplines, under the supervision and support of team members whose disciplines are accountable for those practices. The role release process therefore involves sharing of expertise; valuing the perspectives, knowledge, and skills of those from other disciplines; and trust—being able to "let go" of one's specific role when appropriate. Role release also occurs with respect to the family (eg, parents can be educated about appropriate activities to incorporate into daily routines) (King et al., 2009).

Interdisciplinary and transdisciplinary models of working are now seen as essential features of human services in general (e.g. Anning et al., 2006; Chandler, 2006).

8.3 Team Around the Child

Team Around the Child (TAC) is a UK model of service provision in which a range of different professionals and agencies work together to provide particular children and families with seamless and non-fragmented support. Each child's team is made up of the parents and a handful of key practitioners who commit to meet regularly to share observations, discuss issues as they arise and agree a shared family support plan. Each team becomes the family-owned organisational nucleus of the wider group of people involved (from www.teamaroundthechild.com/tacmodel.html).

According to Peter Limbrick who has championed this approach in the UK (Limbrick, 2001, 2004, 2005, 2009, 2010), TAC was originally designed for babies and pre-school children with multifaceted conditions who require on-going multiple interventions.

The strengths of the TAC approach are that it:

- gives power to parents;
- protects children from intervention overload and protects their quality of life;
- offers a structure for genuine family-centred support; and
- considers the working conditions of practitioners.

The values and philosophy that underpin the TAC approach are essentially those of family-centred practice – partnerships between parents and professionals, mutual respect, parental empowerment, parental control of decision-making, shared information. It is recognised that most families are strong enough to get through the bad times and grow as a result. Support can be essential for this, but too much support might take away the opportunity for growth. Each family's drive to get back to their version of normal family life is supported, and family members are helped so that stress and anxiety are reduced as much as possible.

The Team Around the Child model has begun to be applied more widely as a result of the push for great service integration (Siraj-Blatchford et al., 2007). Limbrick (www.teamaroundthechild.com/tacmodel.html) suggests that it is now valid to talk about two types of TAC: the TAC System for babies and pre-school children with disabilities who need multiple interventions, and the TAC Approach for older children and young people and to those with a variety of needs, both long-term and short-term.

It should be noted that the adoption of the TAC model is being driven by its program logic rather than empirical evidence of its effectiveness. While there are good grounds for seeking to integrate service delivery for families of children with complex needs, there have not been any rigorous evaluations of the TAC service model.

8.4 Summary and conclusions

- For families with multiple and complex needs who require many different forms of service, key worker and transdisciplinary models of service have an obvious relevance. While there is some evidence of the effectiveness of these models, they are difficult to implement well, depend upon well-integrated services, and require experienced and well supported staff.
- The *Team Around the Child* model involves a group of professionals working together when needed to help one particular child. The model is informed by an ethos of flexibility and a focus upon the child and the child's needs. The model is being more widely applied as a result of a need for service integration, despite the lack of hard evidence for the effectiveness of the approach.

PART C: GENERAL SERVICE DELIVERY ISSUES

The next section deals with some general service delivery issues that are relevant for both client groups of interest in this review (i.e. disadvantaged families and multi-problem families). The topics addressed are:

- implementation science;
- motivational interviewing;,
- video feedback techniques; and
- measuring parent/professional relationships.

9. Implementation Science

Issues regarding implementation – that is the way in which evidence or policy is implemented in practice – have long been a key concern within the human services. However, it is only recently that implementation has been recognised as a science, that is, a specific discipline that rigorously investigates the use of methods, interventions, strategies and variables to support the systematic uptake of research findings into routine practice.

At the heart of implementation science is the idea that *improving services is influenced as much by the process of implementing innovative practices as by the practices selected for implementation* (Aarons et al., 2011). The innovative practice (or program)⁴ and the implementation process both need to be effective, as Mildon and Shlonsky (2011) point out:

In order to achieve anticipated effects, *both the intervention program and the implementation program* must work (emphasis added).

Without an understanding of how an intervention is implemented, misleading conclusions about intervention effectiveness may be made. In other words, a program can be deemed ineffective when what led to a lack of improved outcomes is the way in which the program was delivered, rather than the program itself (Breitenstein et al., 2010).

Implementation should not be confused with other processes that involve the spread of innovations such as the following:

- *Diffusion* is the process by which a new practice (or an ‘innovation’) is communicated over time among members of a social system. It is a passive process (Lomas, 1993; Chambers, 2008). An example of diffusion is the publication of a journal article that describes a new innovation. Organisations

⁴ Within the context of human services, an ‘innovative practice’ could be a new program or practice.

and practitioners may choose to adopt that new innovation if they happen to come across it.

- *Dissemination* is the active and planned effort to persuade target groups to adopt an innovation (Chambers, 2008). For example, an organisation that has developed a new, innovative program may strategically target specific agencies to encourage them to adopt that new program
- *Adoption* is the decision to use an evidence-based intervention (Weisz et al, 2005).

In contrast to these other processes implementation is an *active, planned and intentional effort* to mainstream an innovation within an organisation (Chambers, 2008; Weisz et al., 2005). For example, whereas diffusion is a passive process, with the onus on practitioners and organisations to seek out information about a new innovation, implementation actively engages practitioners and organisations. And whereas dissemination involves persuading groups to adopt an innovation, implementation is a much more intense, involved process than 'selling' an innovation and whilst it may involve decision-making around the adoption of an innovation it extends well beyond that decision to the actual 'mainstream' use of that innovation. As Greenhalgh et al. (2004) note:

The move from considering an adoption to successfully routinizing it is generally a nonlinear process characterized by multiple shocks, setbacks, and unanticipated events.

Sustainability can be viewed as the final step in the implementation process or as a separate process. Sustainability is the process whereby an innovative routine reaches obsolescence (Chambers, 2008).

Implementation science is a quickly growing, evolving discipline that is applicable to a broad range of diverse sectors including medicine (e.g. Aarons, 2004; Damschroder et al., 2009; Weinert & Mann, 2008), public health (e.g. Glasgow & Boles, 1999; Kerner, 2008) the public sector (Aarons et al., 2009, 2011; Bonner, 2009), ecology (Bammer, 2005), psychology (McHugh & Barlow, 2010) and human services (including child and family services) (Chagnon et al., 2010; Chamberlain et al., 2008; Mitchell, 2011). In the following discussion information about the key concepts of implementation science – that is the stages and core components for effective implementation – are reviewed. This is followed by a discussion of the key themes emerging from the fields of medicine and public health in regards to implementation science. These fields have generated a much greater amount of information about implementation science, the lessons of which are relevant to child and family services.

Following on from a consideration of the themes from medicine and public health, key themes emerging from the literature pertaining to implementation within the context of child and family services are considered.

In conclusion, a number of key issues pertaining to implementation and implementation science in regards to a home visiting program for vulnerable families and children are identified.

9.1 Stages of and core components for effective implementation

Across the range of disciplines where implementation science is being utilised, implementation is regarded as a staged process. In other words, implementation should not be viewed as a single step and may take a number of years to complete.

Fixsen et al. (2009) identifies six key stages in implementation:

- *exploration*: exploring and assessing the feasibility of programs for the best fit with the target population;
- *installation*: securing funding, staff, access to implementation expertise and creating policies for implementation of the new program;
- *initial implementation*: training staff to carry out the program with competence and putting organizational supports in place;
- *full implementation*: the new program is fully integrated into the agency or community⁵;
- *innovation*: ensuring adherence to the original program, seeking consultation with the originators to achieve excellent outcomes and maintain fidelity; and
- *sustainability*: focusing on continuous training and supports for the sustainability of the program.

It is important to note that although implementation occurs in phases, it may not occur in a linear fashion (Aarons et al, 2011). For example, an organisation may move from full implementation to initial implementation if there have been high levels of staff turnover (Fixsen et al., 2009) or during the initial implementation stage issues with resourcing may arise that require a return to the installation stage to re-examine the resources needed and where they might be found (Fixsen et al., 2011). Each stage of implementation impacts upon the other in complex ways (Fixsen et al., 2009).

Fixsen et al. (2011) argue that a critical stakeholder in the implementation process is the 'implementation team' (or the 'purveyors') (Fixsen et al., 2011). The implementation team consists of individuals who: (a) know interventions from a practice point of view; (b) are skilful users of implementation methods; and (c) are thoroughly engaged in continuous quality improvement cycles in all

⁵ Fixsen et al (2011) define full implementation as the point at which half or more of the practitioners begin to routinely meet performance standards.

aspects of their activities (e.g. reflecting upon their own behaviour and results and making changes to improve outcomes) (Fixsen et al., 2011).

The implementation team is responsible for the active, planned and intentional mainstreaming of innovations into practice. Fixsen et al. (2011) argues that the benefits of having an implementation team are evident throughout the stages of implementation. During the exploration stage, for example, the implementation team can help to mobilise community groups and participate in answering questions such as: what is the problem? What is the evidence-based option for solving this problem (or there are other options available)? (Fixsen et al., 2011).

Without an implementation team Fixsen et al. (2011) note that:

the burden of use of evidence-based programs is placed on would-be practitioners and related personnel. The most pervasive current approaches to using evidence-based programs in practice hold practitioners accountable for (a) learning about the intervention so they know what it is and how to do it in the context of their daily practice and (b) learning about implementation so they know what it is and how to do it in the context of organization functioning and system demands. At best, this is difficult to do in the busy life of a practitioner or manager. Yet, the expectation persists... and the science to service gap continues to widen.

Fixsen et al. (2011) view the implementation team as an ongoing resource for community groups and provider agencies who are delivering the program 'on the ground.'

In addition to the implementation team, a number of features have been identified as the core components of implementation (also known as 'implementation drivers'). These core components were identified by Fixsen et al. (2009) as the components that were common to successful implementation programs. These core components support practitioners to implement the program in the way that was intended (i.e. fidelity):

- staff selection;
- pre-service and in-service training;
- ongoing coaching and consultation;
- staff evaluation (i.e., assessing the use and outcomes of skills – this component helps practitioners continue to improve their effectiveness);
- decision support data systems (i.e., assessing aspects of overall performance of the organisation – provides data to support decision-making regarding the continuing implementation of the core implementation components over time);
- facilitative administrative support (i.e., leadership, making use of data inputs to inform decision making, supporting the overall process, keeping staff organised and focused on desired intervention outcomes); and

- systems interventions (i.e., strategies to work with external systems to ensure the availability of the financial, organisational and human resources required to support the work of the practitioners).

Fixsen et al. (2009) points out that any given practice or program may require more or less attention to any of the core implementation components. Strength in one component can be compensated by weakness in another component (Fixsen et al., 2009).

It important to note that the core implementation components exist independently of the quality of the program being implemented (Fixsen et al., 2009). In other words, even if you have a very high quality program, if the core implementation components are not attended it is unlikely that effectiveness will be achieved. Ineffective programs can be implemented well and effective programs can be implemented poorly.

9.2 Implementation science in medicine and public health

Implementation science, as a formal discipline, is relatively new within the child and family services field (Landsverk et al., 2011). Much of the literature that investigates implementation science pertains to medicine and public health (Landsverk et al., 2011) and much of the research that has looked knowledge utilisation amongst professionals working with children and families has been conducted in the health services sector with nurses (Chagnon et al., 2010). A review of this literature highlights a number of key issues. These are summarised below.

Key issues from medicine and public health about implementation:

- Even if a treatment is shown to be effective in a randomised controlled trial, the efficacy achieved in the RCT is diluted by the rate of adoption at:
 - the clinic level,
 - the individual provider level (i.e. the health professional),
 - the rate of acceptance of patients and
 - patients' adherence rate (Bonner, 2009).

Balas and Boren's (2000) work on utilising clinical knowledge for health care improvement found that although there was a growth in clinical research studies in the medical field there was a slow rate of adoption – on average it takes 17 years for evidence-based findings from clinical research to reach clinical practice.

- Factors that can impact upon implementation fidelity (i.e. the degree to which an intervention is conducted competently and conducted according to protocol) include:

- individual variations in practitioner adhere and competence,
 - lack of available training and technical support,
 - limited resources for supporting the intervention at the site level and
 - competing demands on practitioners' time that limit their commitment or effectiveness (Breitenstein et al., 2010).
- Finding a balance between teaching practitioners to be flexible but not alter a treatment too much is “critically important, but is often easier said than done” (Herschell, 2010). Some research indicates that rigid adherence to an intervention protocol leads to poorer outcomes than moderate adherence, suggesting that some level of practitioner flexibility is beneficial. However, other research has found a direct, linear relationship between adherence and outcomes – i.e., the greater the adherence the better the outcomes (Breitenstein et al., 2010).
 - Herschell (2010) argues that ‘flexibility within fidelity’ is an important phenomenon to consider because it is certain that adopters of an innovation will change them. Because adopters of an innovation will inevitably change it, they need to have adequate knowledge of the existing treatment as well as its theoretical base and sufficient support. They also need to be part of a larger network that enables them to keep up with any change in the treatment and the research about the treatment (Herschell, 2010).
 - Resources, guides and manuals that seek to disseminate the use of evidence-based practice amongst professionals are more likely to be used if they are:
 - easy to understand,
 - easy to implement and
 - do not require specific resources for implementation.

Guidelines that suggest the elimination of behaviour are more difficult to implement than those that recommend the addition of a new behaviour (Brantley, 2009).

- The application of evidence-based knowledge is not a neutral process. It is mediated by the person who applies that knowledge and the context within which the knowledge is being applied. The idea that the ‘journey’ from evidence to practice is a linear, uncomplicated process ignores the human element of practice as well as the conditions under which professionals operate (Greenhalgh et al., 2004; Hancock & Eason, 2004).

It is apparent that in the field of human caring, there is a multitude of factors affecting the application of knowledge into practice. In its neglect of these factors, evidence-based practice appears an incomplete model of the

relationship between theory and professional practice and, as such, needs developing (Hancock & Eason, 2004).

- Implementation should be thought of as an *intervention in itself* which sits on top of the intervention that will be used with patients (Chambers, 2008). An ‘implementation intervention’ may involve, for example, collecting data on site-specific implementation needs, barriers and facilitators (otherwise known as ‘formative evaluation’) and using local service providers, implementation experts and clinical experts to interpret this data and develop site-specific interventions (Curran et al., 2008). Implementation interventions that involve local participation (e.g. local service providers) enhance the adoption and sustainability of the patient intervention (Curran et al., 2008).
- Interventions that are not carefully adapted to the local context will not endure (Greenhalgh et al., 2004). However, the translation of findings from highly controlled research trials to real-world community interventions where there is variability in resources, organisational factors and research acceptance may make that process of adaptation challenging (Wallerstein & Durran, 2010).
- ‘Facts never speak for themselves’, meaning that the evidence base for particular practices is typically ambiguous and contested (Greenhalgh et al., 2004; Hancock & Eason, 2004). For this reason evidence needs to be continuously interpreted according to the local context and priorities. This may involve power struggles among various professional groups (Greenhalgh et al., 2004). Stakeholders may disagree about what constitutes evidence (Wallerstein & Duran, 2010).
- Yano (2008) advocates for careful consideration of organisational characteristics (i.e. the structural and process characteristics inherent to individual organisations) during and after implementation. Characteristics within organisations that can impact upon implementation include:
 - organisational structures: amount of space, availability of equipment, people employed;
 - organisational processes: factors that support the actions between practitioner and patient such as referral procedures, service coordination
 - culture and relationships: groups assumptions about ‘this is the way things are done around here’
 - organisational outcomes: outcomes at the organisational level.

9.3 Implementation science within the child and family services sector

In the child and family services sector, implementation science is concerned with the process whereby research evidence is implemented in practice and, ultimately, how service providers can use innovations effectively.

Although the importance of evidence-based practice has been recognised in this sector since the 1990s, there has been little attention paid to the implementation of evidence based practices into real world settings and few studies have examined the factors affecting knowledge utilisation in the child and family services field and social services (Chagnon et al., 2010; Landsverk, et al., 2011; Mildon & Shlonsky 2011).

As a justification for applying the discipline of implementation science within the human services, Fixsen et al. (2009) argues that the human services are often inconsistent, effective and sometimes harmful because of the way programs are implemented. Referring to the US, Fixsen et al. (2009) argues that,

in human services, our challenge in making use of science is how to build the science and quality into the daily performances of millions of practitioners across the nation.

Translating evidence into practice: key issues

The following discussion outlines some of the key issues emerging from the literature regarding the implementation of evidence into practice in this sector (not including those already identified in the medical/public health literature listed above).

Passive dissemination vs implementation

Mildon and Shlonsky (2011) argue that purposeful, active, integrated approaches to implementing evidence-based practice/programs will yield better results than passive dissemination approaches such as one-off training sessions, tips and fact sheets. This is reinforced by Herschell (2010) who, in an article pertaining to implementation within the field of psychology, argues that:

While we once hoped that fidelity in the field could be achieved with quick, passive implementation strategies like workshop or continuing education training, it is now clear that to be successful, the implementation process must be active, include several core components that impact multiple levels of the mental health delivery system (e.g., staff selection, training, coaching, staff performance assessment, data systems, facilitative administration, and systems intervention), and will likely take two to four years to complete.

The recruitment of implementation leaders or program champions may enhance the implementation process (Mildon & Shlonsky 2011). A leader or champion will

undertake tasks such as: inspiring with a vision, creating a learning environment; and celebrating performance (Mildon & Shlonsky, 2011).

Identifying core components of practice

The core components of practice need to be identified (i.e. what components are critical to the success of the program?) Successful implementation occurs when practitioners implement the core components of practice (Odom, 2009).

It is important to note that core components of practice may be 'tangible' resources. For example, a core component of a program may be the provision of transport for families. Without providing transport, families will not be able to attend and the program will not be effective (Mildon & Shlonsky, 2011).

Expectations of implementation

It is not realistic to expect that all practitioners will implement all components of practice; 80% implementation fidelity may be the maximum for many interventions (Odom, 2009).

What's delivered and how it's delivered

It is important to consider adherence *and* process, that is, the extent to which practitioners are delivering the program as intended *and* the quality with which they are implementing it. For example, for an intervention that is delivered in a classroom questions about quality could include: how well are teachers delivering the lessons and what is the quality of the relationship between teachers and students? (Odom, 2009).

The importance of considering the process is backed by the health literature. Breitenstien et al. (2010) notes that implementation fidelity is the extent to which a program is adhered to *and* the extent to which the program is conducted competently. Competence, in this case, involves characteristics such as communication skills, technical abilities and skills in responding to participants (Breitenstein et al., 2010).

The importance of considering how an intervention is delivered is reinforced by research undertaken within psychology which has found that therapeutic techniques account for no more than 15% of the variance in behaviour change amongst clients and other outcomes. The quality of the client-therapist relationship accounts for 30% of the variance in behaviour change and client outcomes (Clark, 2001a, 2001b; Hubble et al., 1999; Miller & Duncan, 2000).

In keeping with Mildon and Shlonsky (2011), Odom (2009) highlights the importance of considering attendance when reviewing how well a program has been implemented. A good program that is implemented well will have little effect if families and children do not attend the program. Whereas Mildon and Shlonsky

highlight the importance of resources, the issue regarding attendance also highlights the importance of engagement – practitioners need to be able to engage families in order that they then attend a program.

Barriers

A range of barriers can disrupt the implementation of services for children and families. These include:

- *outer context forces* – the service environment and inter-organisational environment (how well organisations relate to and partner with one another);
- *inner context forces* - intra-organisational environment, individual adopter characteristics; and
- the *interconnections* between the outer and inner context (Aarons et al., 2011).

Each of these 'forces' can impact upon each phase of the implementation process. For example, during the exploration phase budget restrictions (an 'outer context' service environment force) may discourage the exploration of innovations because it demands staff time. During the full implementation phase the structure of an organisation (an 'inner context' intra-organisational force) can have an impact upon the ease in which a program is implemented – centralised organisations generally have an easier time implementing programs than organisations that are less centralised or dispersed (Aarons et al., 2011). In any particular context, the forces that disrupt implementation will vary (Aarons et al., 2011).

Holzer et al. (2007) developed a framework for understanding the multiple factors that can impact upon the utilisation of research in practice and policy within the child welfare/child protection sector (known as the 'Cultures in Context' model).

The Cultures in Context model identifies seven factors that determine whether or not research is utilised in practice:

- *Individual attributes of potential research users*: the practitioners' values, beliefs and assumptions;
- *Organisational culture*: the norms, values and rituals present in the workplace;
- *Pragmatics*: the factors that individual practitioners and policy-makers, as well as, to some extent, organisations have little influence over (such as resources and capacity);
- *Nature and extent of the evidence*: the ease with which research can be easily understood and applied with a real-world setting;

- *Linkage and exchange mechanisms*: extent to which researchers and research users come into contact with one another;
- *Competing sources of information and influence*: competing sources of information and influence (e.g. lobby groups, media); and
- *Types of knowledge*: the ways in which practitioners and policy makers have developed views and understandings of the work that they perform.

Another approach to barriers to implementation is outlined by Ely (1990) who identified eight conditions which are necessary in order for the implementation of an innovation to be successful:

- *dissatisfaction with the status quo*: one or more people need to believe that improvement is necessary;
- *knowledge and skills*: staff members need to have the knowledge and skills to implement the innovation;
- *available resources*: tools, materials, equipment, personnel, infrastructure and finances and support structures are some of the resources that may be required. The resources need to be readily accessible and staff should feel confident that they can access them easily;
- *available time*: time is needed to learn, integrate change into practice and reflect on the impact the change has made;
- *rewards or incentives*: rewards could be either intrinsic (e.g. enhanced personal satisfaction with their own practice) or extrinsic (e.g. greater recognition);
- *expected participation*: all participants who are affected by the implementation should be included in decision-making processes;
- *commitment by those involved*: commitment should originate with senior management and endorsed by those affected by the change; and
- *leadership*: both upper management and at the project manager level.

Relationships of trust and collaboration

Collaborative relationships and the bonds of trust (also referred to as 'relational capital') between researchers and practitioners appear to be a key element that facilitates the use of research in practice in the child and family services sector (Chagnon et al., 2010). Both real involvement in collaborative efforts between researchers and practitioners and favourable attitudes towards collaboration with researchers is associated with practitioners' use of research in practice (Chagnon et al., 2010).

The same rule applies for the relationship between the implementation team and the practitioners. Odom (2009) suggests that there is often an inherent tension between purveyors and practitioners when it comes to flexibility and fidelity:

An inherent tension often exists between purveyors and practitioners, with purveyors wanting practitioners to implement the curriculum exactly as it was designed and practitioners wanting to modify components of the practice to fit their context.

Kerner (2008) describes a similar phenomenon:

One camp argued that implementing the interventions with fidelity was the best way, perhaps the only way, to ensure comparable outcomes. Adapting the intervention to help with contextual fit could be considered later, as long as core intervention elements were preserved intact. The other camp pointed out that unless program implementers were able to adapt the intervention a priori to address contextual and population fit, and perhaps imbue a sense of program ownership of the evidence based intervention being implemented, there would be a much lower likelihood of initiating implementation in the first place (p. 195).

This suggests that relationships of collaboration and trust between purveyors and practitioners can be challenging. However, Weisz et al. (2005) suggests that this 'clash' is not irreconcilable – that practitioners need to use therapeutic content in their work with clients but that evidence-based strategies need to be integrated into existing ways of working. As Kerner (2008) notes:

it should be recognized that for every context there is balance that must be reached between, for example, implementing an intervention with fidelity to ensure positive outcomes, and adaptation to help increase the contextual fit and implementation feasibility in real world settings (p. 195).

9.4 Summary and conclusions

- Implementation science is a specific discipline that investigates the use of scientific methods, interventions, strategies and variables to support the systematic uptake of research findings into routine practice.
- Implementation is a complex process. Even in the medical sector where it would appear that the implementation of at least some interventions would be relatively straightforward (e.g. the delivery of specific treatments) a number of factors can complicate the process.
- The potential for a program to be effective depends on the quality of the program being implemented *and* the quality of the implementation process. The two exist independently of one another. In other words, a good program can be implemented poorly and a poor program can be implemented well. Benefits to clients are most likely when an effective program and is implemented effectively.

- The implementation of an innovative treatment is an intervention within itself; just as the intervention will require sufficient resources in order to be effective, so too will the implementation process.
- Interventions need to be carefully adapted to the local context, in order to be sustainable. The 'evidence' upon which the intervention is founded may be contested.
- There are multiple frameworks for understanding the barriers to implementation. Barriers can be 'outer context' (e.g. the influence of lobby groups), 'inner context' (e.g. organisational capacity) and inter-relationships (e.g. the relationship between researchers and practitioners). The multiple barriers to implementation highlight the complexity of implementation.

10. Motivational interviewing

10.1 What is motivational interviewing?

The concept of motivation interviewing was first articulated nearly 30 years ago by Miller (1983) and subsequently elaborated and developed by Miller and Rollnick (1991, 1995, 2002). An account of the initial development and subsequent evolution of the model can be found in Miller and Rose (2009).

The first definition of motivational interviewing was provided by Rollnick and Miller (1995):

Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence.

More recently, MI has been described as a 'collaborative, person-centred form of guiding to elicit and strengthen motivation for change' (Miller and Rollnick, 2009). Elsewhere, MI is described as a refined form of the naturally-occurring communication style of guiding when helping someone to solve a problem (Rollnick et al., 2008). Guiding involves a blend of informing, asking and listening in a flexible manner; skillful clinicians do this in practice, as do good parents and teachers. As such, MI resembles more familiar approaches to helping, but in a refined manner that uses reflective listening in order to guide a person to resolve ambivalence about behavior change (Miller & Rollnick, 2010).

Miller and Rollnick (2010) discuss some of the common misunderstandings regarding MI. They emphasise that it is not a way of tricking people into doing what you want them to do. Nor is it simply a **technique**:

For better or worse, MI is considerably more complex than this. It is better understood as a clinical or communication method, a complex skill that is learned with considerable practice over time. It is a guiding style for enhancing intrinsic motivation to change (Miller & Rollnick, 2010).

They are also at pains to point out that MI is not a comprehensive approach to treatment, but a tool for addressing a specific problem: when a person may need to make a behavior or lifestyle change and is reluctant or ambivalent about doing so.

MI was originally developed for use with problem drinkers, and has subsequently been applied in a wide range of addictions and health behaviours involving a wide range of professionals as a general model for promoting behavioural change. These include medicine and health settings and professionals (Emmons & Rollnick, 2001; Karzenowski & Puskar, 2011; Levensky et al., 2007; Miller, 2005; Rollnick et al., 2008), mental health settings and psychologists (Arkowitz & Westra, 2010), and occupational therapists (Shannon, 2009).

10.2 Elements of motivational interviewing

Although based on principles of client-centered therapy as developed by Carl Rogers (1951), MI is an evolution of this approach (Miller & Rollnick, 2010). MI differs from traditional client-centered counseling in that it is consciously goal-oriented and focuses upon intentional direction toward change (Miller & Rollnick, 2010).

As summarised by Sciacca (2009), the four principles of MI are:

- *Express empathy.* This refers to the practitioner making a sincere effort to understanding the client's standpoint, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences.
- *Develop discrepancy.* This guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be versus how they currently are (or between their deeply-held values and their day-to-day behaviour).
- *Avoid argumentation and roll with resistance.* A third important principle of MI is that the counsellor avoids arguments and confrontations. MI is confrontational in its purpose to increase awareness of problems and the need to do something about them. However, direct argumentation tends to evoke negative reactions from people. In MI, the counsellor does not fight client resistance, but "rolls with it." Statements demonstrating resistance are not challenged. Instead the counsellor uses the client's "momentum" to further explore the client's views.
- *Support self-efficacy.* This guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counsellors focus their efforts on helping the clients stay motivated, and supporting clients' sense of self-efficacy.

Rollnick and Miller (1995) distinguish between what they call the spirit of motivational interviewing and the techniques that are needed to manifest that spirit. They propose that its central characteristic is not technique but its spirit as a facilitative style for interpersonal relationship. In a later elaboration of this point, Miller and Rose (2009) propose that motivational interviewing involves two specific active components: a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk. The first component underlying the efficacy of motivational interviewing is client–counselor relationship and, more specifically, the therapeutic skill of empathic understanding. Emmons and Rollnick (2001) identify the following key features of the spirit of motivational interviewing:

- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
- The therapeutic relationship functions best as a partnership rather than an expert/recipient relationship.
- Motivation to change should be elicited from the client, not imposed by the counselor.
- It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.
- The counselor is directive in helping the client examine and resolve ambivalence.
- Direct persuasion, in which rational arguments for change are presented to the client by the expert, is not an effective method for resolving ambivalence.
- The counseling style is generally a quiet and eliciting one.

Complementing the spirit of MI are specific techniques that focus on evoking and reinforcing client 'change talk', that is, helping the client verbalise arguments for change (Miller & Rose, 2009).

The key practitioner characteristics required to promote positive change are accurate empathy, congruence, and positive regard (Miller & Rose, 2009). The specific skills needed include use of open ended questions, the ability to provide affirmations, the capacity for reflective listening, and the ability to periodically provide summary statements to the client (Emmons & Rollnick, 2001).

Practical guidance on motivational interviewing can be found in Rollnick et al. (1999, 2010) and Rosengren (2009), while training issues have been addressed in studies by Miller et al. (2004), Britt & Blampied (2010) and Forester et al. (2012). As Miller and Rollnick (2010) and Forester et al. (2012) all note, MI is simple, but it is not easy to learn or apply. In practice, MI involves quite a complex set of skills that are used flexibly, responding to moment-to-moment changes in what the client says. Training research indicates that proficiency in MI is not readily developed through self-study or by attending a workshop, but typically requires practice with feedback and coaching over time (Miller & Rollnick, 2010). Forrester et al. (2012) summarise studies they have conducted indicating that training social protection workers in motivational interviewing is not without its problems. In one study, social workers who attended a course on MI were found to have very confrontational communication styles. In another

study, they taped interviews between social workers and an actor playing a client in a child protection situation and found very varied levels of skill – all the social workers successfully raising concerns, but while did so empathically, the majority were highly confrontational. The confrontational approaches tended to create high levels of resistance from the actors playing clients.

Miller and Rose (2009) have developed a causal chain model that links therapist training, therapist and client responses during treatment sessions, and post-treatment outcomes.

10.3 What is the evidence for the effectiveness of motivational interviewing?

Systematic reviews and meta-analyses have been conducted by Burke et al. (2003), Rubak et al. (2005), Hettermer et al. (2005), Lundahl et al. (2010) and Vasilaki et al. (2006). Appraisals of this body of evidence can be found in Stewart (2012).

Burke et al. (2003) report on a meta-analysis of controlled clinical trials of individually delivered interventions that incorporated the four basic principles of motivational interviewing: expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. They found 30 trials that met these criteria. Overall, MI was equivalent to other active treatments and superior to no-treatment or placebo controls for problems involving alcohol, drugs, and diet and exercise. The efficacy of MI for alcohol, drug, and diet and exercise problems was in the medium range overall and appeared to be sustained at follow-up points as long as 4 years post-treatment. These MI studies also showed evidence of clinical impact, with 51% of people who received MI treatment improved at follow-up compared with 37% of those receiving no treatment or treatment as usual.

Rubak et al. (2005) conducted a systematic review and meta-analysis of randomized controlled trials using motivational interviewing as the intervention in the management of lifestyle problems and disease. They identified 72 randomised controlled trials in all, and found that MI outperformed traditional advice giving and helped elicit changes in client's behaviour in 80% of the studies. MI had a significant and clinically relevant effect in approximately three out of four studies, with an equal effect on physiological and psychological diseases. Psychologists and physicians obtained an effect in approximately 80% of the studies, while other healthcare providers obtained an effect in 46% of the studies. The review has also shown that MI can be effective even in brief encounters of only 15 minutes and that more than one encounter with a patient increases the likelihood of effect (Rubak et al., 2005).

Rubak et al. conclude that, although MI outperforms traditional advice giving in the treatment of various behavioural problems and diseases in controlled trials,

evaluation of its application in clinical settings is currently lacking. They suggest that there is a need for large-scale studies of randomised controlled trials and qualitative studies on how to implement the methods of MI in daily clinical work.

Hettema et al. (2005) report on the findings of a meta-analysis of 72 clinical trials of MI spanning a range of target problems. The average short-term between-group effect size of MI was 0.77, decreasing to 0.30 at follow-ups to one year. However, MI was not consistently effective: there was considerable variability in effectiveness across providers, populations, target problems, and settings. Overall, these results provide support for the use of motivational interviewing in the areas of addictive and health behaviors. There was evidence that MI was useful as a brief intervention in itself, and that it also appears to improve outcomes when added to other treatment approaches. One counterintuitive finding was that effect sizes were greater when the practice of MI was not guided by a manual. It seems that when therapists did exactly what the manual instructed them to do, pushing to complete the change plan even if the client resisted, they violated good MI practice and got poorer results.

Vasilaki et al. (2006) conducted a meta-analytic review of randomized control trials of MI interventions, focusing on its efficacy as a brief intervention for excessive drinking. They identified 22 relevant studies, of which nine compared brief MI with no treatment, and met methodological criteria for inclusion. These studies yielded an aggregate effect size of 0.43, supporting the effectiveness of MI as a brief intervention.

Lundahl et al. (2010) conducted a meta-analysis of 119 randomised controlled trials of MI to investigate the unique contribution it had on counseling outcomes and how it compares with other interventions. The outcomes studied included substance use, health-related behaviors, gambling, and engagement in treatment variables. Their analyses suggested that MI has a small but positive effect across a wide range of problem behaviours, although it was more effective in some situations than others and was ineffective or less effective than other interventions about 25% of the time. However, 75% of participants in these studies gained some benefit, with 50% gaining a small but significant benefit and 25% a moderate to strong benefit.

Overall, these reviews present convergent evidence that MI can be an effective intervention with a range of addictive and health-related behaviours. Miller and Rose (2009) summarise the evidence thus:

After three decades of research, motivational interviewing is a psychotherapeutic method that is evidence-based, relatively brief, specifiable, applicable across a wide variety of problem areas, complementary to other active treatment methods, and learnable by a broad range of helping professionals. A testable theory of its mechanisms of action is emerging, with measurable components that are both relational and technical.

10.4 Summary and conclusions

- Motivational interviewing involves a collaborative, client-centred counselling style for eliciting behaviour change.
- The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment from the client.
- The findings of systematic reviews provide strong support for motivational interviewing when compared to traditional advice giving.
- MI is flexible in its administration and can be delivered as a freestanding intervention, or as a motivational prelude to other treatment.
- In the context of sustained home visiting programs, it is critical to ensure that the parent wants the help and is motivated to change (i.e. to find more effective ways of meeting their child's needs). MI would seem to be an approach that could be used for this purpose. Its collaborative and client-centred approach is compatible with family-centred practice and family-partnership model. Although it has not been explicitly trialed in home visiting work, it deserves consideration as one of the tools that home visitors should have at their disposal.

11. Video feedback techniques

11.1 Parent-child interactions

As Sameroff (2004) points out, treating early relationship problems is important from two aspects: the relief of current suffering and the prevention of long-term consequences. In studying parent-child interactions, researchers have focused on the individual characteristics both of the child and the parent, and on the way the merging of their individual styles determines the success of the mother-child relationship (Kelly & Barnard, 2000). This research shows that

- infants come with a unique set of characteristics (such as different temperaments and differing tolerances for sensory stimulation)
- for synchronous relationships to develop, these individual characteristics must evoke differences in mothering
- parents also come with unique characteristics (such as their awareness of their child's development and abilities, and their energy levels)
- the reciprocity that develops as both partners respond and adapt to each other is the basis for a mutually satisfying relationship between them (Kelly & Barnard, 2000)

Where children come from families in adverse circumstances, there are also additional problems, regardless of whether the children have disabilities or developmental delays (Kelly & Barnard, 2000). Research with this population shows that

- early environmental characteristics that have been identified as risk factors contributing to poor outcomes in children include low maternal intelligence, low maternal educational achievement, maternal depression or low self-esteem, low maternal age at time of child's birth, large family size and poverty
- parents who are experiencing adverse environmental circumstances tend to be less responsive and sensitive in their interactions

11.2 What are video feedback techniques?

Video-feedback is a tool used in infant mental health services to promote parent-infant interactions. It involves a focus upon the observable interactions between a child and parent, which become the initial focus of the therapy and, as such, serve as a therapeutic 'port of entry' (Sameroff, 2004). Parent interactions with the child are understood both as reflection of family structure and care giving nurturance and as a reflection of the caregiver's and child's representational world (McDonough, 2004). Video feedback is usually part of a multimodal approach which makes use of instruction, therapeutic counselling and/or other forms of parental support (Brisch et al., as cited in Fukkink, 2008). The approach seeks to facilitate the parent's understanding of growth and development of their child. Caregivers are actively involved in observing both the behaviours of their infant and their own style of interaction and play with their child.

The use of videotape in treatment allows for immediate feedback to the parent(s) or family regarding their own behaviour and its effect on the infant's behaviour.

Through viewing samples of parent-child play interaction, family members become more aware of important interactive behaviours that are positive and need to be reinforced, elaborated and extended, and those interactions that were less enjoyable or inappropriate requiring redirection, alteration or elimination (McDonough, 2004).

The use of videotape also provides the parents with the opportunity to listen more carefully to what they say to their child and the manner in which they say it.

11.3 Programs that utilise video feedback

- ***Interaction Guidance (McDonough, 1995, 2000, 2004)***
Interaction Guidance is an intervention developed primarily to reach families that have been difficult to engage; that are burdened by social adversity such as poverty, violence, and lack of education; that have a limited capacity for introspection; and that have

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resisted previous offers of help using more traditional psychotherapeutic methods. In an effort to reach overburdened families, interaction guidance therapists invite families to take an active role in the creation and evaluation of their family's treatment. The goal is to develop a therapeutic approach that is sensitive to each family's strength and vulnerabilities. (McDonough, 1993, 2000, 2004).

- ***Modified Interaction Guidance (Benoit, 2001-02)***

This modified version of McDonough's Interaction Guidance was developed by Benoit (2001-02) and takes the form of 5-7 weekly sessions, each involving approximately 10 minutes of videotaped interactions between the parent and child, followed by 45-60 minutes of observation of the video, discussion and feedback. The approach can be used with more than one parent and more than one child in the room (Benoit, 2001-02).

- ***Video Interaction Project (VIP) (Mendelsohn et al., 2005, 2007)***

The VIP approach involves the use of videotaped interactions by child development specialists while parents wait to see their child's pediatric provider for well-child visits. The goal of VIP is to support the parent-child relationship and thereby enhance cognitive, language, and social-emotional development. The VIP approach is relationship based: a single child development specialist builds a caring relationship with each family that forms the foundation for the intervention (Mendelsohn et al., 2007).

VIP sessions begin at the first visit to the pediatrician when the infant is approximately 2 weeks old and continue regularly until age 3 years. Each 30- to 45-minute session includes (1) discussion of parental expectations and concerns about the child as well as the child's present and anticipated developmental progress, (2) receipt of a developmentally appropriate learning material (e.g., toy or book) that promotes parent-child engagement, (3) a 5- to 10-minute videotaped recording of the parent and child engaging in activities of the parent's choice, which is then rewound for the parent and the child development specialist to view together. As the tape is watched, the parent and the specialist each make observations based on the videotape, with the specialist highlighting the parent's strengths and suggesting activities to practice at home (Mendelsohn et al., 2007).

- ***Marte Meo Developmental Support Program (Aarts, 2008)***

The Marte Meo Developmental Support Programme, developed by Maria Aarts, is a practical model for supporting development in everyday communication moments. The central focus of the programme is to identify, activate and develop skills to enable and enhance constructive interaction. This programme uses video review and from this training participants learn very concrete information about supporting children's development in daily interactive moments (infancy to school age children) and for transferring this information to parents and other significant carers.

As described by Neander and Engstrom (2009), the starting point in the Marte Meo intervention is the question raised by the parent. The therapist makes a short video recording (3–7 minutes) of the child interacting with his/her parent(s) and analyses it, using a number of basic principles for a natural supportive dialogue. The therapist then chooses sequences to review with the parent, to create a link between the parent's initial question and the therapist's idea of what kind of support the child needs. The basic

purpose is to afford an opportunity for joint observation and reflection on the child and his/her needs. The parent becomes an active, reflective participant in the work of developing his/her interaction with the child, and the child is mentalized instead of problemized. The parent is encouraged to practise in everyday situations, and the process continues with new recordings, analyses and joint reflections (Neander & Engstrom, 2009).

Marte Meo programs have been developed for a variety of developmental problems (crying infants) and developmental disabilities (including autism, hyperactivity, intellectual disability). Programs are also available for a variety of settings (child care, child protection, family support, foster care) and purposes (assessment, quality improvement).

- ***Video-based Intervention to Promote Positive Parenting (VIPP)***(Juffer et al., 2007)
Similar to Interaction Guidance, this program was developed in the Netherlands after research indicated that parents needed a mirror of their daily interactions with their child in order to change their behaviour. It is a brief and focused parenting intervention program that has been used in a variety of clinical and nonclinical groups and cultures. VIPP aims to enhance parental sensitivity and positive parent–child interactions and thereby strengthen the attachment relationship. The recommended age range for using the intervention is between 6 months and 5 years.
- ***Video Interaction Guidance (VIG)*** (Kennedy et al., 2011)
This is another intervention which builds positive relationships through filming and feedback sessions. By micro-analysing actions and communications in this way, clients are supported to resolve their current difficulties and increase their sensitivity and attunement within the relationship.

11.4 What is the evidence for the effectiveness of video feedback techniques?

A number of studies have been analysed to elucidate the effectiveness of video feedback techniques (Bakermans-Kranenburg et al., 2003; Barlow & Schrader-MacMillan, 2010; Fukkink, 2008).

Meta-analyses of the effectiveness of attachment-based interventions carried out in the Netherlands (Bakermans-Kranenburg et al., 2003) found that relatively short interventions using video-feedback were more effective than those without and that interventions that focused on adult sensitivity alone were the most effective. In the UK, key findings from a review of studies conducted by the Department for Children, Schools and Families (Barlow & Schrader-MacMillan, 2010) indicate that targeted early interventions that are aimed at increasing parental sensitivity and promoting attachment are effective in preventing emotional maltreatment. They cite evidence of the effectiveness of video interaction guidance in improving parental sensitivity. Another meta-analysis of family programs using video feedback (Fukkink, 2008) found significant positive

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effects of video feedback interventions on the parenting behavior and attitude of parents and the development of the child. Parents become more skilled in interacting with their young child and experience fewer problems and gain more pleasure from their role as parent.

What evidence is there regarding the specific video feedback programs described earlier?

- **Interaction Guidance** (McDonough, 1995, 2000, 2004). Despite widespread use, there have been few studies of the efficacy of Interaction Guidance. In a preliminary study in Switzerland, Interaction Guidance was found to be as effective as brief psychoanalytical psychotherapy in improving mothers' interactions with their infants, perceptions of their infants, and symptomatology in a middle-class, clinic-referred sample (Cramer et al., 1990). Interaction Guidance has also been used in a program for maltreated infants and toddlers in foster care (Larrieu & Zeanah, 1998; Lieberman & Zeanah, 1999).
- **Video Interaction Project (VIP)** (Mendelsohn et al., 2005, 2007). Mendelsohn et al. (2005) performed a randomized, controlled trial to assess the impact of the Video Interaction Project (VIP). A sample of Latino children at risk of developmental delay on the basis of poverty and low maternal education (none had completed high school) were assessed for cognitive and language development at age 21 months. Results differed depending on the level of maternal education, with the VIP having a moderate impact on children whose mothers had between seventh and 11th grade education but little impact on children whose mothers had sixth grade or lower education. A follow up at the age of 33 months (Mendelsohn et al., 2007) found that the VIP was associated with improved parenting practices including increased teaching behaviours as well as lower levels of parenting stress. VIP children were more likely to have normal cognitive development and less likely to have developmental delays. This study provides evidence that a paediatric primary care-based intervention program can have an impact on the developmental trajectories of at-risk young preschool children.
- **Modified Interaction Guidance** (Benoit, 2001-02). In a small randomised control trial, Benoit et al. (2001) tested whether the Modified Interaction Guidance approach would reduce atypical behaviors and disrupted communication in parent-infant interactions. The subjects were caregivers who had been clinically referred for infant feeding that were considered to reflect relationship difficulties. A comparison group with similar feeding problems received training in feeding techniques. They found that those receiving Modified Interaction Guidance showed a significant decrease in measures of disrupted caregiver behavior from pre- to post-intervention, whereas there was no change in disrupted caregiver behaviour in the control group. A subsequent reanalysis of the data (Madigan et al., 2006) indicated

that benefits were immediate: the total number of disrupted caregiver behaviors decreased significantly after the first treatment session, and a change to a classification of not-disrupted was also observable after the first treatment session for the majority of caregivers initially classified as disrupted. However, statistically significant changes in the level of disrupted caregiver behavior was not evident until the caregiver had received all three treatment sessions.

- **Marte Meo approach** (Arts, 2008). Although widely used in Europe, there appears to be limited published evidence of the efficacy of the Marte Meo approach. In an Israeli study (Weiner et al., 1994), a Marte Meo video-based home training program was provided to families having problems in parent-child interactions with their young children. Compared to a control group, only the families receiving the intervention showed significant gains in all the eight areas of positive parent-child communication that are the focus of the program. These gains were generally sustained 6 months after program completion. Vik and Braten (2009) report a clinical study using the Marte Meo approach with three mothers with postnatal depression. This found various improvements in mother-interactions as well as the mothers' holding behaviours (which shifted from an avoidance or anxious stance to closer and more secure holding).
- **Video-based Intervention to Promote Positive Parenting (VIPP)**(Juffer et al., 2007). Groeneveld et al. (2011) conducted a randomized controlled trial to test the efficacy of a video-feedback intervention to promote positive parenting-child care (VIPP-CC) in home-based child care. Caregivers were randomly assigned either to the intervention group or to the control group. Global child care quality improved in the intervention group but not in the control group. The program did not change observed caregiver sensitivity. After the intervention however, caregivers in the intervention group reported a more positive attitude toward sensitive caregiving than caregivers in the control group. The study shows that the family-based intervention can be applied with some minor modifications in a professional group setting as well. Other evidence of the efficacy of the VIPP approach in work with vulnerable families is summarised in Juffer et al. (2007).

11.5 Summary and conclusions

- Video feedback techniques involve a focus upon the observable interactions between a baby and caregiver. The techniques are typically part of a multimodal approach which makes use of a range of different types of support.
- Family programs that utilise video feedback techniques vary in their design and procedures and include behaviour-orientated programs and psychotherapeutic approaches.

- The evidence regarding the effectiveness of video feedback techniques is mixed. Some studies have shown that video feedback brings about positive outcomes for parents but not for children, whilst other studies have shown that video feedback does have positive effects on children’s developmental outcomes.
- While there is some evidence of its effectiveness, the technique requires considerable skill and training to do well and avoid doing harm, and therefore might be best left to infant mental health specialists (or only used under the supervision of such specialists).

12. Measuring parent/professionals relationships

As noted in section 4.1 of this review, the quality of parent-professional relationships is critical to the effectiveness of an intervention. It is important, therefore, to measure this variable.

There are two main types of tools for evaluating the quality of parent-professional relationships. They are those that:

- measure parents experiences of the parent-professional relationship; and
- measure service providers’ attitudes, beliefs and behaviours in regards to their relationships with parents.

A number of tools include both service provider and parent measures. A small number of measures are designed to evaluate a whole agency’s attitudes, beliefs and behaviours in regards to their relationships with parents. The majority of all of the available measures focus upon family-centred practice (i.e. assessing the extent to which family-centred practice was ‘delivered’ and ‘received’). Two measures that can be used for measuring the quality of parent-professional relationships include:

- ***The Measure of Processes of Care (MPOC-56)*** (King et al., 1995): the MPOC-56 was one of the first psychometrically sound measure developed that could discriminate parents perceptions of the services they experience. The MPOC-56 is a validated self-report measure of parents’ perception of the extent to which the services they and their child receive are family-centred. It includes a total of 56 items and 5 scales:
 - enabling and partnership,
 - providing general information,
 - providing specific information about the child,
 - coordinated and comprehensive care for the child and family, and
 - respectful and supportive care.

As of 1999, a shorter version of the MPOC-56 has been made available. This shorter version is the MPOC-20, which includes a total of 20 items.

- **Help-Giving Practices Scale** (Trivette & Dunst, 1994): The Help-Giving Practices Scale is a 25-item scale that measures a variety of help-giving behaviours and practices. Each item includes five responses from which the respondent selects a behaviour that best describes a particular help-giver practice. The scale gives an overall score as well as four subscale scores, each measuring a particular aspect of help-giving beliefs and practices:
 - empowerment ideology (helpgiver beliefs about the capabilities of people),
 - participatory actions (help-giving processes used to promote help-seeker knowledge and competencies),
 - help-giver traits (behaviours associated with effective help-giving, such as active listening, honesty, and empathy), and
 - help-seeker reactions to aid (response-cost consequences of accepting or refusing help).

Dunst et al. (2002) report the use of a 12-item short form of this scale, half the items describing relational help-giving practices (empathy, warmth, genuineness, beliefs about help-seeker capabilities) and half describing participatory help-giving practices) behaviours that actively involve people in identifying goals and courses of action, and which strengthen capacities and skills).

- **The Parenting Experiences Scale** (Trivette & Dunst, 2003) is a one-page scale that assesses parents' perceptions in four areas: three of which relate to their experiences in early intervention programs, while one relates to their own parenting abilities. The first section asks about the amount of contact between the family and the early intervention staff. The second section asks parents about their perceptions of how they are treated by staff from the early intervention program. The third section explores how parents feel in terms of their role as parents, and the last section examines the extent to which families feel they can influence the resources and supports they receive from the program.

In addition to specific measures, Roberts et al. (1998) highlights the value and importance of formative evaluation. They describe one approach to formative evaluation whereby service providers interviewed parents and collected data relating to assessments and referrals undertaken on an ongoing basis throughout the life of a program. They continuously reviewed this data in order to identify which principle appeared to have been the basis for decision made and service provided. They could then use this information to determine whether they needed to make changes to conform to the principles of service delivery that underpinned

the program. These principles included, for example, family empowerment and family-driven services.

12.1 Summary and conclusions

- The quality of the relationships between the parents and professionals involved in the home visiting program will have a significant impact upon the effectiveness of the program. Parent-professional relationships that are founded upon respect, a strengths-based approach and a sense of common purpose are most likely to produce optimal wellbeing for the families involved.
- The practitioners delivering the home visiting program need to have specific skills in order to develop effective relationships with parents. That is, the skills to: start people talking (observation of people's behaviour and mood, door openers); keep people talking (non-verbal attending, minimal encouragers, reflective listening, available attitude); understand what people are saying and feeling (observing, reflecting feelings, questioning and clarifying, repeating and rephrasing, paraphrasing and summarising); and help people move forward (questioning, summarising, assertiveness and challenging, clarifying goals, problem solving).
- A range of tools could be used to evaluate the quality of parent-professional relationships in the home visiting program. Some tools assess the parent's experience of the relationship whereas others assess the service provider's attitudes, beliefs and behaviours in regards to their relationships with parents.
- A formative evaluation of parent-professional relationships may be especially useful in a home visiting program. A formative evaluation allows the program as a whole, and individual practitioners, to reflect upon their practice and, where necessary, amend their practice in a timely manner in order to enhance the effectiveness of the program.

PART D: SUMMARY, CONCLUSIONS AND IMPLICATIONS

13. Summary and conclusions

13.1 Key themes

A number of key themes emerge from this review of effective processes and strategies:

- There is general support for the notion that process aspects of service delivery matter for outcomes – that *how* services are provided is as important as *what* is provided.

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- A number of key elements of effective service delivery processes have been repeatedly identified in the research literature. Effective services are relationship-based, involve partnerships between professionals and parents, target goals that parents see as important, provide parents with choices regarding strategies, build parental competencies, are non-stigmatising, demonstrate cultural awareness and sensitivity, and maintain continuity of care.
- These process variables appear to be of particular importance for the most vulnerable families, who appear to be less likely to make use of professional services that do not possess these qualities.
- Other key factors identified include the importance of providing practical support to address families' most pressing needs, and the need to coordinate services to address the barriers that parents face in accessing services as well as the background factors that have led to the families having difficulties in caring for their children.
- Three elements of effective help-giving/family-centred practice have been identified: relational help-giving, participatory help-giving, and technical quality and knowledge. The third of these refers to the service provider's knowledge of and ability to deliver the strategies available to help parents achieve the goals they have identified. The effective use of evidence-based strategies is critical for ensuring that changes occur in the way that parents interact with and care for their children, which is in turn a prerequisite for change in the children themselves.
- There appears to be a number of necessary, but not sufficient, factors associated with enhanced early intervention outcomes. They can be divided into primary (threshold) factors that function in an all-or-nothing manner and secondary factors (fine-tuning).
 - *Primary factors* include: shared decision-making between parent and professional; quality of relationship between the parent and professional; non-stigmatising presentation of intervention; cultural awareness and sensitivity; flexible settings/hours; and provision of crisis help prior to other intervention aims.
 - *Secondary factors* include: choice of theoretical model; choice of timing of intervention; choice of location to offer intervention — home, clinic, community location; and choice of intervenor — professional or paraprofessional.
- Professional attitudes and perceptions also appear to be important – e.g. seeing vulnerable/marginalised families as facing barriers to accessing and using services rather than irresponsibly failing to use them

- Ways of effectively engaging and empowering vulnerable and marginalised families have been identified. These include: services that help them feel valued and understood, and that are non-judgmental and honest; services that have respect for their inherent human dignity, and are responsive to their needs, rather than prescriptive; services that allow them to feel in control and help them feel capable, competent and empowered; services that are practical and help them meet their self-defined needs; services that are timely, providing help when they feel they need it, not weeks, months or even years later; and services that provide continuity of care – parents value the sense of security that comes from having a long-term relationship with the same service provider.
- The concepts of ‘complex’ and ‘multiple’ needs are used by various disciplines and service sectors in a variety of ways. However, the essence of complex needs as implying both *breadth of need* (more than one need, with multiple needs interconnected) and *depth of need* (profound, severe, serious or intense needs).
- It is the cumulative effect of multiple environmental stressors and risks that make families more vulnerable. At all three levels (individual, family and community), parents’ problems are likely to be multiple, overlapping, and cumulative. If parents have problems in one area they almost certainly had problems in other areas of their life, further compounding parenting difficulties. The greater the number of stress factors that were reported by parents, the less likely they were to be ‘coping’ with parenting.
- We do not know how many families or what percentage of families can be considered vulnerable, and therefore would benefit from additional support and services. We have data on the numbers of children who fall into particular risk categories, such as poverty, but not on how many children and families are exposed to multiple risk factors, or whether the number of such families has increased.
- The previous literature review (CCCH, 2012) identified a number of manualised home visiting packages that have been shown to be moderately effective. The present review has identified a number of more flexible models for working with vulnerable families that are more consistent with process features and therefore might serve as models for the current project.

13.2 Specific strategies

A number of specific strategies for working with disadvantaged and multi-problem families have been investigated:

- ***Multi-systemic therapy.*** This approach is not obviously applicable to an intensive home visiting service. It appears to be too intensive and costly,

there is not enough evidence of its effectiveness, and its usefulness with families with young children is unknown.

- **Wraparound models of service delivery.** This is more obviously applicable approach, but hard to do well, partly because of the difficulties in coordinating services for sustained periods. Moreover, it has had limited use with families of young children.
- **Key worker and transdisciplinary models.** For families with multiple and complex needs who require many different forms of service, key worker and transdisciplinary models of service have an obvious relevance. While there is some evidence of the effectiveness of these models, they are difficult to implement well, depend upon well-integrated services, and require experienced and well supported staff.
- **Motivational interviewing.** Supporting evidence for this approach is not strong, but the key elements seem relevant and worth pursuing. It functions as a support strategy rather than a wholesale approach. It has not been applied to this target group.
- **Video feedback techniques.** There are some tools for assessing parent/professional relationships.
- **Measuring parent / professional relationships.** Assessing the relationships between parents and professionals is a valuable aspect of service delivery, and there are some tools available for the purpose. A formative evaluation of parent-professional relationships may be especially useful in a home visiting program. A formative evaluation allows the program as a whole, and individual practitioners, to reflect upon their practice and, where necessary, amend their practice in a timely manner in order to enhance the effectiveness of the program.

13.3 Discussion

The review of the implementation science literature suggests that although the science related to developing and identifying 'evidence-based practices and programs' has improved over the past decade, the science related to implementing these programs with fidelity and good outcomes for consumers lag far behind. In general, implementation refers to what a program consists of when it is delivered in a particular setting. There are a number of different aspects to implementation, including: program fidelity, dosage, quality, participant responsiveness, program reach, and adaptation (changes made in the original program during implementation).

The evidence indicates that the level of implementation affects the outcomes obtained in promotion and prevention programs. The benefits of a home visiting program to children and families will be enhanced by an active, planned and

intentional process of implementation. Factors important in effective implementation include considering the local context, the balance between flexibility and fidelity, and the importance of competent practitioners.

Behind the implementation issue lies the question of exactly what is being implemented. It is assumed that the actual program or service being delivered is evidence-based, and that the challenge is how to ensure that it is being delivered according to the program guidelines and schedules. However, definitions of evidence-based practice indicate that it has three elements: best research evidence (the results of formal trials of intervention strategies), clinical expertise and practice wisdom (individual clinical knowledge as well as collective practice wisdom), and client characteristics, values and context (the unique preferences, culture, concerns and expectations each client or family brings). All of these need to be integrated when making decisions about what strategies are to be used in addressing the intended goals.

According to this analysis, there are three types of fidelity that appear to be important to effective delivery of services such as intensive home visiting. :

- program fidelity – delivering evidence-based programs in accordance with guidelines
- process fidelity – delivering services in ways that are consistent with best practice
- values fidelity – delivering services that are congruent with family values and beliefs

If the ultimate goal is to maximise 'take-up', i.e. the use that parents make of the expertise and support provided by professionals, then effective implementation should involve all three of these forms of fidelity.

14. Implications for the Australian SNHV trial

14.1 Implications

Recommended core features of a prospective home visiting model are as follows:

- The process variables identified as essential for effective service delivery represent the *threshold* features of the model – the bedrock on which the service is based. These service features are the starting point for all service delivery as well as the core qualities that continue to infuse all subsequent service delivery. The key qualities include relationship-based, partnership-based, capacity-building, provision of choices, addressing immediate practical issues, and addressing background factors. To ensure that service delivery is faithful to these core practices, measures of process fidelity should be regularly used.

- The identification of goals and of strategies to achieve these goals needs to be done in partnership with parents. To help ensure that the process of selecting goals and strategies is done systematically, decision-making algorithms and guidelines should be developed. To ensure that the goals and strategies are compatible with parental values and priorities, measures of values fidelity should be regularly used.
- The strategies used should be evidence-based. Service providers should be able to draw on a suite of evidence-based strategies to address the range of challenges that parents face in caring for their children. To ensure that evidence-based strategies are delivered consistently and rigorously, measures of program fidelity should be regularly used.
- It is clear from the literature reviews that delivering an intensive home visiting service for vulnerable families is a complex and skilled process. Families needs and circumstances vary greatly, and the service model needs to be flexible enough to cater for these variations while maintaining a constant core of evidence-based practice. In the framework just outlined, the constant core is provided by the process features of service delivery, while the flexibility comes from the deployment of evidence-based strategies according to family need.
- For such a model to be effective, a service delivery framework and program logic model will need to be developed.
- Consideration will also need to be given to the training of service deliverers in process delivery skills and in content strategies

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