Mol an Óige/Family Preservation

Final Evaluation Report

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EXECUTIVE SUMMARY

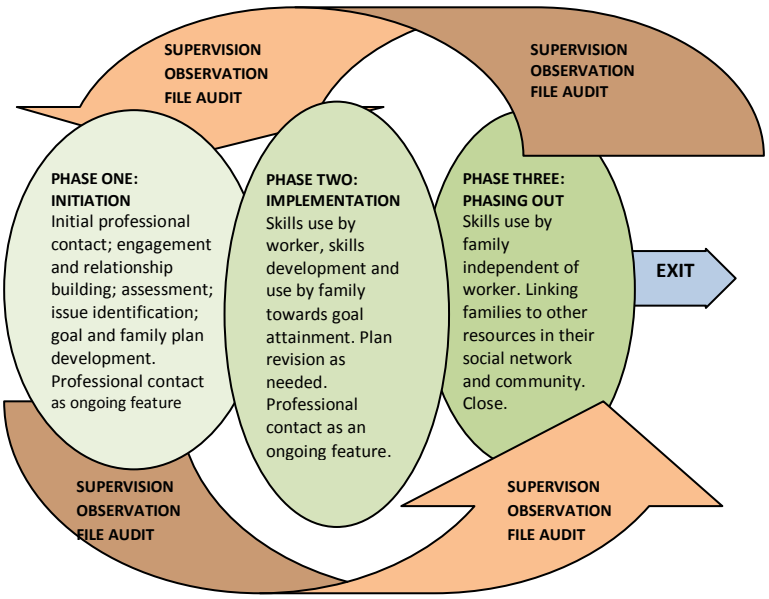
INTRODUCTION

In 2007, HSE West Child and Family Services in Mayo and Roscommon introduced a new way of working with children and Families. Known as Mol an Óige, this new way of working was modelled on an approach developed and operated by Boys Town USA. Three distinct parts were adopted from the American organisation: the In-Home Family Preservation service; the Treatment Foster Care service; and the Common Sense Parenting programme. As part of this new arrangement, Child and Family Services in both counties asked the UNESCO Child and Family Research Centre to evaluate the In-Home Family Preservation and Treatment Foster Care services. This document is an Executive Summary of the final evaluation report of the former, the In-Home Family Preservation Service.

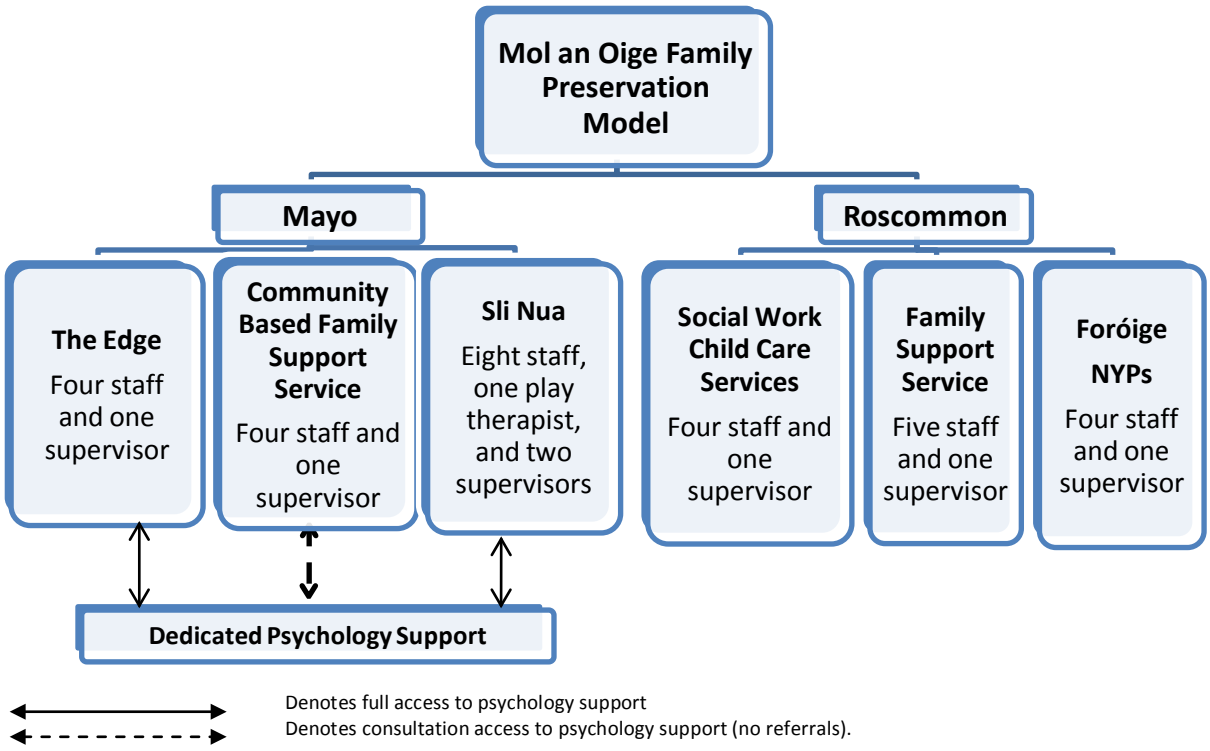
IN-HOME FAMILY PRESERVATION SERVICE: PROGRAMME DESCRIPTION AND CONTEXT

The Mol an Óige Family Preservation Model (hereafter 'Mol an Óige') is predominantly a teaching model aimed at working in a strengths and outcome-orientated way to meet the varying needs of children and families in different settings. Owing its origins to both ecological and multi-systemic treatment models, Mol an Óige as delivered in Roscommon and Mayo was introduced by the HSE and Boys Town USA to services in both counties in 2007. The model draws on behavioural approaches to addressing issues within a nested context of individual, family, peer, school and community domains. The emphasis is on developing practical skills in families through building relationships, teaching, creating a positive family environment, and promoting self-determination. It is designed for families where there is a risk of an out-of-home placement or where such a placement has already occurred. It can also be used to prevent serious problems from occurring in children's and families' lives.

The Model has three phases: Initiation and Relationship Building; Implementation; and Phasing Out. The support provided by each worker to families occurs within a structured process of pre and post intervention assessment, outcome-orientated family plans, supervision, observation, fidelity monitoring, and file auditing.



The diagram below portrays the Mol an Óige service context in Mayo and Roscommon.



While some workers across these services operate the model exclusively, others do not, but use it alongside other duties (e.g. running groups, drop-in work, etc).

EVALUATION METHODOLOGY

The aim of the study was to examine the implementation and impact of Mol an Óige for families and staff. To this end, a mixed methods research design was used.

Research Methods

- **Literature Review:** A short literature review was undertaken, focusing on the theoretical and philosophical underpinnings of the Boys Town approach, addressing the themes of wellbeing and support. A review of Boys Town programme resources was also undertaken.
- **Interviews**: Individual and focus group interviews were undertaken with all staff in 2009, with additional individual interviews undertaken with all staff (32) in 2012. Thirty families, incorporating 35 parents and 12 young people were interviewed over the same period. Interviews with 15 wider professional stakeholders on their perceptions of the Model were undertaken in Summer 2012;
- **Survey**: A baseline and follow up survey was administered to all staff in 2008 and 2012 respectively;
- **File Analysis**: Limited file analysis of all cases was undertaken, and full file analysis (including pre and post assessment scores) was undertaken on 58 cases where family consent was secured. Time analysis data per case was gathered in the early

implementation stage. Regarding case outcomes, services were asked to indicate whether they thought the case closed successfully or not.

- **Fidelity Data:** Monitoring of programme fidelity was undertaken by supervisors in both counties and forwarded to Boys Town for analysis. Boys Town kindly agreed to share this data with the evaluation team.

LIMITATIONS

The main limitation is the small amount of pre and post intervention assessment data available to the evaluation team. While a huge effort was made by all staff to contact and follow up with families regarding the provision of written consent for full file analysis, a statistically sufficient response rate was not achieved. This sample was neither representative nor random. The absence of families for whom the intervention did not work, for whatever reason, is another limitation in the report.

FAMILY OUTCOME FINDINGS

General File Analysis

Across the period 2007 – August 2012, Mol an Óige worked to achieve a range of goals with families, with the three main categories of goals being parenting support, behaviour-related and school-related. It was used in 273 cases, with 225 of these having closed at the time of analysis. The average length of intervention in closed cases was 8.3 months. When cases were examined based on whether they were successful or not, an interesting initial picture emerged. In total, 60% of cases were deemed to have been successful, with 40% being deemed unsuccessful. Amongst the 60% of successful cases, the vast majority of goals were achieved, with parenting, behaviour (including criminal) and school-related goals accounting for 68% of all goals achieved. Conversely, when unsuccessful cases were examined, the vast majority of goals were not achieved, with parenting, behaviour (including criminal) and school-related goals accounting for 61% of all goals not achieved. That drug and alcohol, family relationship and return a child home-related goals accounted for a further 30% of goals not achieved is of note here. Also of note is the average length of intervention in unsuccessful cases: 7.5 months.

A number of reasons were provided regarding cases being unsuccessful. In 15% of these cases, goals were deemed to have been simply not achieved, with no further reason given. In other cases, families moved away, cases were transferred to more appropriate services, or children were (almost immediately) taken into care. However, the single most common reason provided within this group for cases being unsuccessful was ‘disengaged’, accounting for 51 out of 91 (56%) total cases. Of interest here was the amount of time spent by services trying to engage with these families: 6.5 months. Two factors were apparent in disengaged cases: the young person or parent explicitly refused to engage; and children were already in the care of the State or open to social work. However, it requires saying here that there were also cases where children in the care of the State were returned home successfully through Mol an Óige and did not require the intervention further. Hence, it did

not appear from the data available that level of need was always a determinant of case success.

Consented File Analysis

Consent for full file analysis, including pre and post assessment measures, was received from 58 families. Of these 58, ten were ongoing cases and thus had no post assessment form completed, while another twenty had either no pre or post assessment form completed. This left 28 cases where some form of pre and post assessment was undertaken, with smaller numbers again present for different types of assessment. Clearly, this was a very small sample size and was further limited by the non-representative nature of it, across both the Mol an Óige population as a whole and across the six services.

When assessment items relating to parenting were examined, slight overall improvements were noted in the Strengths and Difficulties Questionnaire (SDQ) total scores, but the majority of cases did not change category. Similarly with the Parent-Child Relationship Inventory, there were slight improvements in scores. Neither of these measures showed any statistically significant change, but this was not surprising given the small number of cases. Results were more promising in the two main assessment forms used by staff, the Family-Based Ecological Assessment (FBEA) and the Strengths and Stressors assessment. Between 73% and 77% of cases recorded overall improvement in parenting items, while approximately 25% showed no change. When the young person's behaviour was considered, again the rates of improvement were high, almost 77% in the EBFA and 100% in Strengths and Stressors, although this was based on a very small number of cases. Of note here was the amount of improvement in child SDQ scores, and statistically significant improvement in pro-social and hyperactivity scores. There was also statistically significant improvement in Adolescent Wellbeing scores. When school related assessment items were examined, rates of improvement were less pronounced. 54% of cases of school behaviour improved under Strengths and Stressors, while the FBEA noted a score of 31% under this item, and a 44% improvement in school attendance, with large amounts of no change under this heading, as well as others.

Family Interviews

A variety of families participated in the interview process: some had successfully closed, some were closing and others were still working with family workers at the time. Families spoke of not accessing Mol an Óige-type services until they were almost at crisis point in their lives, with some families highlighting that they were not aware of such services until a particular contact put them in touch. However, once service provision began, participants were positive about the Mol an Óige process they experienced. In particular, the skills of the workers were cited often and regarded positively by parents and young people. Among those which had closed, or were closing, both parents and young people were very positive about the impact the work had on their lives, individually and as a family. Where relevant, improvements in school relationships were noted in the vast majority, and participation in wider community activities was also common. Change at the peer level was notably less. For some families, there was a lack of clarity about when the service actually ended, or whether they were free to source additional, less intense support from services if required.

Staff Interviews

Staff also commented on the ability of the intervention to improve outcomes for families. In the main, they reported that there was great potential for it to impact positively on families, having witnessed changes in families they had worked with. For staff, the key determining factor in the intervention achieving good outcomes was the motivation of families to change their behaviours and persevere through the work. The structured, goal-orientated aspect of the model was viewed also as a significant factor in families persevering as it allowed them to see progress. However, capacity to take on the skills in the model and sustain them, as well as other mediating factors such as addiction and the timeliness of the intervention, were cited as playing a significant part in determining whether the intervention could be successful for families.

PRACTICE FINDINGS

Mol an Óige introduced some new elements to the working processes of staff and the organisations operating them, while also reforming or reinvigorating others. Core to the operation of the model was the use of a particular skill set, a structured form of case supervision, observation, file auditing and an overall assessment of workload. In addition, working in a goal-orientated manner, with a related clear but evolving family plan to work from, was central to the model. In introducing this new way of working to practice, recognition of a reduction in caseload was implied, given the additional intensity required in family work and increased paperwork associated with it (e.g. revisions to family plans).

Staff reported many challenges initially in adopting the Mol an Óige model as a way of working. In particular, many staff reported the significant challenge in taking on new model skills and applying them with fidelity, and more generally in familiarising themselves with the model in an overall sense. Others spoke of the challenge of observation initially, the accompanying feedback which followed and the potential affront this was to their then practice and experience. Associated with this, the nature of supervision being purely based on cases was highlighted by some as both an initial and ongoing challenge.

It is clear from both the interview and survey baseline and follow up findings from staff that in a general sense they were very positive about this way of working. Survey findings highlighted that staff competencies relating to particular Mol an Óige skills and the overall approach increased since they began operating the model. This is not that surprising, but when these are combined with interview findings they do indicate that many staff feel comfortable and experienced in operating the model. Indeed, for many staff, they simply reported it as being their way of working rather than a 'new' way of working. In short, it has become innate in their practice. From a practice point of view, it has not encroached on their sense of autonomy, nor has it prevented additional skills being incorporated into their work. Staff felt that the Mol an Óige is more a framework, a way of working, rather than a prescriptive model. It permitted them to be creative, within an overall framework or structure which works for them.

Related to this was the increased perception of capacity to work for families. Staff were clear that particular elements of the approach, such as the family plan, provided great

definition to family work and served to further improve the relationships with families with which they worked. Staff viewed it as a core support to their work, as an opportunity to joint problem solve, and in the main, as a reassurance to their work and their practice approach. This was borne out in the staff surveys, where improvements in attitudes to supervision greatly increased after experience of working the model. In particular, that overall supervision scores saw a statistically significant increase is very important in this regard. Compared to the baseline responses, Staff were more positively predisposed to supervision as a supportive process than prior to implementing Mol an Óige. Related to this were the observations and file audit processes which are part of the supervision package. They were viewed as constructive to practice, and contributing, along with supervision, to improved working.

While staff viewed supervision as a resource, they also drew on a number of other resources when implementing their work. Colleagues were key supports in delivering the model. They provided an opportunity to share knowledge, discuss particular practice issues with the model, and contributed to a worker's overall practice experience of the model. For those who were not coterminous, or located in the same building as colleagues, the absence of this resource was felt. In addition, more experienced staff were viewed as a positive support by staff less experienced in using the model. The role of dedicated psychology personnel for some services was a very strong, beneficial feature of the operation of the model in these services, and a vital, problem-solving support to staff who had access to it. A range of other supports, particularly other professionals and services, were also accessed by the workers, dependent on the specifics of each case.

Practice and Interagency Working

Mol an Óige aimed to work across the five domains of individual, family, school, peer and community, through linking with other organisations and professionals involved with families or those best placed to meet their additional needs. While working collaboratively was not new to Child and Family Services, the operation of the model required it to be central to meeting families' needs.

Staff were, in the main, positive about their perceptions of connecting with the various domains outlined above. Survey data highlighted that their perceived ability to connect with family members, schools and other organisations had increased or greatly increased since using the model. However, they were less certain in both interview and survey data about their ability to work for change in the peer domain. This picture was also borne out in family data, as highlighted above.

While there were small declines in some interagency-related questions between baseline and follow up, in an overall sense there was a statistically significant increase in staff perceptions about interagency working in the same period. Positive changes in attitudes towards being part of a multidisciplinary team, perception of respect from other professionals and a reduction in the amount of unpleasant experiences with other agencies were all statistically significant. While not possible to interpret this as being exclusively down to the operation of the model, it is clear from this and interview data that the model is having a positive effect on fostering connections with other agencies.

When data from other professionals is considered, it is clear that while many are explicitly aware of the model or its tendencies – such as working from a strengths-based perspective – others are not. There was some evidence to suggest that these professionals worked with Mol an Óige staff closely to reinforce common messages to particular families, but in the main there was little evidence of them taking this on as an approach. The main reasons given across the data for this was that these professionals already worked from a similar perspective, or that they were busy in their own work spheres. However, for those professionals who have worked with Mol an Óige staff, they were very positive about the impact it had on their service users.

FIDELITY AND IMPLEMENTATION FINDINGS

Implementation

A number of factors were identified as being central to the programme's implementation. At the core level, training and support was provided by Boys Town USA throughout the period 2007-2010. This involved five different site visits to Ireland, as well as the provision of email and telephone support in certain cases. Staff perspectives on the training approach adopted in the initial phase were generally negative. It was reported to be too fast, too focussed on skills and not enough on the process of applying the model. Further training in 2010 was reported to have lacked clarity about its purpose, particularly in relation to changes to the family plan and assessment forms. However, as staff data revealed, this situation was compensated for by staff working through the model in their own way, adapting, learning on the job, and through support accessed via more experienced colleagues and particular individuals within delivery organisations skilled up to training level, which was deemed to be extremely valuable.

At the organisational level, it is clear that a conscious effort was made to provide as many resources as possible to staff. Many staff recounted the willingness of the organisation to purchase specific programme resources to support implementation, as well as provide access to financial resources through their services to meet the additional needs of families. Staff also accessed non-programme resources and other supports through their own previous experience, their organisation, and drew on the experience again of colleagues in working through particular situations, cases and contexts. Notably, there appeared to be involvement of senior management within the organisation. While many staff highlighted the central leadership role played by senior managers in the organisation in bringing Mol an Óige to their service, some also highlighted the willingness of these managers to undertake observations and provide feedback to staff. That they were familiar with the model and indeed with many families progressing through it was viewed as strength of the implementation process.

At the external level, the extent of implementation was affected by a series of political, economic and socio-cultural factors which all impacted on the previous two levels, and still has the potential to do so. There is a strong emphasis on religion in the original Boys Town programme. However, such an emphasis was removed from the Irish version, and therefore not implemented. Furthermore, while staff commented on the American-style phrases and interaction style, they reported adapting programme elements to an Irish audience. The

sense that this was a model associated with particular individuals at particular times was commented on by some staff operating the model as being central to its introduction and early implementation.

Fidelity

While there were challenges in monitoring total fidelity, the reports analysed by Boys Town and forwarded to the services over 2007-2009 tell us much about fidelity to skills and particular aspects of the approach. Aspects core to the model, such as teaching components and relationship building, displayed steady progress towards effective implementation (scoring an average of three out of five) by 2009 and progressed steadily upwards throughout 2010, in so far as these can be tracked through the new fidelity measures. Similarly with Relationship Building/Relationship and Engagement, scores progressed through 2009 to effective implementation, and to consistent and effective implementation (average rating four out of five) in 2010. These, along with scores for safety and the provision of concrete support, indicate that fidelity - where measured – was broadly adhered to. If the new, post 2010 skills-based fidelity reports are taken on their own, overall scores are maintained at the consistent and effective implementation level (i.e. average rating of four out of five). In an overall sense then, fidelity to the core aspects of the approach was achieved.

DISCUSSION

Outcomes for Families

The overall case data indicate that, at one level, Mol an Óige as an intervention appears to have succeeded for the majority of families. Of note here is the relatively low number of families which services are aware of that have re-entered the intervention. Thus we can say that as an intervention, it shows promise. However, there is a sizable proportion in these figures which, for whatever reason, it has not worked. Examining unsuccessful case figures more closely is not possible given the limitations of the data. Regarding cases where goals simply were not achieved, the fundamental question is why were they not achieved? Data from staff is useful here. Was a lack of parent capacity to take on the skills a factor in these cases? Were addiction issues at play, or was it something else? Is it possible that the level of need for some of these families may have been too high for Mol an Óige to work in the manner in which it did in other cases? Is it possible that the amount and frequency of support provided was a factor? The predominantly voluntary nature of this intervention is underlined in these figures and in the staff interview data. When families are adamant about not engaging after lengthy attempts to build relationships with them, there is little workers and services can do but to try and understand why. Generating an understanding of why individual families disengage should be a focus of each service's work. Thus, information gathered in a systematic, timely manner is crucial to any further analysis.

Turning to the assessment measures data, several issues emerge. Assessment items relating to the main goals outlined above show improvement, and thus show significant promise for the intervention. In particular, high rates of improvement in parenting domains are noteworthy. Furthermore, it is very promising that some standardised assessments

scores relating to behaviour and wellbeing of young people show statistically significant improvement. Yet, there is a large amount of 'no change' recorded in the two main assessment forms: the FBEA and the Strengths and Stressors. While 'no change' is at face value self explanatory, many items in both assessments in this study were scored '0'. These elements of the assessments which were not deemed a stress and thus required no intervention greatly outnumbered those which required intervention, which impacted greatly on the no change statistic. Moreover, any interpretation of this data must be treated with caution given the very small number of cases for which there is information.

In considering the data from families, it is clear that for those involved, goals have been achieved and family lives are enhanced. Homes are happier, calmer places where parents' capacity has increased, behaviour has improved and, where relevant, school attendance has increased. For those whose Mol an Óige experience was ongoing, they spoke of challenging times and cited the support they received from the worker as being important. However, for some families there is a lack of clarity about how the service ends and for others a clear desire to access some form of less intense support from time to time should the need arise. Considering these points, it may be useful for services to consider how the final phase of the intervention concludes and, in some cases, consider the provision of a lesser form of family support for some families as Mol an Óige comes to an end, to aid family consistency of approach or to overcome particular issues. This would be best assessed on an individual basis. While Common Sense Parenting (a parenting programme) may be a useful step-down support for some parents, group programmes or settings do not suit all.

Learning for Policy and Practice

There is much to be learned for practice from Mol an Óige. It is important to acknowledge that the work processes and structures required are intensive for all involved: family, worker and supervisor. There is a transaction cost involved in developing practice through Mol an Óige, but this is not unusual when adopting and implementing any new approach. However, the sense of structure given to work with children and families by Mol an Óige is prominent. This goal or outcome-orientated approach, linked to a family plan which is agreed with families as the focus of engagement and support, is a key element; it provides clarity and process: a beginning, middle and end. Intervention work is documented clearly and quickly, progress, or lack of, is readily identifiable, and occurs within an organisational boundary of structured supervision, observation and file auditing which are supportive. More importantly perhaps, is the sense of accountability (for the service and the family) and transparency which the model offers. Its strength for practice is most plainly seen in staff views on it: for those who have experience of working pre Mol an Óige, either in their service or in a previous iteration thereof, it has become a preferred way of working when they compare it to their previous experience. For those who are not currently or exclusively doing a Mol an Óige case, that they incorporate elements of the approach into their other practice – such as the plan and/or the outcome-orientated work is testament to its value to practice. However there are current staff needs. For those whose skills have lapsed, retraining may be required, while ongoing training and development was the highest ranked desired support for practice in the survey findings. The opportunity for workers to come together to share experiences would also be useful in reducing isolation felt by some and support practice.

Mol an Óige firmly contributes to the changing landscape of children and family policy and services in Ireland. Its emphasis on working in an outcomes-focused way fits neatly with policy's emphasis on achieving good outcomes for children, as outlined in *The Agenda for Children's Services*, but also more recently in the Health Information and Quality Authority's (HIQA) (2012) *National Standards for the Protection and Welfare of Children.* The evidence compiled in this report highlights Mol an Óige's ability to protect, promote and support the welfare of children and families 'at-risk' in the community, as well as children who are in the care of the State. It aims to, and does, include the voices of parents and young people in decision-making about them throughout the process of engagement. Child protection, welfare and safety are core principles underpinning its operation. It emphasises leadership, management and accountability of services through its structures, especially its supervisory elements – regular case supervision, observation of practice and file auditing - and brings service supervisors into direct contact with families on an ongoing basis. It seeks to harness the resources of the family, agency and community to best meet the individual needs of children and parents. These are important themes and principles which underpin work in the Children and Family Domain in Ireland now, and into the future. Thus, local management in both counties should consider disseminating their experience of Mol an Óige to a wider audience and seek to contribute their important knowledge about the programme, and its effects, to ongoing debates about child and family services in Ireland.

Fidelity and Implementation

Overall, fidelity reports denoted that effective implementation was achieved. Services should consider maintaining fidelity monitoring as a practice support, particularly if some staff are to be re-skilled. Furthermore, developing an opportunity for staff of different experiences to come together intermittently in a community of practice and share experiences of programme implementation would serve to reinforce fidelity and foster collaboration.

The fidelity monitoring reports also raise another implementation issue: organisational capacity. Capacity to deliver all aspects of the model is central to its implementation. While a willingness to reduce caseloads is an appreciation of the more intensive work involved, some workers were required to maintain other aspects of their work, and some were willing to maintain those other aspects. However, this did not prevent Mol an Óige from being operated in both counties. Its implementation placed a greater emphasis on supervisors to regularly go into homes with workers to observe, monitor fidelity and provide feedback to the worker in a timely fashion. There is clearly a resource requirement here. While some supervisors did have the capacity to do this on a consistent basis, others did not. Organisational upheaval, additional and different workloads and increasing pressures on supervisors and some staff placed a strain on the operation of the model, and the capacity of staff to implement it and observe it. There is little doubt that the implementation of the model suffered as a result.

While there were some reservations expressed about its potential to be the only approach to be used, or the one 'best-way', the majority who did comment on this aspect of the model's initial phase cited it as a passing concern. However, the loss of leadership through retirement and long-term sick leave in both counties through the implementation phase, as well as the proposed organisational move to a new agency, has created doubt amongst staff

about the future of the model. While they perceive it strongly to add value to their practice, the organisational uncertainty has the potential to create a vacuum regarding its future use. At a delivery level, staff are also fearful of proposed reductions or capping of mileage allowances which may prevent them from doing the amount and extent of work required, as well as what the move to a new agency structure might bring.

OVERALL EVALUATIVE JUDGEMENT AND RECOMMENDATIONS

From the discussion set out here, and more fully in the Final Report, a number of points can be made about Mol an Óige:

1. It is clear from the range of data that, as an approach, Mol an Óige shows significant promise for families in overcoming their difficulties in a strengths-based, capacity building manner. However, given the limitations of the data, further research is required, incorporating rigorous pre and post assessment measures and complete file analysis for all cases as central parts of a research approach.

2. Mol an Óige offers strong potential as a framework to structure practice with children and families with various levels of need in a focused, outcome-orientated manner which can be time-limited. It provides a mechanism to contribute to an accountable, transparent, structured service which works for staff and families while creating the space for creative practice to flourish.

3. Mol an Óige plays a prominent role in increasing interagency working between professionals and creates a positive perception amongst other professionals of those operating it. While other professionals may not be taking on all the skills of Mol an Óige, they are certain about its impact on service users and the way in which Mol an Óige staff work. That these other professionals are working with children and families in a variety of different settings – schools, social work services, psychology, and nursing – underscores it potential to bring professionals together in working for children and families.

The following are recommendations for services in Mayo and Roscommon to consider in operating Mol an Óige in the future:

1. In light of the information presented here, Mol an Óige shows significant promise for achieving outcomes in families. It is recommended that the intervention continue to be offered by services to those families who wish to engage, and in light of further recommendations below. However, the development nad implementation of a full quasi-experimental research plan to assess outcomes for Mol an Óige families is recommended.

2. While some families' resilience increases after the intervention, others may require additional support. While programmes like Common Sense Parenting may be a suitable route for some, groups do not suit all, and may not be necessary. Services

should examine the requirements of cases for providing less intense, semi-formal support after Mol an Óige has concluded.

3. Services should re-examine the referral criteria for Mol an Óige and assess whether it is being pitched at too high a level of need in certain cases. Further to this, where it does not exist, services should move to a joint referral process. Structures already exist for this to readily occur. It would foster further sharing, collaboration and dissemination of knowledge about model experience. It would also serve to formally identify the small number of families which re-enter Mol an Óige via different services. While current data sharing restrictions may complicate this process, these should be addressed.

4. Services should engage in assessing for outcomes. Assessments are undertaken for case development, but it is also important that post-intervention assessments are undertaken for outcome impact. There is plenty of experience of using a variety of assessment tools in services. Such experience should be utilised. Some services have begun undertaking six month follow up assessments. All services should replicate this approach. Management and services should examine the appropriate *outcome* measures to be used in each case – SDQ, PCRI or AWB, or a combination of these.

5. Information is critical to the workings of any service. Each service should examine its own past caseload to identify further factors not available to the research team in explaining why families refuse to engage or disengage.

6. It has been clear to the evaluation team that while some services have access to their service data quite readily, others do not. Services should develop a process of gathering case data for their own use in a timely and systematic manner, particularly as cases close. This could be modelled on templates developed for the evaluation, with some expansion. This data should be kept by each supervisor or service manager and analysed regularly.

7. It is clear from staff data that Mol an Óige works for practice. It is recommended that such an approach to practice continue. However, services should explore the need for refresher training or other skills development options. Where they do not exist and where possible, services should explore the possibility of having dedicated Mol an Óige workers. Where this is not possible, dedicated Mol an Óige case work time should be set aside.

8. Critical to the full operation of the model for practice is the capacity to provide observation and supervision. These are core aspects of the model, and require resourcing.

9. Services should examine the possibility of creating a Community of Practice for those operating Mol an Óige. Such a community could serve to underscore fidelity, create a joint problem solving arena, and provide an opportunity for staff to meet. Establishing such a structure within each county initially should be considered.

10. Where it does not exist, management should explore the potential for dedicated psychological support to be made available to Mol an Óige staff on a clinic basis. Where this has existed, it has been a clear support.

11. Services should maintain fidelity reports. They serve as a useful tool to structure observation, are part of the infrastructure of staff support and contribute to the delivery of the model.

12. Services should engage Boys Town to discuss the possibility of having fidelity report analysis continue into the future, or about sharing their method of analysis with services in Mayo and Roscommon for in-house analysis into the future.

13. In the interests of refreshing fidelity to the model, services should explore the possibility of sharing a small amount of staff observations, if capacity and management lines permit.

14. Services should seek to disseminate knowledge about their activities in the community about what they do, and in the policy and practice world about how they do it and what it achieves.

15. While not a focus of the evaluation, it is clear Common Sense Parenting plays a role in supporting parents in both counties. Services should consider evaluating this programme.

CHAPTER ONE: INTRODUCTION

1.1. Introduction

In 2007, HSE West Child and Family Services in Mayo and Roscommon introduced a new way of working with children and Families. Known as Mol an Óige, this new way of working was modelled on an approach developed and operated by Boys Town USA. Three distinct parts were adopted from the American organisation: the In-Home Family Preservation service; the Treatment Foster Care service; and the Common Sense Parenting programme. As part of this new arrangement, Child and Family Services in both counties asked the UNESCO Child and Family Research Centre to evaluate the In-Home Family Preservation and Treatment Foster Care services. This report is the evaluation of the former, the In-Home Family Preservation service.

Following this introduction, this Chapter proceeds to provide a short history of the development of the entire Mol an Óige Initiative in Mayo and Roscommon. It then outlines the specific focus on this report, the In-Home Family Preservation Service as operated in Mayo and Roscommon, as well as the service context in both counties. It then presents the objectives of the evaluation study before detailing the methodology design and implementation. A section on data analysis follows before the limitations of the study are identified. To conclude, the remaining chapters in the report are outlined.

1.2. Programme Initiation

The introduction of the Mol an Óige Initiative to Mayo and Roscommon arose out of local managerial interest in developing a new way of working to meet the needs of children and families experiencing a range of challenges in their lives. As part of this, the development of an outcomes-focussed way of working for practice, applicable across a range of settings and services, was a core consideration. Aware of Boys Town USA's Continuum of Care approach to meeting the needs of children and families and its potential in the Irish context, communication between senior Boys Town representatives and the Child Care managers of both counties began in early 2006. This resulted in an exploratory site visit by Boys Town representatives to Mayo and Roscommon in May 2006. This visit was followed by a series of detailed discussions, culminating in the signing of a contact between the Child Care services in both counties and Boys Town USA in October 2006. The central aims of this contract were to provide resources, training and support in the implementation initially of two elements of the Boys Town Continuum of Care: the In-Home Family Preservation Service and the Treatment Foster Care Service. A third element, the universal Common Sense Parenting Programme, was added in 2008. As can be seen in Figure One below, all three elements feature at different points on the Continuum of Care, and have both prevention and intervention aspects to them to varying degrees.

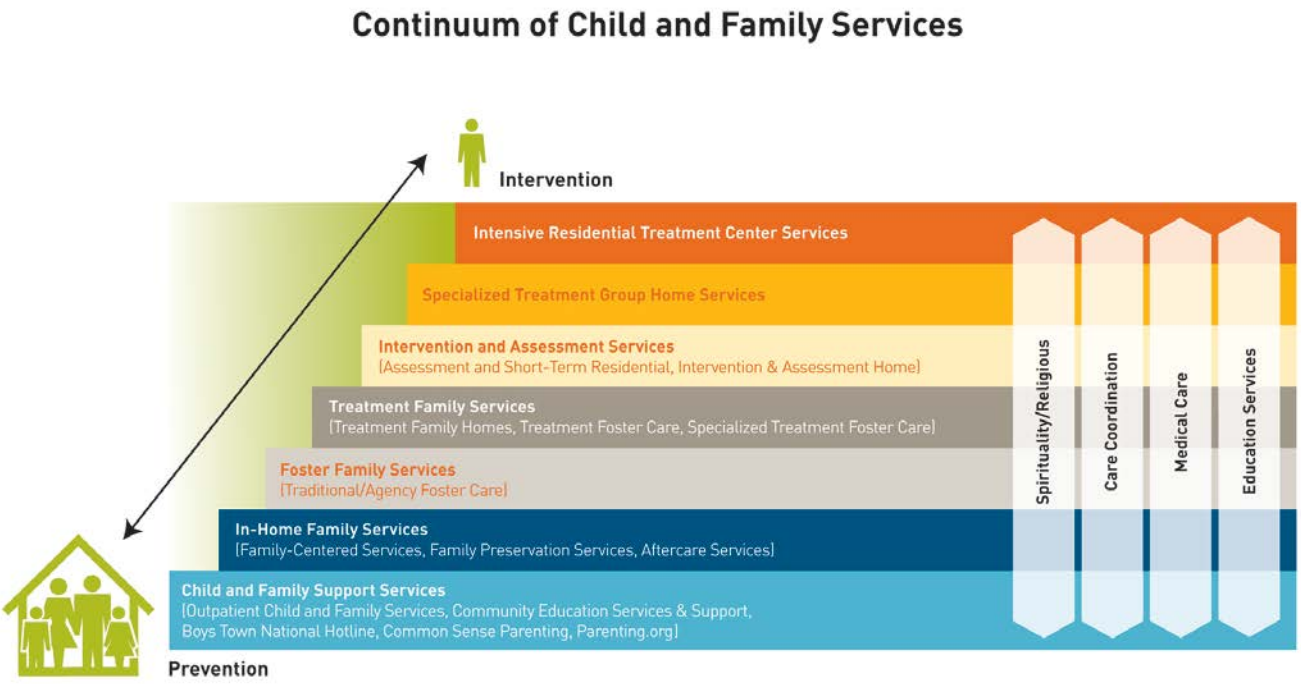


Figure 1: Boys Town USA continuum of care

Following the formal agreement, 13 staff from Mayo and Roscommon visited Nebraska in November 2006 to examine the operation of services in a range of settings. This was followed by a four-week visit by two staff to Nebraska in June 2007. The main aim of this visit was to develop the capacity of the Irish services to deliver training and support to colleagues in the ensuing period. Between July 2007 and February 2010, two Boys Town staff undertook five two-week visits to Ireland [July 2007, October 2007, February 2008, June 2008, February 2010], providing training on a range of elements of the Initiative to both family workers and supervisors, and support to service delivery in both counties. After the final visit from Boys Town staff services operated the programmes independent of American support.

1.3. In-Home Family Preservation Service: Programme Description

The Mol an Óige Family Preservation Model (hereafter 'Mol an Óige') is a teaching model of family support, aimed at working in a strengths and outcome-orientated way to meet the varying needs of families in different settings. Owing its origins to both ecological and multi-systemic treatment models, Mol an Óige as delivered in Roscommon and Mayo was introduced by the HSE and Boys Town USA to services in both counties in 2007. The model draws on behavioural approaches to addressing issues within a nested context of individual, family, peer, school and community domains. The emphasis is on keeping children, young people and families safe, developing practical skills in families through building relationships, teaching, creating a positive family environment, and promoting self-determination. It is designed for families where there is a risk of an out-of-home placement or where such a placement has already occurred. It can also be used in a way to prevent serious problems from occurring with a child or in a family.

1.3.1. Programme Process in Mayo and Roscommon

Mol an Óige is best characterised as a three phased process, with the boundaries between each phase being fluid and overlapping.

Initiating Mol an Óige

Families can be referred by professionals or can self-refer into services operating the model[1]. While some families are referred as part of a child protection plan, and are thus required to participate, engagement more generally by families is on voluntary basis. Once a referral occurs and has been deemed appropriate, family workers operating the model meet with family members to discuss issues prevalent in their lives which they require support with, and seek their agreement to begin implementing the approach. They may also meet with other professionals involved with the family. If families wish to continue with the intervention, further visits are arranged in the family home to build relationships and begin the assessment process. Assessment can occur over the course of these first meetings and involves the use formal assessment tools and practice knowledge to identify strengths existing in the family home and other domains. This period is also used to identify a particular need which can be met immediately, known as a Quick and Early. Further exploration of issues between the family worker and family members occurs, which leads to the preliminary identification of goals or outcomes for the proposed work. These outcomes are incorporated into a family or service plan alongside referrer concerns, with particular roles, activities and expectations of all involved aligned to each outcome. Building relationships, identifying issues through exploration and assessment, and the development of the family plan are central to this part of the work. The use of family worker skills from the model begins immediately.

Implementing the Family Plan

Work on implementing the family plan begins. This involves work in the family home with the parent and/or young person. A key part of this work is the teaching of particular parenting skills by family workers to parents to address the goals set out in the plan. The Mol an Óige approach advocates a number of skills to be provided to families, as well as a number of methods or techniques which can be used by family workers in imparting these skills. Workers and parents/young people continue to work together to develop these skills through a range of techniques. If relevant, workers also work with young people in other settings to address particular needs or issues. The emphasis on ecology is important. Workers link with other services in the community dependent on the goals of the family plan, and in many cases seek to work in different settings, such as schools, and incorporate staff from those settings into the work. Family plans are reassessed regularly to identify progress and to incorporate new goals if and when they emerge. Generally, the aim of this part of the work is to build skills in families and provide a range of supports to enable them to deal with issues independent of support into the future. There is no set dosage regarding

[1] Not all services in this evaluation permit self-referral. Some services only take referrals from Social Work. In addition, referrals to particular services are first considered by in-house referral committees.

the intervention. Length of intervention and frequency of visits are on a needs basis, are affected by the availability of the worker, but ultimately are decided by the family.

Phasing Out

As goals are achieved, and parents display and report confidence in using skills to manage behaviour, family workers begin a process of phasing out support for families. This involves a reduction of direct in-home support to families, but can involve visits to reaffirm skills or reassure parents of their abilities to address issues which arise, as well as ongoing telephone contact as and when required. Linking families to other supports or activities is a part of this aspect of the work. Accessing such supports or activities is, as with other aspects of the model, ultimately up to the family. Assessment occurs again at the end of the intervention, with a final meeting bringing the work to a close.

1.3.2. Programme Support

Staff Supervision is a fundamental aspect of the Mol an Óige Model and central to its structure. Underpinning this is an emphasis on staff autonomy, within a framework which emphasises programme fidelity, implementation and working to achieve outcomes. While the term supervision is used, there are three distinct aspects to it:

- Observations of practice. While they do not occur at every visit, observations of staff by supervisors are aimed at ensuring effective implementation of the programme. Supervisors maintain a low profile and do not provide any direct intervention or support. Feedback from observations is provided directly to staff afterwards. Observations of staff also permit fidelity reports to be completed;
- Staff supervision: supervision of staff occurs regularly and is linked to case work. In supervision meetings, elements of relationship building, teaching, service planning, all feature, along with monitoring of progress. The model emphasises a feedback process which promotes the generalisation of skills in different settings. It views it as a two-way process. Supervision also permits the provision of resources for staff.
- File Audit: often occurring within supervision as well, a dedicated piece of work on randomly auditing a case worker's file is undertaken to ensure that service planning, note taking and associated documentation is completed in line with the model and is up to date.

An illustration of this description of Mol an Óige, with supervisory mechanisms wrapping around the family process, is outlined below in Figure Two:

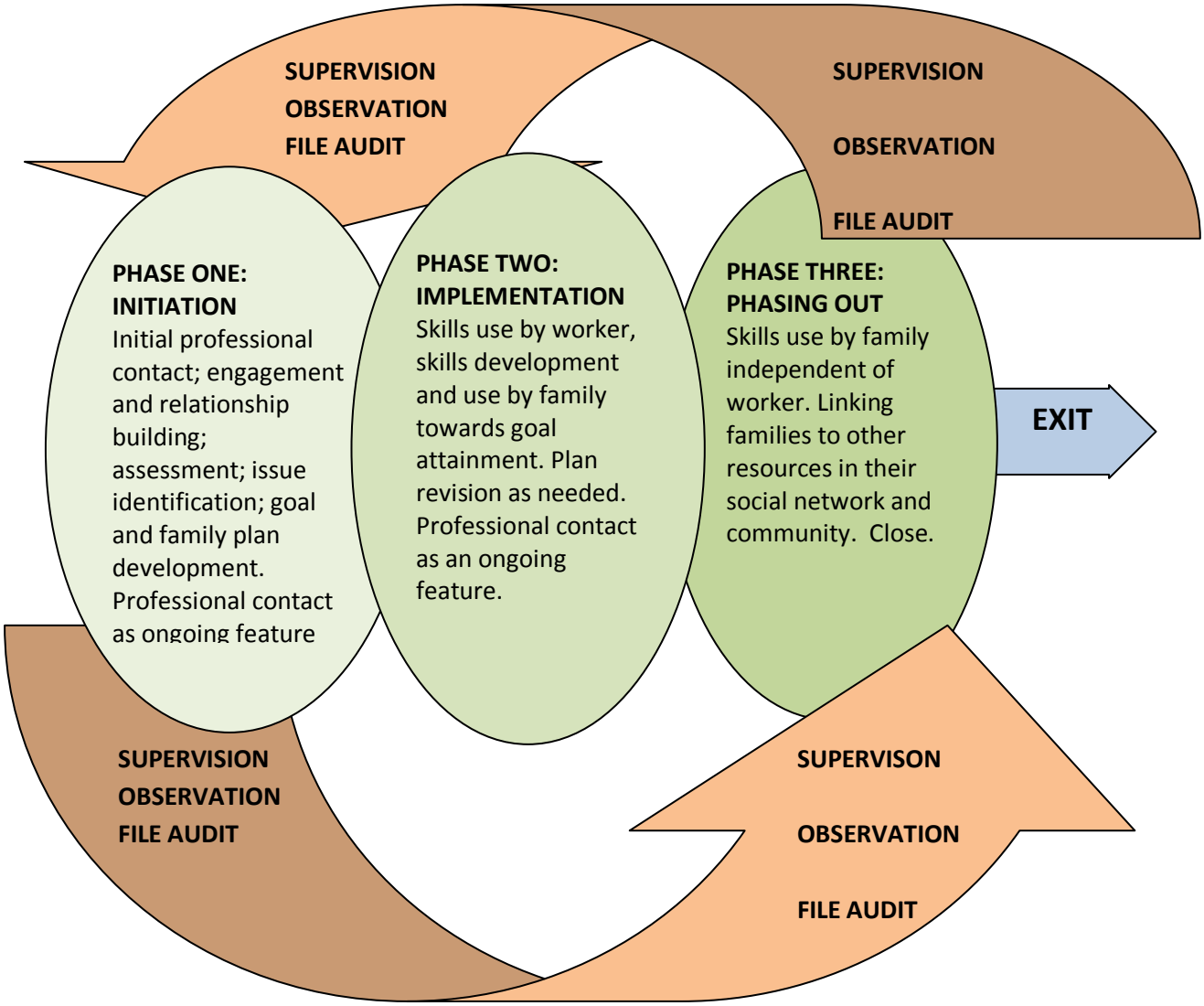


Figure 2: Mol an Óige structure and process

1.4. Programme Service Context

Drawn from the In-Home Family Services level on the Boys Town continuum of care, Family Preservation in Boys Town operates through workers known as family consultants, who are available to families on a 24 hour basis, seven days a week and are supported by a range of other professionals and services as and when required. The service context in Ireland is somewhat different.

Mol an Óige is operated by six services across the counties of Mayo and Roscommon. Outlined below are details of each of the services (see Figure Three below). As intended by the Model's introduction and its origins in Boys Town's Continuum of Care, services meeting different levels of need operate the service.

In Roscommon the Model operates across three services:

- Family Support Service: a community-based family support service providing a range of supports to families.

- The Social Work Department: members of the child care team attached to Social work offices across the county provide support to children and parents in cases open to the Department.
- Foróige Neighbourhood Youth Projects (NYPs): Community-based youth development and family support services working for young people between the ages of ten and 18, and their families.

In Mayo the model is operated in three services[2]:

- The Community Based Family Support Service: A partnership between the HSE, Foróige and individual projects located in the community, this service offers and provides a family support service to parents and children up to the age of 17. It operates from four different sites around the county.
- Sli Nua: attached to the Social Work department, Sli Nua is a family support service aimed specifically at keeping a child at home of preparing parents for the return of a child. It also provides foster care support. The service is offered throughout the county.
- The Edge Project. A community-based alternative to secure care placement, this service supports young people aged ten to 17 whose behaviour poses real and substantial risk to their safety, health, development and welfare. It operates throughout the county.

The three services in Mayo are supported by a dedicated psychologist for the model. The Edge and Sli Nua have referral and consultative access to the Psychologist, while the Community-Based Family Support Services has consultative access.

[2] Foróige Neighbourhood Youth projects also operate Mol an Óige in Mayo but are not included in the evaluation.

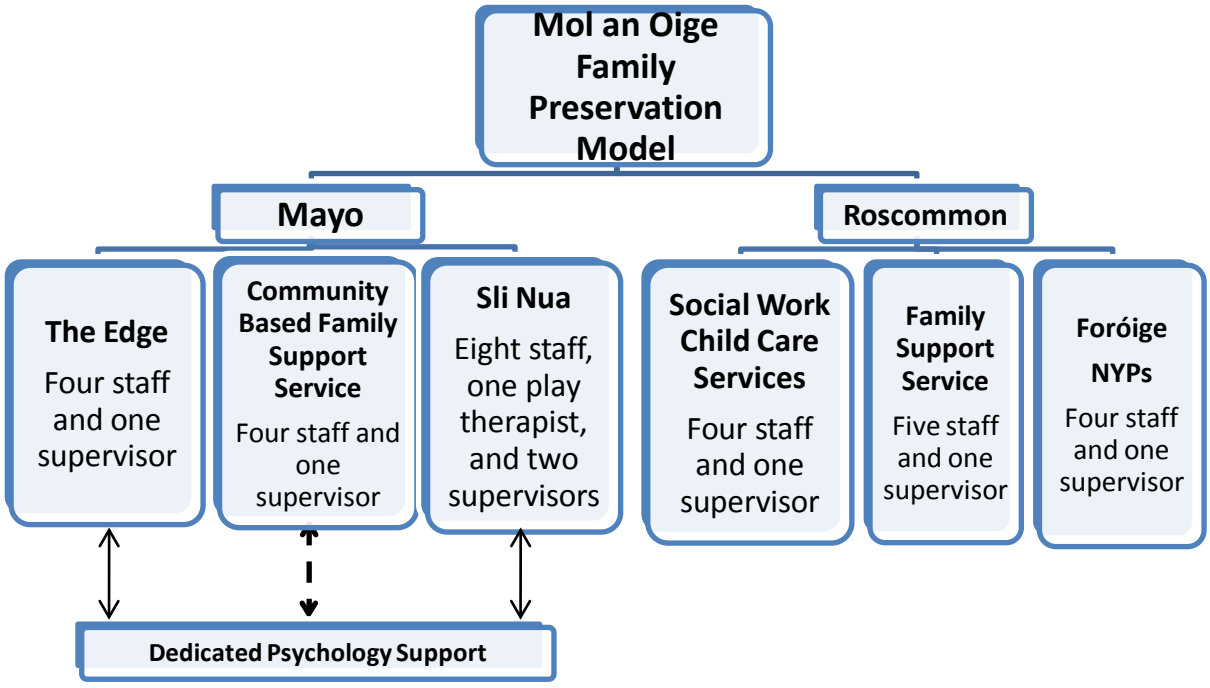


Figure 3: Mol an Óige service provision structure in Mayo and Roscommon

Denotes full access to psychology support
Denotes consultation access to psychology support (no referrals).

1.5. Evaluation Objectives

The aim of this research is to evaluate the implementation and impact of the model for families and staff. To this end a number of overarching objectives guide the research:

- Assessing the implementation of the model in relation to a number of key areas including:
  - referral criteria and processes;
  - direct work with children and families;
  - staffing;
  - training support; and
  - fidelity to the underpinning theoretical models;
- Assessing the outcomes for participating children and families;
- Assessing the impact of the model on work practices;
- Reflecting the views of stakeholders on the model;
- Assisting services in collating and interpreting internal project data; and
- Assessing wider impacts of the model in areas such as skill development and collaboration.

1.6. Evaluation Methodology: Design and Implementation

To address the requirements of the evaluation outlined in section 1.4. above, a mixed-methods approach was adopted. There are many definitions of such approaches in research literature (Johnson et al., 2007). For this report, Creswell and Clark's (2007, p.5) definition is adopted. They argue that a mixed-methods approach "focuses on collecting, analysing and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone." Each particular method used in this study is outlined below.

1.6.1. Literature and Programme Resources

A short literature review was undertaken for this research. The literature review focused on the theoretical and philosophical underpinnings of the Boys Town approach, addressing in particular the themes of wellbeing and social support. A review of Boys Town programme manuals was also undertaken. Both pieces featured in the interim report and are reproduced in the appendices of this report.

1.6.2. Interviews

The main research method used in this evaluation was one-to-one semi-structured interviews.

a) Staff interviews initially occurred in 2009 and 2010. At this point, twenty two people were interviewed: 13 were interviewed on a one-to-one basis and nine were interviewed across two focus groups. Five of these one-to-one interviews were conducted via telephone. These interviews lasted between 25 minutes (individual interview) and one hour and forty minutes (focus group), and were exploratory in nature;

   In-depth, detailed follow up interviews were conducted between March – July 2012 with 32 staff. All these interviews were conducted in person and on a one-to-one basis at the participant's place of work. These interviews revisited themes which emerged in the initial round of data collection. They also focused on additional issues which arose over the course of the evaluation (e.g. focusing on the supervision process, the role of workers and supervisors, resources, supports). Across both phases, but particularly the second phase, all staff involved in the model were requested to participate, with services asked to nominate staff relevant to the research and forward email and telephone contact details to the evaluation team;

b) Interviews with families also occurred in two phases. Initial interviews with families were undertaken across 2009 and 2010. While some families volunteered through their services for interview at this stage, not all were interviewed. Further interviews with families occurred between March and late August 2012. Staff were

asked to inquire with families about their willingness to participate in the research. Information sheets and consent forms were forwarded to each service for distribution to families. Once families had consented, contact details were passed to the evaluation team and interviews were arranged. In some instances, staff accompanied the researcher to family homes (due to geography issues) but did not stay for the interview process. The majority of interviews took place within family homes, with others taking place in other locations (e.g. service, café, hotel lobby). In total, 30 families (35 parents and 12 young people) participated in the interview process across both phases;

c) Wider stakeholder interviews occurred in April 2010, and between April and July 2012,. In total, 15 stakeholders were interviewed. Firstly, staff were asked to nominate a number of professionals with whom they have worked with when implementing the model. The evaluation team then selected ten professionals from these nominees and requested them to participate. These stakeholders were purposively sampled so as to ensure as wide a distribution of professions as possible. Independent of this, based on knowledge accumulated over the period of the evaluation, the research team requested three other individuals to participate in the research. All bar one of these interviews were conducted in person, with one being conducted over the telephone.

1.6.3. Staff Questionnaire

A practice based, anonymous postal questionnaire was developed at the beginning of the evaluation and administered to family workers. They were requested to complete the questionnaire and return it to the evaluation team. The aim of this questionnaire was to develop a baseline picture of practice before complete implementation of the model occurred. In total, 23 surveys were received, with preliminary findings being reported on in the interim report. Note that one of these surveys was removed for the final analysis due to most of it being left blank. This resulted in a response rate of 92%.

The same questionnaire – with an additional section on Mol an Óige skills – was administered to family workers again via SurveyMonkey in October 2011. Due to issues with this process (missing data), the survey was re-administered via post and email from November 2011. In total, 22 surveys were completed and received between November 2011 and August 2012, representing an eligible response rate of 92%. Again, these were anonymous.

1.6.4. File/Case Data

A multi-strand approach to gathering file data was adopted.

At the first level, discussions with staff occurred regarding the possibility of gathering time analysis data on their implementation of the model. A time analysis template was developed and forwarded to all staff who were requested to monitor their time use across a

period. This data provided a picture of time use *per case* (not per worker) and was reported on in the interim report. After this point, the gathering of this data stopped. The data displayed great variation in the use of time across different cases.

At the second level, the research team, with the support of staff, drafted a letter which was forwarded to all families who had gone, or were going through, Mol an Óige, requesting consent for their full file data to be used anonymously in the evaluation. In total, 171 families were written to, and consent was received in 58 cases, representing a total response rate of 34%. In these 58 cases, staff completed detailed file templates, recording a range of family and standardised measure data. The evaluation team provided support where requested, and met with individual workers to advise on the data gathering process. It also followed up with workers on individual case data for verification, validation and clarification purposes. This data was received between March and June 2012.

At the third level, a process was developed to capture as much information as possible at the service level about the nature of cases in a general sense. The aim here was to gather as much data as possible (e.g. on goals, and whether they were achieved, length of intervention, number of family members worked with) without straying too far into the personal domain of individual cases. In this regard, the evaluation team worked with services to ensure that no potentially identifying information was included, as well as providing more general support in this process as required. Again, the evaluation team followed up with workers on individual case data for verification, validation and clarification purposes. This data was gathered between June and September 2012.

1.6.5. Fidelity Data

Fidelity data was provided directly by services to Boys Town as part of the contractual agreement between it and the HSE. However, Boys Town provided the evaluation team with annual summary reports of their analysis of fidelity data for inclusion in this evaluation. This data is presented as provided and analysed by Boys Town.

1.7. Data Analysis

A number of analyses methods were used in this study. Interview data was thematically analysed, using a hybrid approach of deductive and inductive coding (Fereday and Nuir-Cochrane, 2006). Data was subjected to a first round of open coding. While a number of issues emerged directly as a result of the evaluation objectives and interview schedules, open coding permitted other forms of information to emerge freely. Once all the data had been analysed, it was subjected to a second cycle of coding to permit refining and re-categorising of codes, as well as the preliminary identification of patterns in the data and potential themes. The data was subjected to a final cycle of coding to confirm themes and, where possible, cluster these themes into overarching categories. NVivo software was used to handle this data.

Goal data from case files was subjected to a similar process. All goals were first entered onto an excel spreadsheet and reviewed. A second review was then undertaken to identify particular themes amongst the goals (e.g. parenting, behaviours, parent-child relationships). Potential labels were noted from these themes and used in the third review process. Here, goals were reclassified under the labels and an 'other' category developed. Finally, all entries in this 'other' category were examined and where possible, goals were re-categorised into existing categories, with a reduced number of 'other' goals remaining under this label.

Three of the standardised measures were analysed using SPSS: the Strengths and Difficulties Questionnaire; the Parent-Child Relationship Inventory and the Adolescent Wellbeing Scale. Given the possibility of tracking pre and post intervention change through the consented case file process, paired sample t-test analysis was applied to these measures.

Data emerging from both the Ecological Family Based Assessment and Strengths and Stressors forms were handled differently. The data were reviewed initially. Small case numbers and great variation in the extent of completion in the individual parts of the form within each case was noted. The evaluation team felt it more appropriate therefore to calculate degrees of change rather than use pre and post t-tests due to the potential to have large amounts of missing data. This was particular the case given the EBFA, but also to a lesser extent the Strengths and Stressors. Excel was used to mange and analyse this data.

SPSS was used to analyse the baseline and follow up staff surveys. Given the anonymous nature of the survey, paired sample test analysis was not possible. Also worth consideration here was the potential for a small number of staff which completed the first survey not completing the second survey, and vice versa. To take account of this, while still ensuring statistical rigour in the analysis, a nonparametric independent sample test, a Mann-Whitney U test, was used.

1.8. Limitations

The main limitation is the small amount of pre and post intervention assessment data available to the evaluation team. While a huge effort was made by all staff to contact and follow up with families regarding the provision of written consent for full file analysis, a statistically sufficient response rate was not achieved. The achieved sample was neither representative nor random.

In discussions with staff and management during the course of the evaluation, it was decided to try and generate a picture of experience for those families who disengaged from the intervention for whatever reason. However, despite preliminary indications from five families regarding their willingness to participate, none of these families consented to interview.

1.9. Report Outline

Following this detailed introduction, Chapter Two outlines data from both the consented and general case files. Chapter Three presents findings from the follow up staff survey and comparison of these with the original baseline. Chapter Four presents detailed findings from the staff interviews. Chapter Five outlines findings from interviews with parents and young people. Chapter Six contains the perspectives of local professional stakeholders. Chapter Seven presents fidelity data. Chapter Eight contains a detailed discussion and a series of recommendations for consideration.

CHAPTER TWO: ANALYSIS OF FILE DATA

2.1. Introduction

This Chapter presents findings from the analysis of file data undertaken for the evaluation. As outlined in the methodology section of the introduction, a twin approach to gathering this file data was undertaken, thus there are two sections to this Chapter. Following this introduction, the first section of this Chapter outlines data pertaining to *all* cases which the evaluation team was provided data on. It provides headline data on a variety of issues, such as number of cases per year, number of children and parents involved, assessments, goals, achievement of goals, whether cases were deemed to have closed successfully or unsuccessfully in the judgement of the service, and reasons provided for cases closing successfully/unsuccessfully. The second section provides additional information on those 58 cases for which consent for file analysis was received. This will involve information on the sources of referral, assessments undertaken, and the pre and post assessment scores. The Chapter concludes with a summary.

2.2. File Data on All Cases

2.2.1. General Figures

Information was received from all six services on Mol an Óige Cases. In total, information was received on **273** cases from 2007 – 2012. The distribution of cases across years is outlined in Figure Four below. Note that figures for 2012 are up to August.

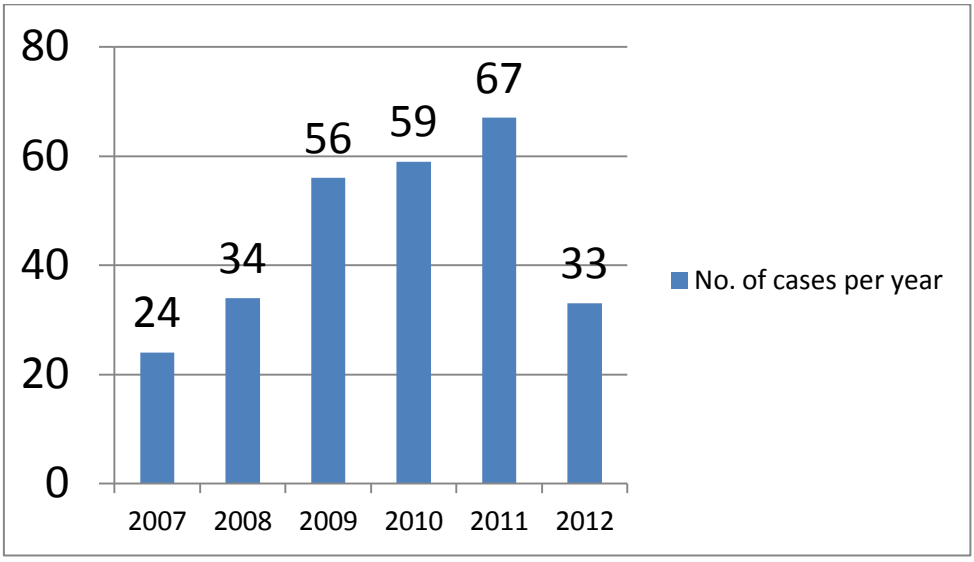


Figure 4: Distribution of cases per year

Across all 273 cases, 364 parents and 252 young people were worked with. The average length of intervention was 7.85 months, the median length of intervention was seven months, and the mode was six months. Of the 273 cases, 225 were closed at time of writing while 48 were open or ongoing. Across the 225 closed cases, the average length of intervention was 8.3 months.

Out of the 225 cases deemed closed, four continued to receive drop-in support, while another was redirected to another family support service for additional support. Twenty two cases reopened to Mol an Óige over the period in question. Of these, twelve cases were deemed to have closed successfully while ten did not. Seven of the unsuccessful cases simply had reopened, two reopened in an attempt to return a child home, while one was reopened to foster parent support. Across the 12 successful cases which reopened, two were for child protection issues, three for a re-emergence of original behavioural and parenting issues, three for dedicated pieces of parenting support at particular times in the life of the family (e.g. moving home, separation), one with a view to returning another child home, and three cases were just deemed to have reopened with no further reason given.

The distribution of all 743 goals across open and closed cases is as follows (Figure Five), with an average of 2.73 goals per case:

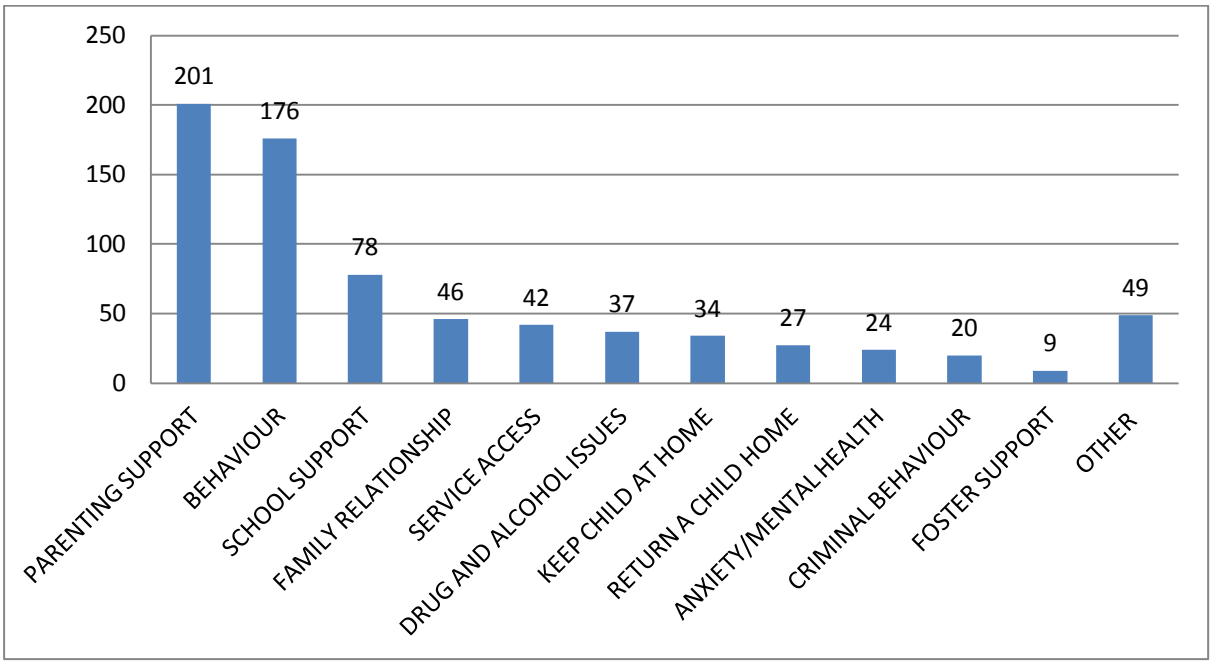


Figure 5: Type of goal across all cases

2.2.2. Goals/Outcomes across Closed Cases

In total, all closed cases accounted for 634 goals. The average number of goals per case was 2.81, however there was a wide distribution of numbers of goals per cases. This distribution is presented in Figure Six below (note in eight cases goals were not specified, hence 217 as total under 'one goal').

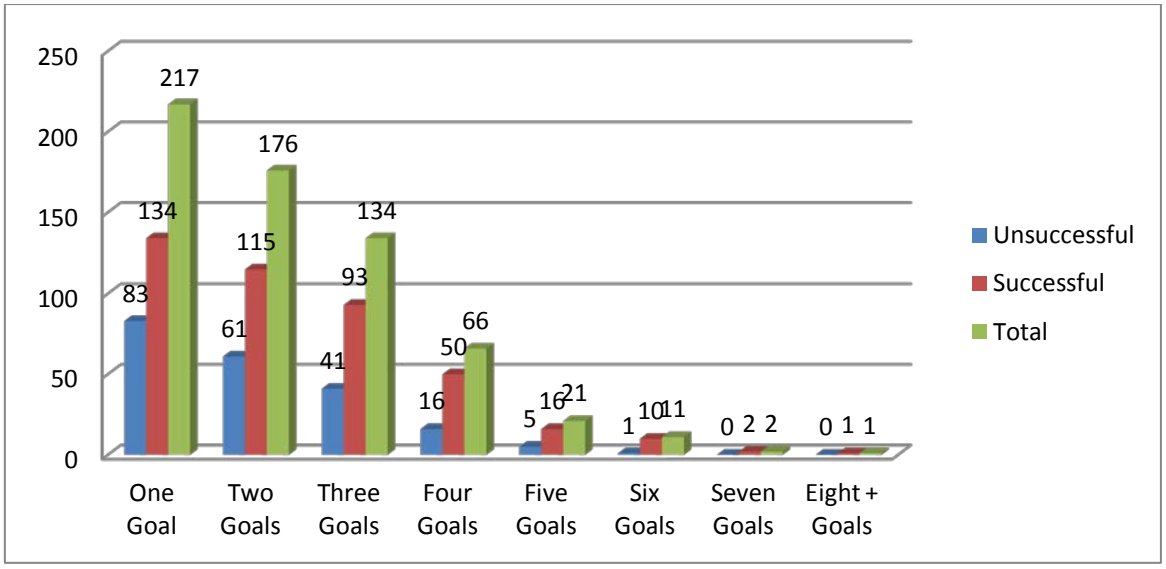


Figure 6: Numbers of goals per case

All cases here had at least one goal; 176 cases had two goals or more; 134 cases had three goals or more and so on. Note here that 41 cases only had one goal. 83% of all goals were accounted for by cases which had between 1 – 3 goals.

Figure Seven below shows the total closed case distribution of goals across categories:

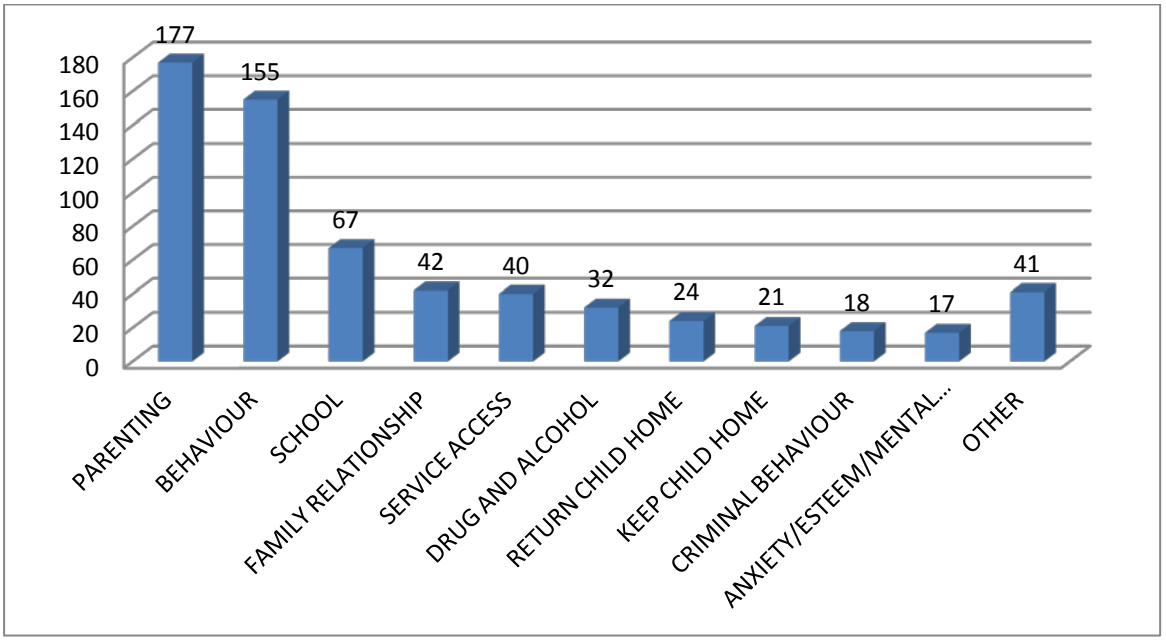


Figure 7: Distribution of goals across all closed cases

All services were asked to indicate whether the goals were achieved, irrespective of whether the case was adjudged to have been closed successfully or not. The graph in Figure Eight below illustrates the extent to which goals were achieved or not achieved.

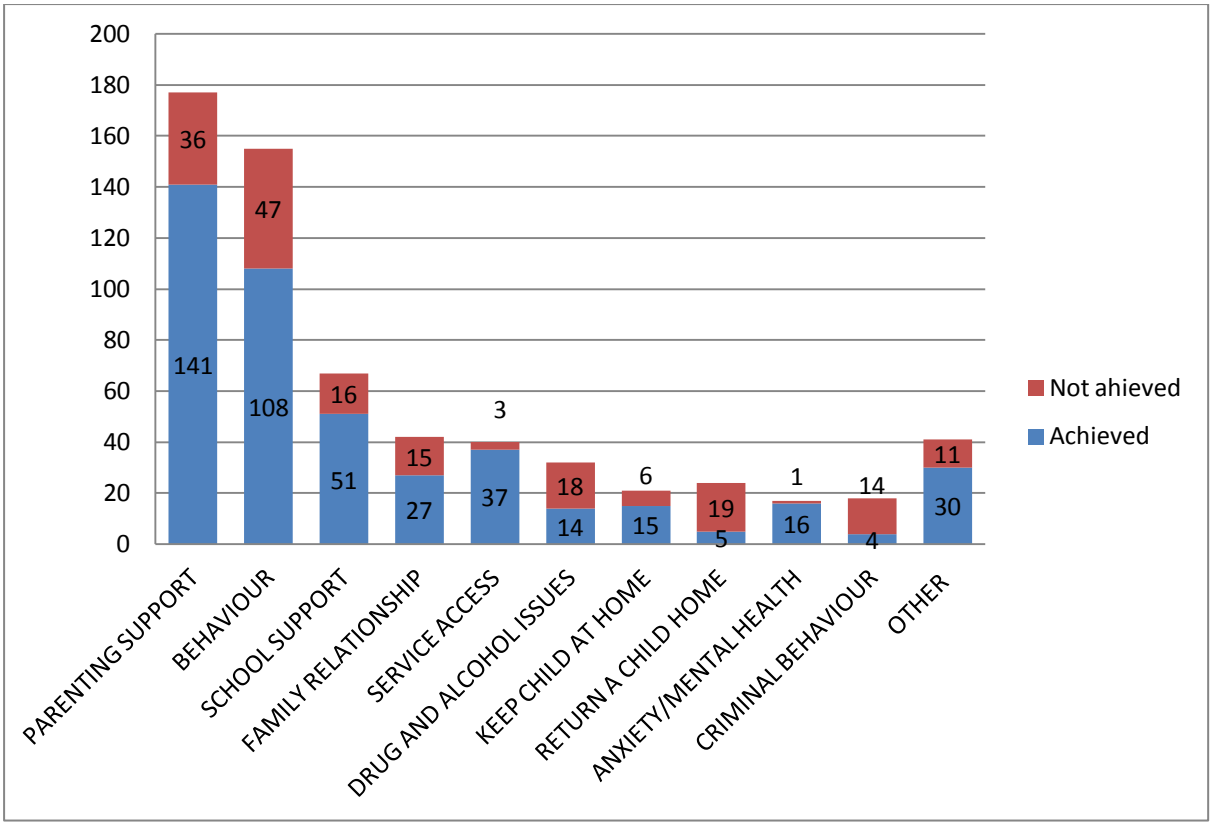


Figure 8: Goals achieved/not achieved in all closed cases

2.2.3. Assessment in all Closed Cases

Across all closed cases, there was evidence of pre intervention assessment in 171 instances (76%), with 166 (74%) of these being based on one of the core model assessment forms, either the Family Based Ecological Assessment or the Strengths and Stressors. This leaves 54 cases where there was no assessment undertaken. When these cases are examined, the following reasons were provided (Figure Nine below):

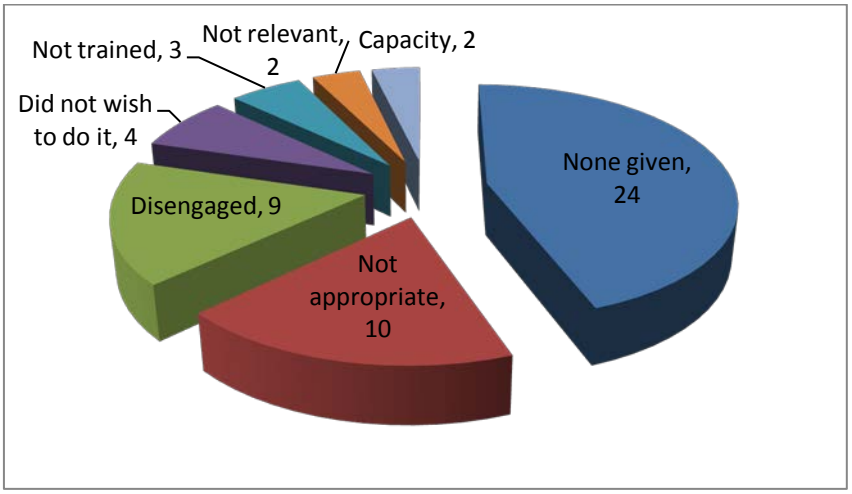


Figure 9: Reasons provided for no assessment being undertaken

Of the 24 instances where no reason was given, two of these cases began 2007, four in 2008, nine in 2009, six in 2010, and three in 2011. Of those cases deemed to have

disengaged, all were deemed to have disengaged immediately after opening (e.g. 'disengaged after service began') or moved away.

In relation to the transition through the service to post intervention assessment, of the 171 cases which had some form of pre-intervention assessment, 88 of these had no post intervention assessment, although 50 of these 88 cases were deemed to have closed successfully.

2.2.4. Case Success

Each service was asked to indicate whether in its opinion each case closed successfully or not. Out of 225 cases, 132 (59%) were deemed to have closed successfully, while 91 (40%) were deemed to have closed unsuccessfully. In two cases (1%), no judgement was made.

2.2.5. Successful Cases

Across the 132 successful cases, 188 parents and 132 young people were worked with. The average length of intervention was 8.8 months.

2.2.5.1. Assessment in Successful Cases

When cases deemed to have closed successfully are examined, no pre-intervention assessment was undertaken in 17% of cases (n=22). Of this 17%, cases were relatively evenly spread throughout the period 2008-2011.

2.2.5.2. Goal Attainment in Successful Cases[3]

Examining the cases which were deemed to have closed successfully, the following distribution of goal achievement was identified (see Figure Ten below):

[3] Goals from the two cases which were not judged successful or unsuccessful are included here.

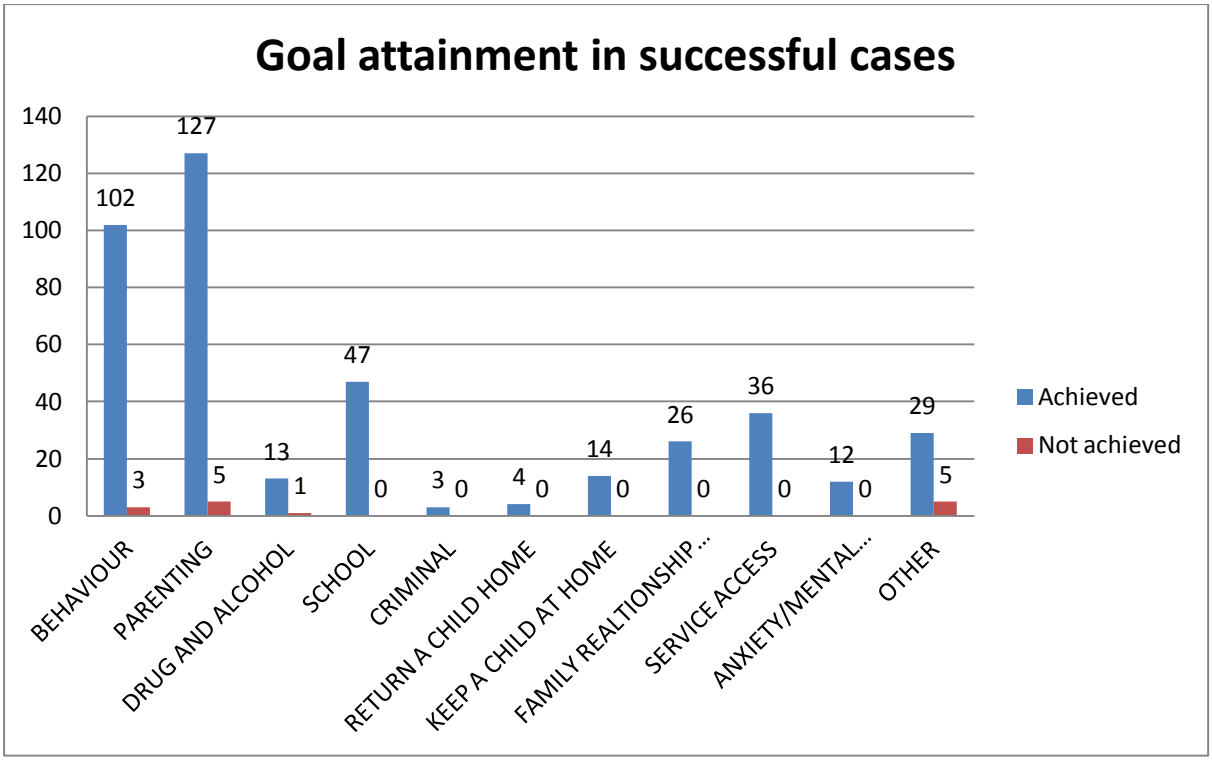


Figure 10: Goal attainment in successful cases

2.2.6. Unsuccessful Cases

Across the 91 unsuccessful cases, 111 parents and 64 young people were worked with. The average length of intervention was 7.5 months. The following graph shows the level of goal attainment in unsuccessful cases (Figure Eleven):

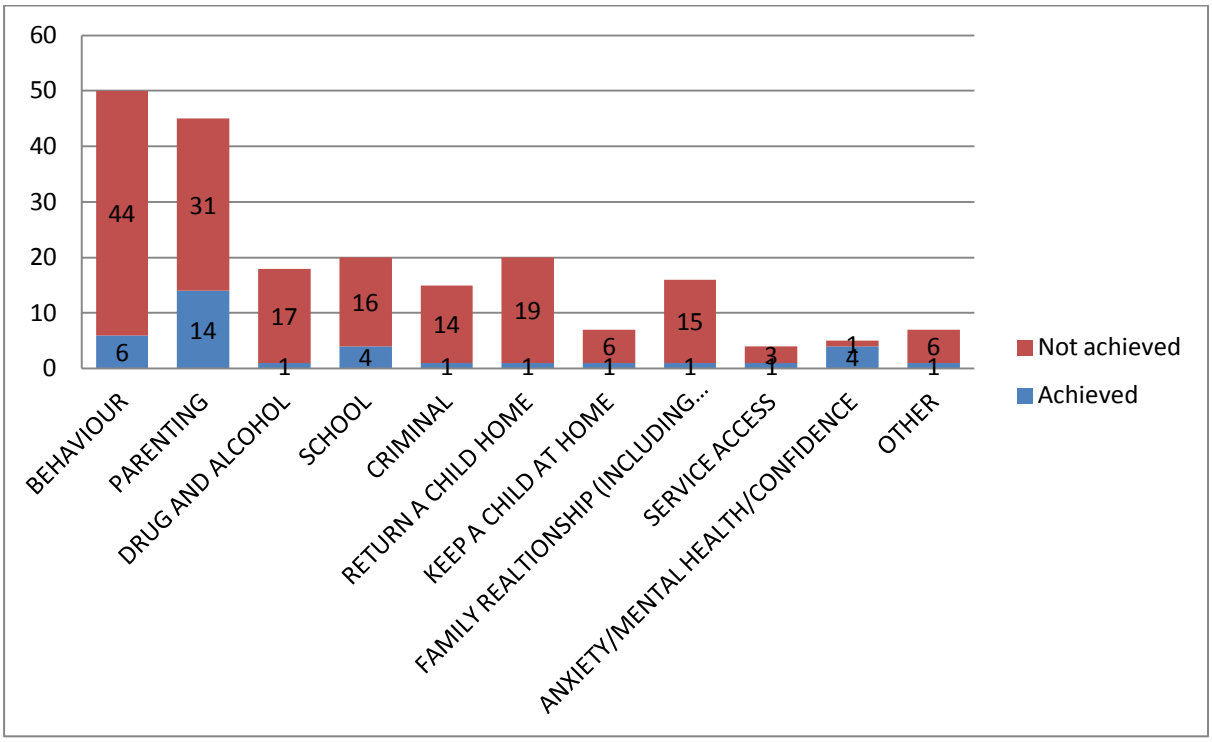


Figure 11: Goal attainment in unsuccessful cases

The following reasons were outlined in the various files for the categorisation by the service of each these cases as unsuccessful (Figure12):

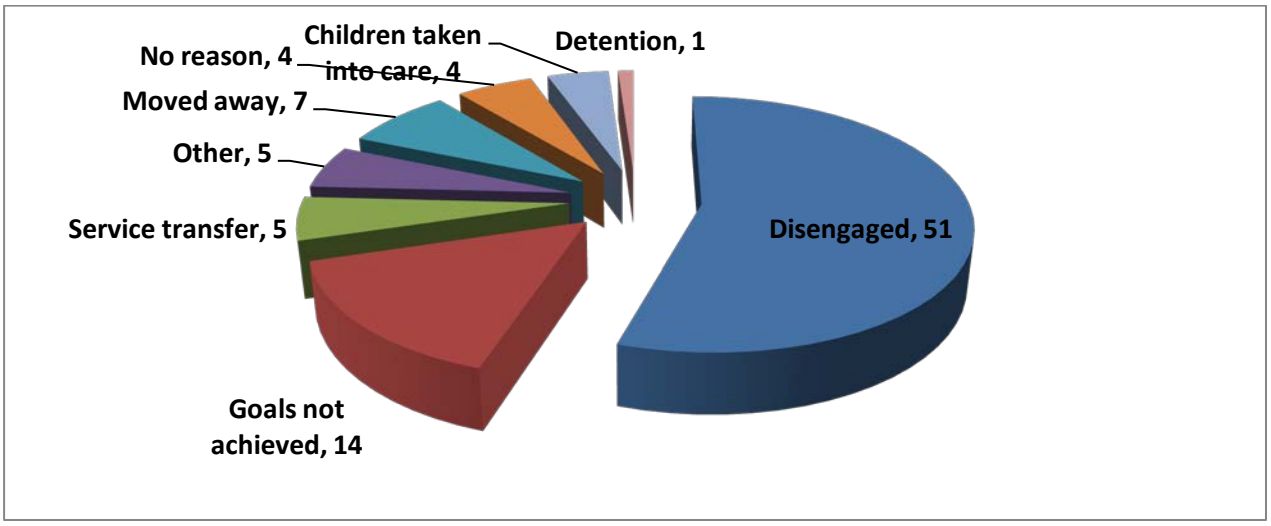


Figure 12: Reasons for cases being deemed unsuccessful

Of note here is the variety of reasons provided for cases being deemed unsuccessful. When the 'disengaged' category is removed, the single largest categories are where goals were not achieved (15%) and when families moved away (8%). Service transfer and 'other' (e.g. maternity leave) account for another 11% together. Of the 14 cases which were deemed not to have achieved their goals, half had the core goal of returning a child home. In these cases, children remained in care. Other prominent goals amongst this group included ten parenting goals, six behaviour goals and three criminal behaviour goals.

When the 51 cases deemed 'disengaged' are examined more closely, a number of things are notable. The first thing to note is the average length of intervention: 6.5 months. The minimum length of intervention was 0.5 months and the maximum was 21 months. When examined qualitatively, there is great variety in the disengaged cases. Fourteen cases were classified disengaged because the young person or parent was deemed to have explicitly refused to engage. It should be noted, however, that in such cases workers still engaged with parents for as long as possible, following programme practice. Six cases were closed due to a 'lack of engagement', while another 12 cases were worked on to varying degrees but ultimately were classified as disengaged; all these had the central goal of returning a child home or keeping a child at home. Other singular reasons identified included a young person voluntarily entering care, another being placed on remand, one parent disengaging due to feeling the programme had not worked, and another disengaging due to the feeling the programme had worked. One family simply 'withdrew'.

2.3. Consented File Analysis

In addition to undertaking analysis of all files, consent was sought to undertake a complete file analysis of specific information, in particular pre and post assessment scores. What is outlined below is shorten version of this analysis, with further information contained in the appendices.

In total, information on 58 cases was received. The cases had a total of 77 children and 33 parents directly and indirectly involved in Mol an Óige. Directly, 34 children cases, 16 parent cases and 8 parent and child cases consented for full file analysis.

A number of these cases contained incomplete assessment information. For example, a number of pre-intervention assessments may have been undertaken, but for whatever particular reason no post-assessment intervention was undertaken. This significantly limits the ability of the evaluation team to objectively assess the effectiveness of the intervention based on pre and post assessments scores. In total, the following was the case for the different assessments forms used (Table One) :

MEASURE	***PRE***	***POST***
SDQ		
Parent	*27*	*17*
Child	*22*	*14*
Teacher	*4*	*2*
AWB	*26*	*19*
PCRI/PAF	*32*	*14*
FBEA	*15**	*13**
Strengths and Stressors	*29*	*16**

Table 1: Pre and post assessment figures

*These figures represent the absolute maximum case values and do not reflect that in many cases not all of the post intervention assessment form was completed.

These figures should also be considered in light of the total number of Mol an Óige cases which were undertaken and closed up to mid-2012 (i.e. 225). Hence, they cannot be treated in any way as representative of the entire Mol an Óige caseload across two counties and six services over 5 years.

2.3.1. Length of Phases

The average length of time from referral to start date was 1.65 months, with a range of 0 – 11 months. Forty two (n=42) out of 58 cases indicated the length of phase 1. On average, phase one was 2.12 months in duration. Phase two (n = 43) lasted on average 4.58 months. 32 out of 58 cases indicated using a fading-out period (phase 3), with an average duration of 2.41 months. In total, the average length of cases was 9.31 months (*SD* = 4.20, range = 5 – 19 months).

2.3.2. Referral

The majority of cases were referred from the Social Work Department (19 cases, 33%). This was followed by cases from "Psychology", for example CAMHS, Addiction Services, and Psychologists, and "Other" sources (e.g., ISPCC, Garda Diversion Programme, Family Support Worker, School, Child Guidance, Childcare Team leader, and NYP) which both accounted for 24% of referrals. A further 17% were self-referrals, while 2% did not record a referrer (See Figure 13).

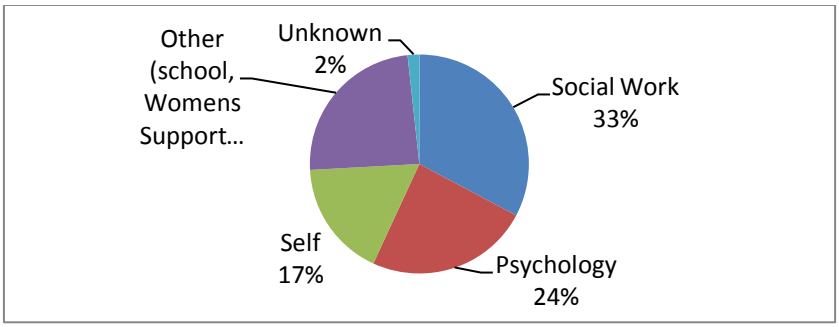


Figure 13: Source of referral

There were three primary reasons for referral (19 cases): violent/aggressive behaviour by child (e.g., threatening behaviour towards family); School difficulties (e.g., suspended from school, not attending school); and Parenting difficulties (e.g., poor parenting, Mum is worried about her daughter; see Figure 14). Thirteen cases had a reason for referral that was categorised under "Substance Abuse/Misuse", for example "alcohol and drug abuse" and "underage drinking". "Mental Health Issues" (e.g., child has ADHD), "Relationship breakdown" (e.g., Young person bullying younger sibling), and "Behaviour Management" (e.g. engaging in promiscuous behaviour with strangers) were also prevalent, with six cases categorised under each of these headings. A further four cases had "Issues with Gardaí" (e.g., known to Gardaí), while 10 cases were categorised as "Other" (e.g., return child home).

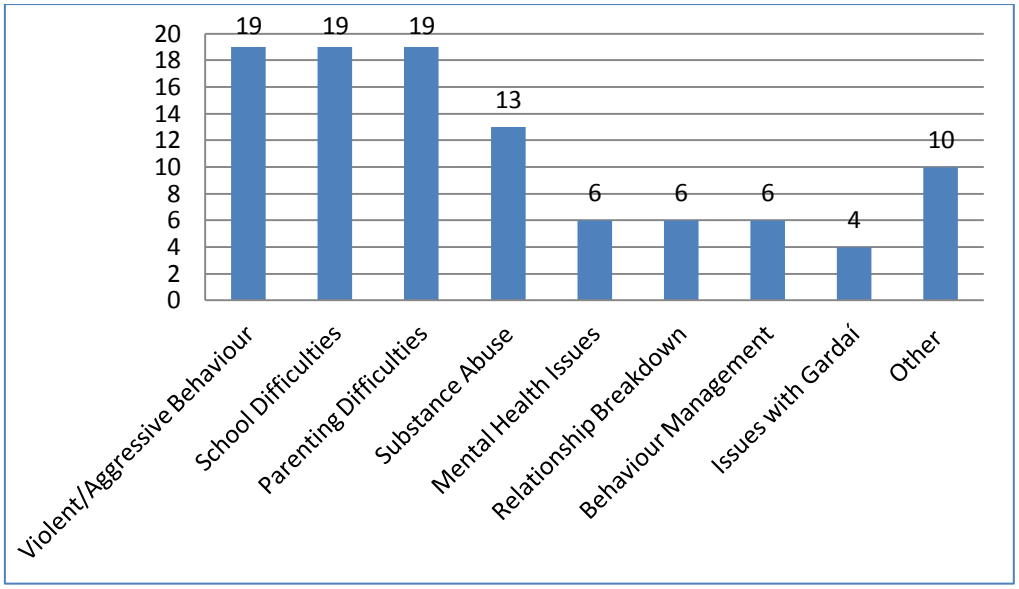


Figure 14: Reason for referral

A total of three cases out of 58 were reopened after initially being closed. A reason was given for one case, where the child went to live with ex-partner and so a new file was opened with the ex-partner. No reason was given for the other two reopened cases, but one was closed again after two months, while the other remained open at the time of data collection. In total, 43 cases did not reopen, two cases were closed but used drop-in services, seven cases were still open at time of data collection, while a further three had no information recorded.

2.3.3. Standardised Measure Scores

2.3.3.1. Strengths and Difficulties Questionnaire

Due to the low numbers (n = 27 pre-assessment, n = 17 post-assessment), results are first presented for the "total difficulties" scale and the "prosocial behaviour" scale, and then SDQ subscales, for each of the completed parent, child, and teacher versions. For ease of interpretation, "Total Difficulties" scores are categorised into one of three groups; "Normal" (0-13 parent, 0-15 child, 0-11 teacher), "Borderline" (14-16 parent, 16-19 child, 12-15 teacher), and "Abnormal" (17-40 parent, 20-40 child, 16-40 teacher). "Prosocial behaviours" are also categorised into one of three groups; "Normal" (6-10 parent, child & teacher), "Borderline" (5 parent, child & teacher), and "Abnormal" (0-4 parent, child & teacher).

In total, the majority of cases across parent, child and teacher assessments showed no change. The most improvement in range of scores (e.g., from "Abnormal" range of scores to "Normal" range of scores) was seen in the child assessments, with the highest number of improvements (and only significant pre- and post-assessment difference) in SDQ-Child Prosocial scores (n = 6). Looking at the SDQ subscales (Table in Appendix), similar trends were found, with the majority of subscales showing no significant change over time. The one exception to this was "SDQ-Child Hyperactivity" subscale, (t (13) = 2.342, p < .05), which

showed a significant decrease in average scores from 6.29 (*SD* = 2.49), to 5.00 (*SD* = 2.45). Also of note is that, while a high number of cases reported school difficulties (19 cases in reason for referral), a low number of assessments included the SDQ-Teacher measure (*N* = 4 pre, *N* = 2 post-assessment).

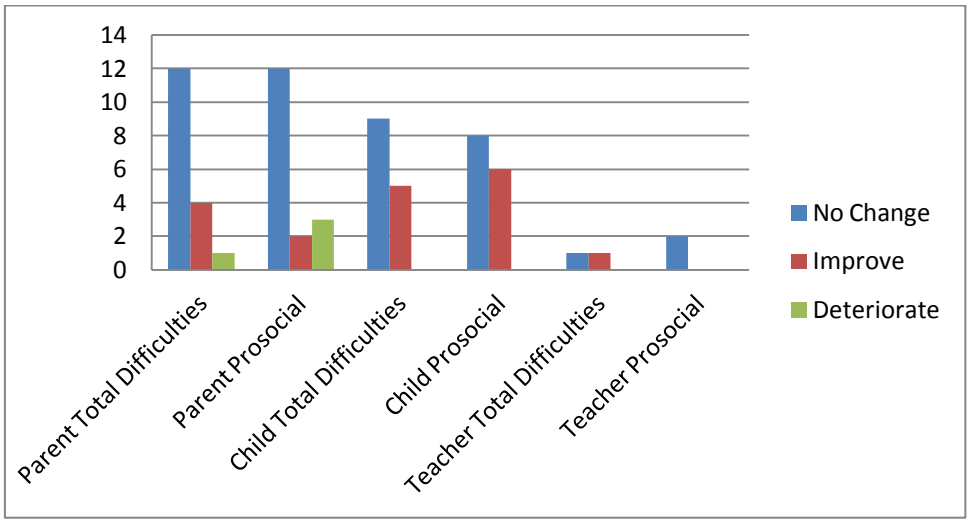


Figure 15: Overall SDQ scores

2.3.3.2. Adolescent Well-Being Scale

The Adolescent Well-Being Scale (AWB) is a 17-item screening tool for depression among 7- to 16-year-olds scored on a three-point scale: *most of the time*, *sometimes*, and *never*. A total of 26 cases recorded an AWB score at initial assessment. A further 18 cases were followed-up. The average score at initial assessment was 11.83 (*SD* = 5.71, range 3-35). The average score at follow-up was 5.99 (*SD* = 3.23, range 1-13). Using a paired sample t-test, a significant difference was found in AWB scores, $t(17) = 4.815$, $p < .001$. Adolescent Well-Being scores were found to significantly improve between initial assessment and follow-up.

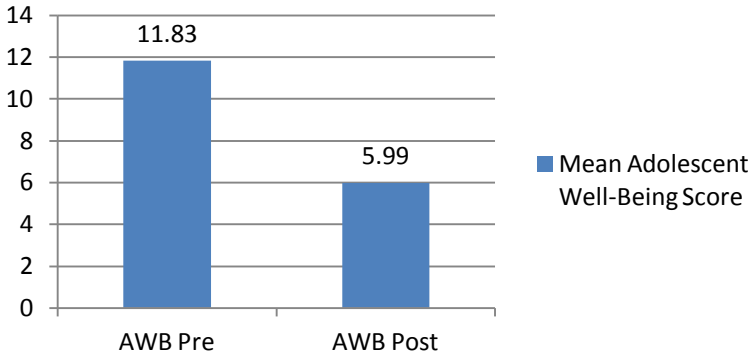


Figure 16: AWB pre and post assessment scores

2.3.3.3. Parental Well-Being

The Parent and Child Relationship Inventory is a self-report measure of parental well-being. The measure is divided into four subscales; Support, Satisfaction, Involvement, and Communication. In order to facilitate ease of interpretation, scores are categorised into

one of three levels of need; "Low", "Some", and "High". See Table 2 for breakdown of categories by subscale.

No significant difference was found between pre and post assessment scores for support, ($t(13) = .911$, $p = .379$, satisfaction, $t(13) = .665$, $p = .518$), communication, ($t(13) = .451$, $p = .659$), and involvement, ($t(13) = .583$, $p = .570$). Of major note here is the loss of follow-up assessment data (over 50% of cases).

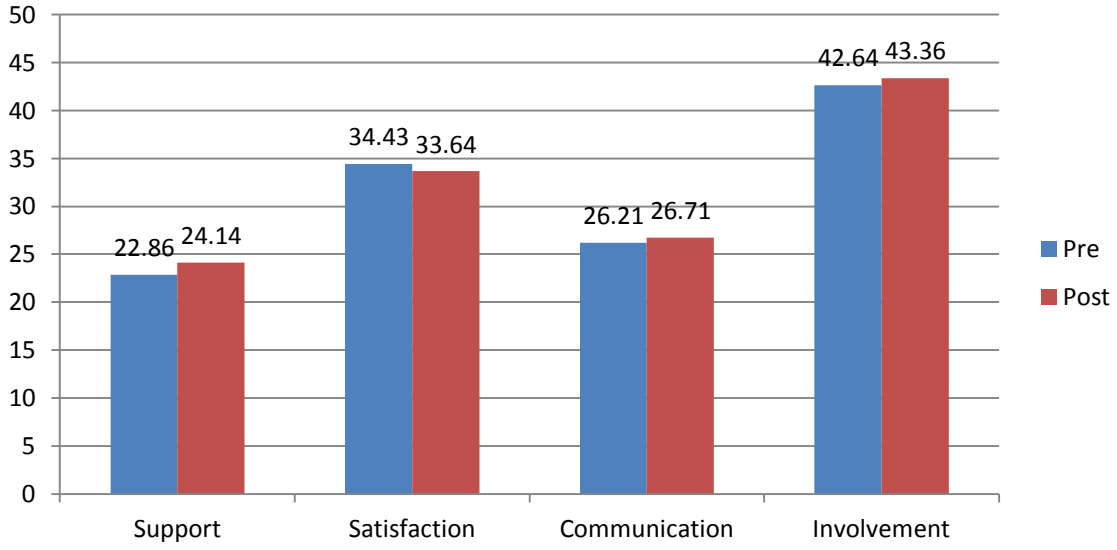


Figure 17: PCRI pre and post assessment scores

2.3.3.4. Family Based Ecological Assessment

The Family-Based Ecological Assessment (FBEA) is a measure of 5 ecological domains (Individual, Family, School, Peer and Community). Each domain consists of a number of domain components that refer to a particular assessment element (e.g. in Family domain "general parenting" is a domain component). Each domain component is determined to be not applicable (N/A), an Asset (rated as +1), a Liability (rated as -1 to -4), or Neither (rated as 0). In this evaluation, focus will also be given to the change from pre- to post-assessment. The change is documented by a sign ("+" for increase in scores, "-" for decreases in scores) and a whole number to indicate degree of change (e.g., if a rating moves from "-2" to "0", that is an increase of "+2"). No changes are indicated by a "0".

Assessing Change

Change is assessed in the following manner. First, the breakdown of changes in each case is recorded for each of the components of the domain (e.g., for each of the 18 components of the "Family Functioning" domain (see appendices). Following this, the total number of negative, positive, and "no changes" is calculated by summing the number of cases in each component that could be categorised under each heading. This is presented in a table indicating the percentage of cases over the domain that had a positive, negative, or no change (see appendices). Secondly, the percentage of cases for each component that has a positive change is calculated.

2.3.3.4.1. Family Domain

There are 18 components in the "Family Functioning" domain. The number of cases per component ranged from 7 to 13 cases. In total, 200 scores from 13 cases were recorded over the 18 domain components. Overall, improvement in the "Family Functioning" domain across all 18 components was seen in 33.50% of cases. There was no change between pre- and post-assessment family functioning scores in 60.50% of cases, while scores deteriorated in 6.00% of cases (see Figure 18).

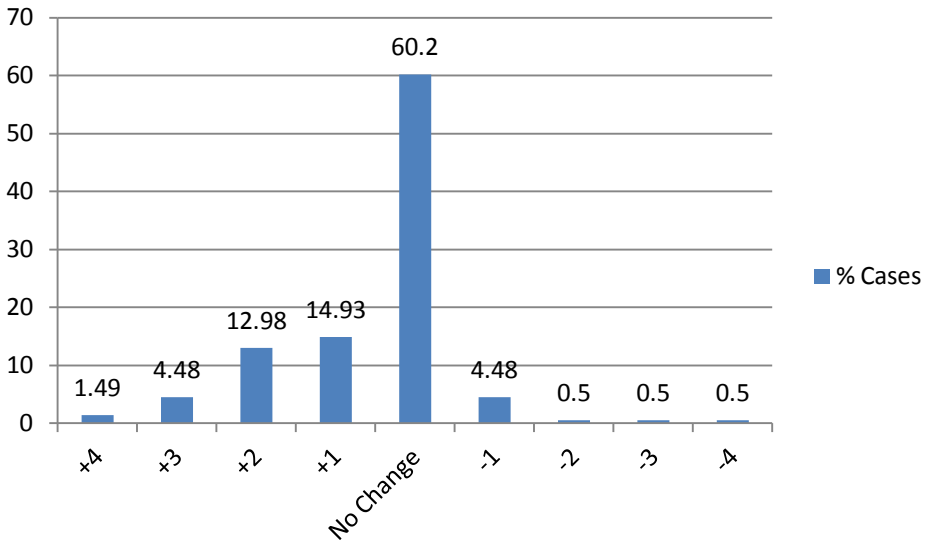


Figure 18: FBEA family functioning % cases change

Further analysis of the instances of 'no change' cited above revealed that 94% of all Family Domain components across all these cases were rated as assets (+1) or neither assets nor liabilities (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment (see Figure 19 below).

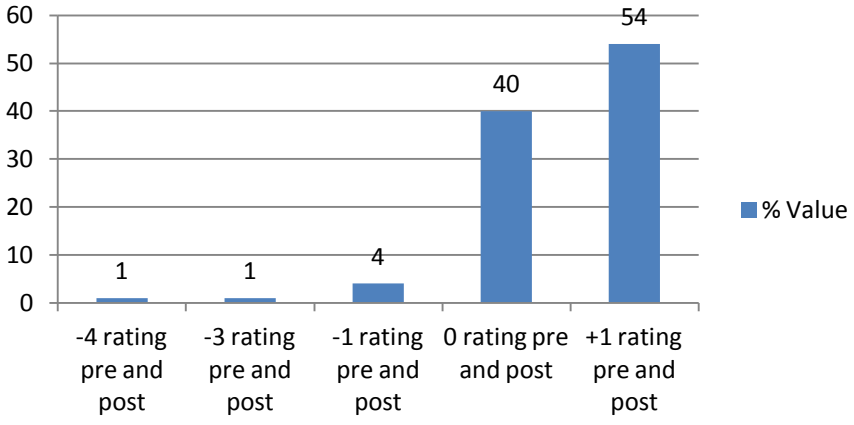


Figure 19: Breakdown of 'no change' cases in Family Domain components

2.3.3.4.2. Parenting Domain

There are 3 components in the "Parenting" domain. The number of cases per component was 13 cases. In total, 39 scores from 13 cases were recorded over the three domain components.

Taking "Parenting" as an individual domain, improvements were seen in 61.54% - 84.62% of cases (see Figure 20). The majority of cases assessed for parenting showed an improvement of +2 (33.33% cases, n = 13). A further 20.51% (n = 8) and 17.95% (n = 7) of cases improved by +1 and +3 respectively. 25.64% of cases (n = 10) did not show any change, while 2.56% (n = 1) decreased in score by -1.

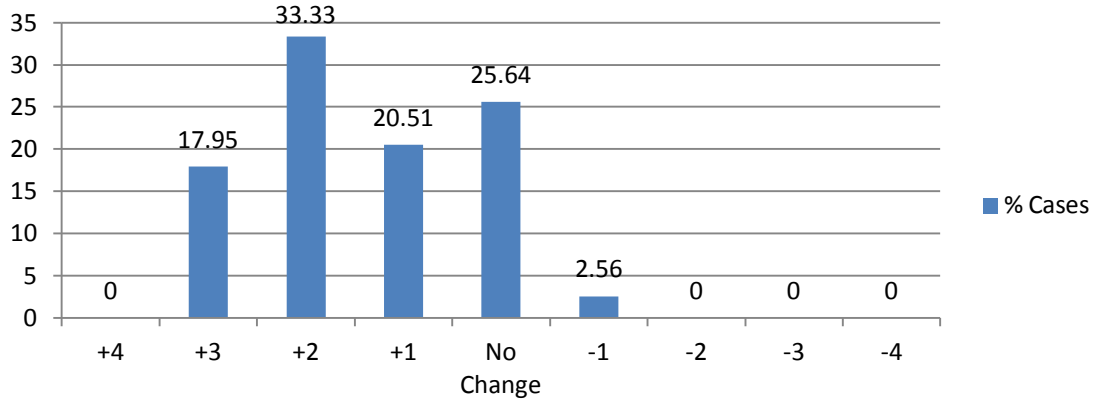


Figure 20: Percentage of cases by each degree of change in Parenting Domain

Further analysis of the instances of 'no change' highlighted above revealed that 80% of all Parenting Domain components across all these cases were rated as assets (+1) at pre-intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment (see Figure 21 below).

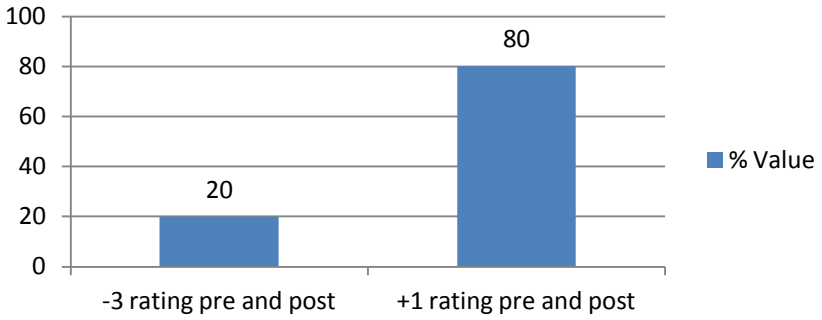


Figure 21: Breakdown of 'no change' cases in Parenting Domain components

2.3.3.4.3. Child Functioning

There are 14 components in the "Child Functioning" domain. The number of cases per component ranged from nine to 13 cases. In total, 151 post-assessment scores from 13 cases were recorded over the 14 domain components.

Looking at improvement in domain components, the most successful changes were seen in the "Relationships with Others" component (improvement in 76.92% of cases), the "Criminal Justice Involvement" component (improvement in 66.67% of cases), and the "Daily Life Management" component (improvement in 46.15% of cases). In contrast, the lowest success was evident in the "Spirituality" component (improvement in 11.11% of cases), and the "Employment" (improvement in 22.22% of cases) and "Developmental Status" component (improvement in 27.27% of cases). Overall, improvement in the "Child Functioning" domain across all 14 components was seen in 40.82% of cases. Looking at the degree of change (Figure 22), there was no change between pre- and post-assessment "Child functioning" scores in 51.66% of cases, while scores deteriorated in 7.95% of cases.

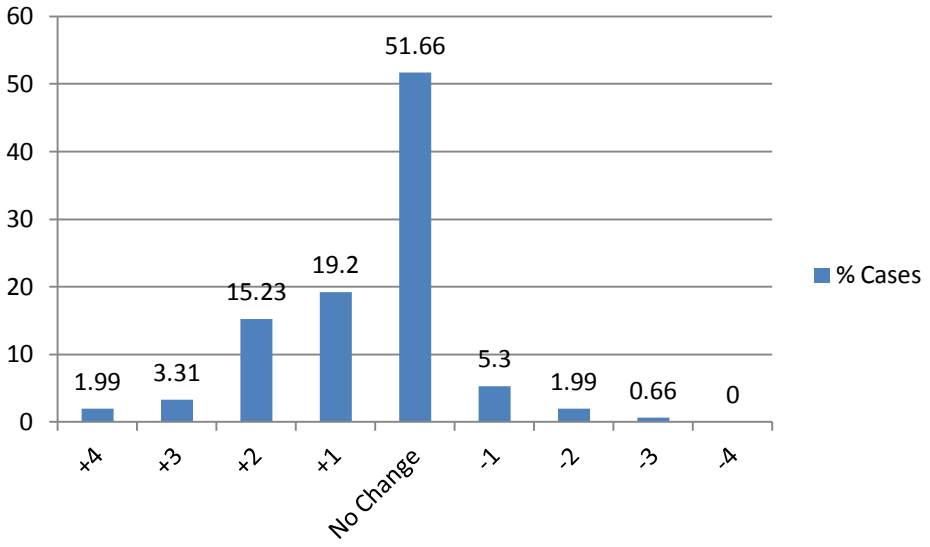


Figure 22: Percentage of cases by each degree of change in Child Functioning Domain

Further analysis of the instances of 'no change' highlighted above revealed that 82% of all Child Functioning Domain components across all these cases were rated as assets (+1) or neither assets nor liabilities (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment. Of note also is the 18% of all components across all cases which were liabilities but did not improve post intervention (see Figure 23 below).

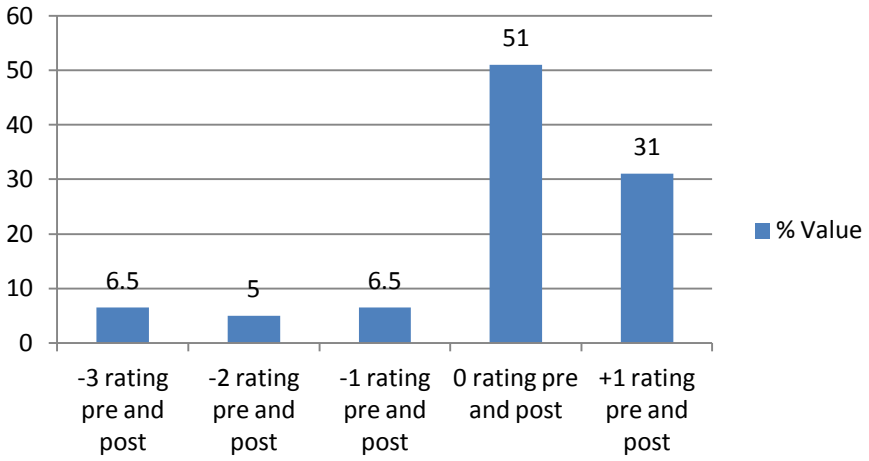


Figure 23: Breakdown of 'no change' cases in Child Functioning Domain components

2.3.3.4.4. Peer Domain

There are 9 components in the "Peer" domain. The number of cases per component ranged from 9 to 13 cases. In total, 105 post-assessment scores from 13 cases were recorded over the 9 domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Substance Use of Peers" component (improvement in 54.54% of cases), followed by the "Level of Involvement with Peers" component (improvement in 53.85% of cases), and the "Patterns of Peer Interaction" component (improvement in 46.15% of cases). The lowest success was evident in the "Other Friendships" component (improvement in 27.27% of cases). Overall, improvement in the "Peer domain" across all nine components was seen in 40.95% of cases. Looking at the degree of change (Figure 24), there was no change between pre- and post-assessment "Peer Domain" scores in 50.48% of cases, while scores deteriorated in 7.62% of cases.

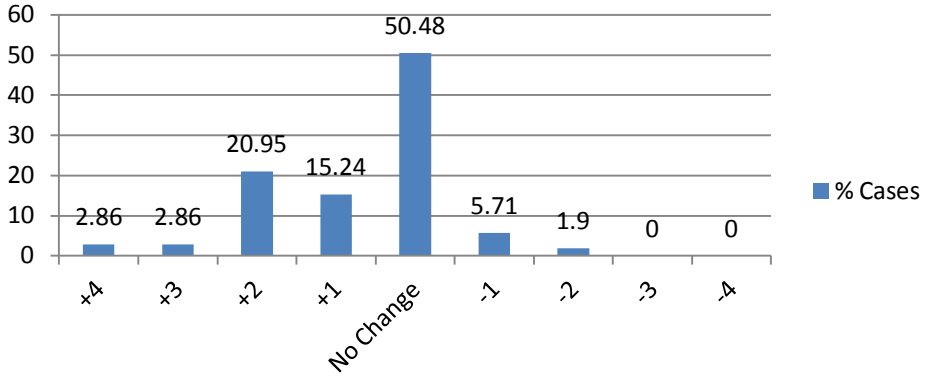


Figure 24: Percentage of cases by each degree of change in Peer Domain

Further analysis of the instances of 'no change' highlighted above revealed that 68% of all Peer Domain components across all these cases were rated as assets (+1) or neither assets nor liabilities (0) at pre- intervention assessment. This is important to note, as workers were

instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment. Of note also is the 32% of all components across all cases which were liabilities but did not improve post intervention (see Figure 25 below).

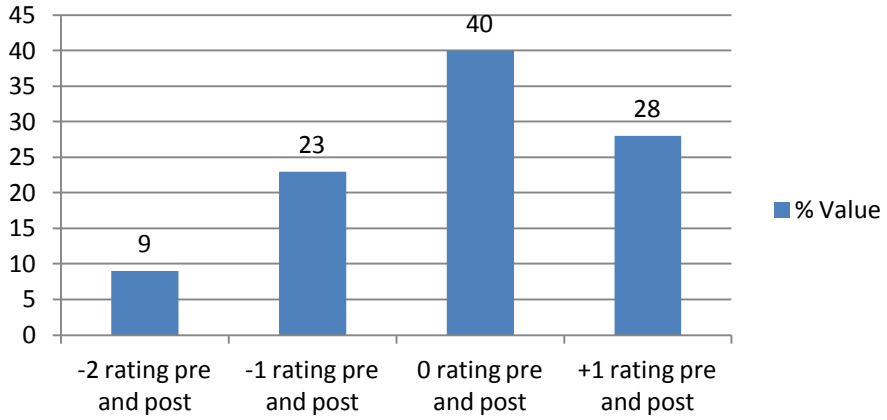


Figure 25: Breakdown of 'no change' cases in Peer Domain components

2.3.3.4.5. School Domain

There are eight components in the "School" domain. The number of cases per component ranged from ten to 13 cases. In total, 95 post-assessment scores from 13 cases were recorded over the eight school domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "School Attendance" component (improvement in 41.17% of cases), and the "School Achievement" component (improvement in 38.46% of cases). The lowest success was evident in the "School Support Systems" and the "Drug Activity in School" component (improvements in 10.00% of cases). Overall, improvement in the "School domain" across all eight components was seen in 24.21% of cases. Looking at the degree of change (Figure 26), there was no change between pre- and post-assessment "School Domain" scores in 68.42% of cases, while scores deteriorated in 7.37% of cases.

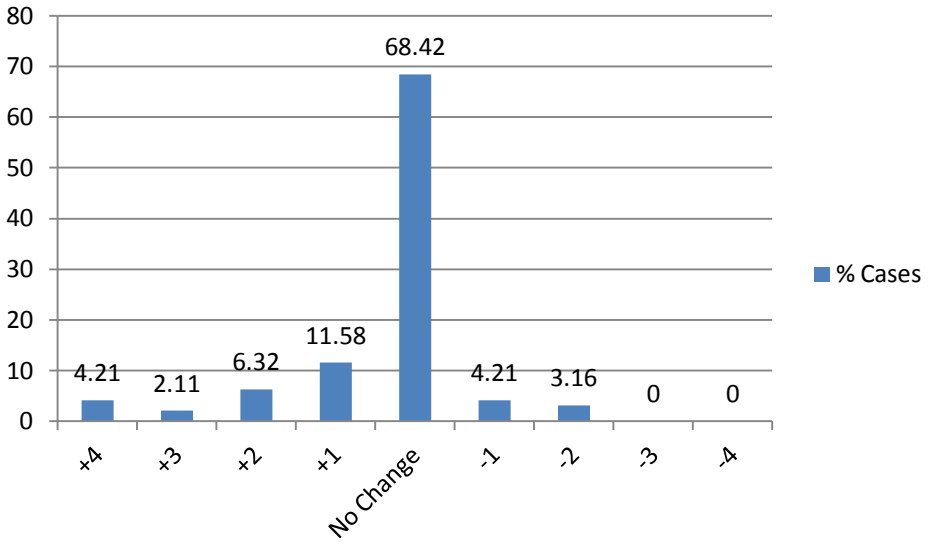


Figure 26: Percentage of cases by each degree of change in the School Domain

Further analysis of the instances of 'no change' highlighted above revealed that 86% of all School Domain components across all these cases were rated as assets (+1) or neither assets nor liabilities (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment (see Figure 27 below).

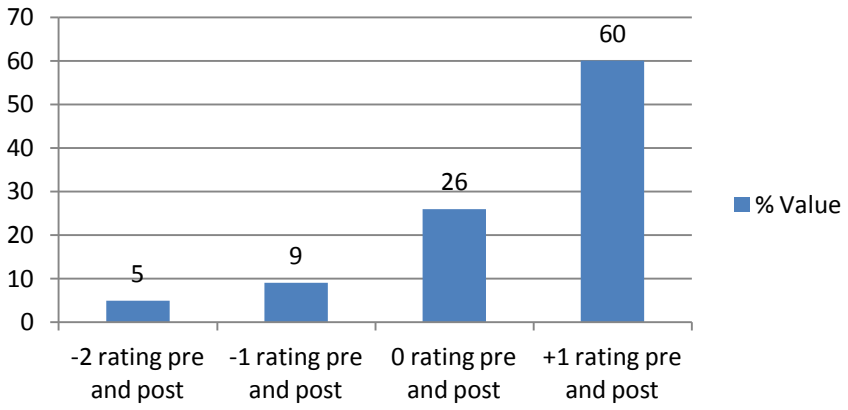


Figure 27: Breakdown of 'no change' cases in School Domain components

2.3.3.4.6. Community Domain

There are ten components in the "Community" domain. The number of cases per component ranged from nine to 13 cases. In total, 121 post-assessment scores from 13 cases were recorded over the 10 community domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Community Involvement" component (improvement in 45.45% of cases), the "Neighbourhood Involvement" component (improvements in 41.67% of cases) and the "Accessibility to Community Resources" component (improvements in 38.46% of cases). The lowest success was evident in the "Availability of Religious Institutions" component with

successful improvement in 0% of cases. Overall, improvement in the "Community Domain" across all 10 components was seen in 18.98% of cases. Looking at the degree of change (Figure 28), there was no change between pre- and post-assessment "Community Domain" scores in 79.34% of cases, while scores deteriorated in 1.65% of cases.

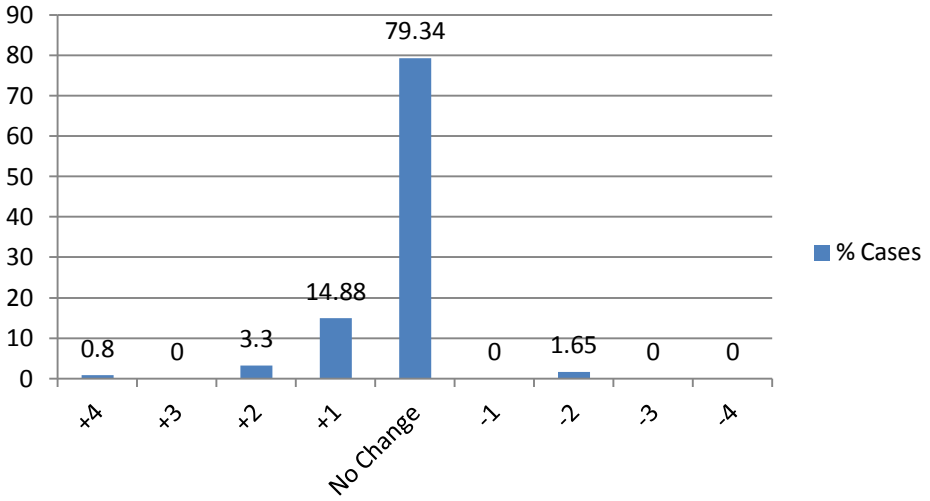


Figure 28: Percentage of Cases by each degree of change in the Community Domain

Further analysis of the instances of 'no change' highlighted above revealed that 87% of all Community Domain components across all cases were rated as assets (+1) or neither assets nor liabilities (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a liability (-1 to -4) in the pre-intervention assessment (see Figure 29 below).

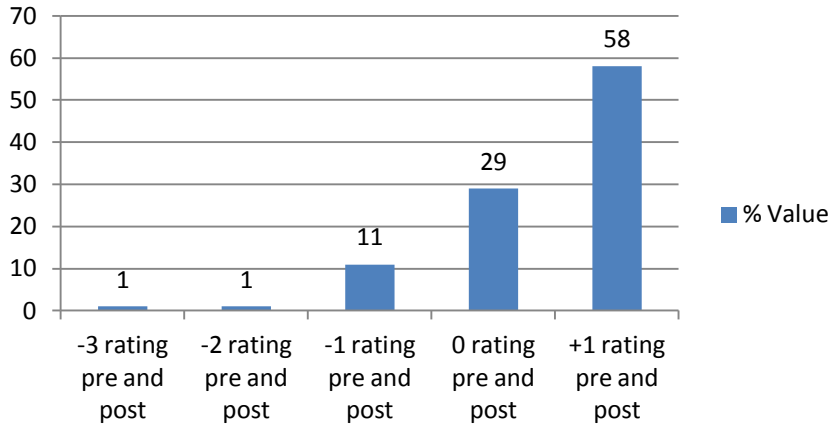


Figure 29: Breakdown of 'no change' cases in Community Domain components

2.1.3.4.7. Summary of Family-Based Ecological Assessment

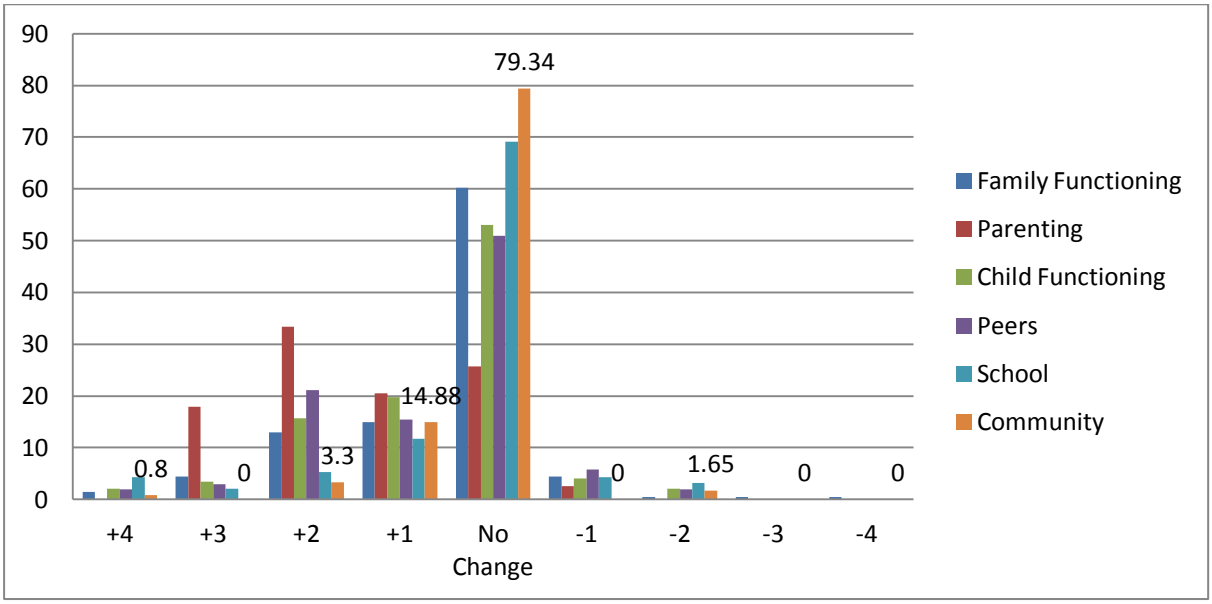


Figure 30: Degree of change in each domain of the FBEA

In summary (Figure 30), the most change in the FBEA between pre- and post-assessment scores was seen in the "Parenting Domain", with 71.79% of cases recording an improvement in scores. Given Mol an Óige's focus on parenting skills and working towards supporting parents more generally, these are encouraging scores. The domain that registered the largest proportion of "no change" was the "Community Domain", with 79.34% of cases recording no change. This is unsurprising given the relative difficulty of changing a component such as "availability of religious institutions". It also may underscore the difficulty in working the full ecology of parenting.

It is clear that the majority of cases that record pre- and post-assessment scores do not report a change. As highlighted in each individual domain section however, significant percentages of components across all cases were scored as assets, or neither assets nor liabilities in pre-intervention assessment, and were thus not the focus of intervention work. Hence, the high percentages of "no change" in the graphs above and below must be interpreted with caution. In addition, given the low number of cases in some components (e.g., n=9), improvements in a small number of cases may lead to large percentage improvements overall. Thus, caution is advised when interpreting components with low numbers. Overall, while the majority of cases showed no change, a higher proportion of cases recorded improvement across the six domains compared to decreases in scores (see Figure 31).

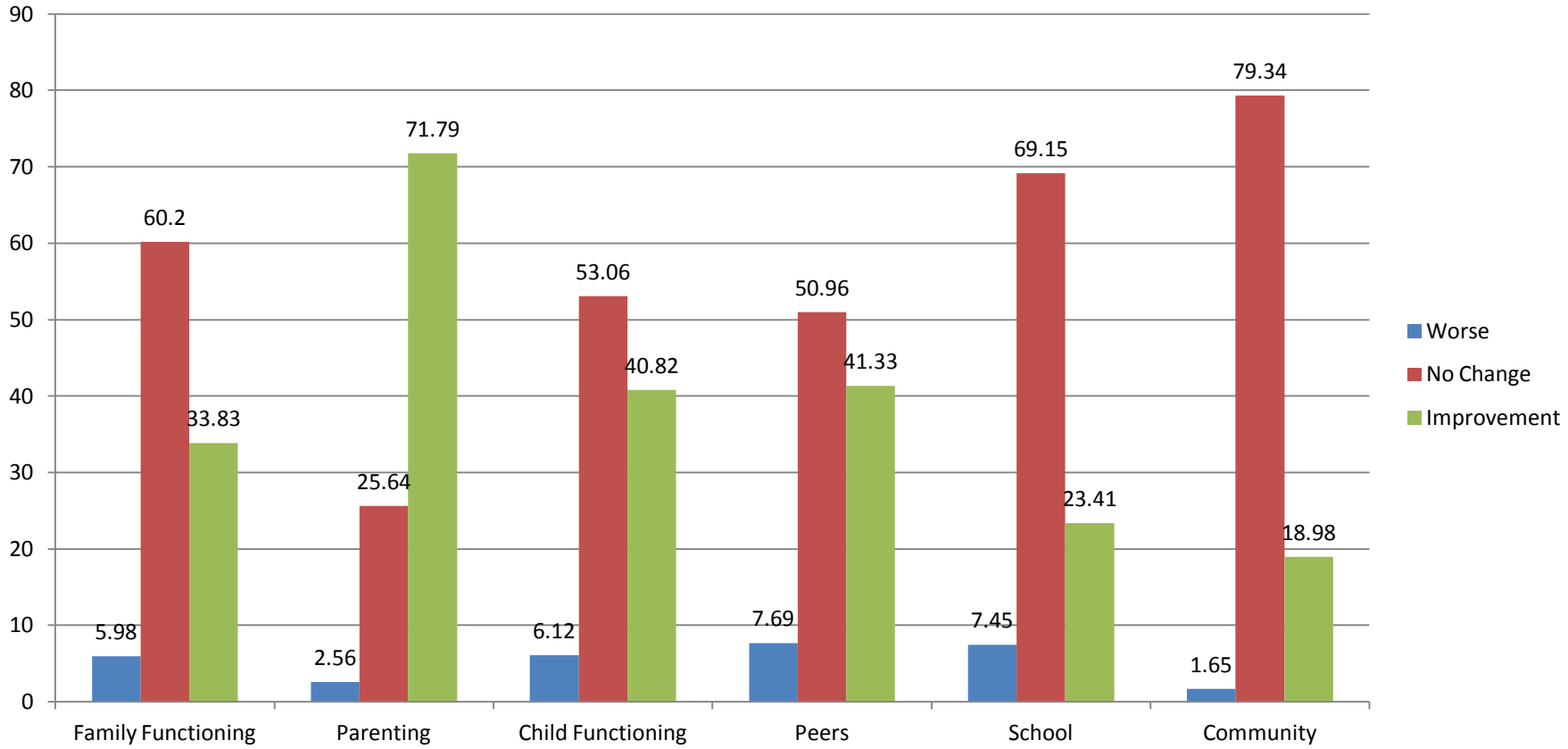


Figure 31: Percentage of Scores by change in each domain of the Family-Based Ecological Assessment

2.3.3.5. Strengths and Stressors

The Strengths and Stressors Tracking Device (SSTD) is a rapid assessment measure of family well-being that assesses the particular strengths and needs of families. The measure assesses families in the domains of environmental conditions, social support, caregiver skills, and child well-being on a scale from -3 to +2. In using the Device as a guide to service family plan development, workers were instructed to concentrate on only those items in the assessment which were stresses (-3, -2, -1) for families. Those items rated "0", or community norms, and those rated positively (+1, +2) were not the focus of intervention. This point needs to be considered when examining the entire range of scores in this measure.

In the current dataset, there are two sources of scores with pre- and post- assessment data available from 16 cases: worker scores in each case (n=16) and parent scores in some cases (n=10) for each component. In order to present clear information, this data will be combined (N = 26), and total changes (-6 to +6) of each component will be reported.

2.3.3.5.1. Environmental Conditions

There are 9 components in the "Environmental Conditions" domain. The number of case scores per component ranged from 24 to 26. In total, 225 post-assessment scores from 16 cases were recorded over the 9 environmental conditions components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Financial Management" component (improvement in 52% of case scores), the "Income" component (improvement in 44.00% of case scores), and the "Food & Nutrition" component (improvement in 40.00% of case scores). In contrast, the lowest success was evident in the "Personal Hygiene" component (improvement in 12.00% of case scores) and the "Safety in Community" component (improvement in 20.00% of case scores). Overall, improvement in the "Environmental Conditions" domain across all nine components was seen in 32.44% of cases. Looking at the degree of change (Figure 32), there was no change between pre- and post-assessment "Environmental Conditions" scores in 48.89% of cases, while scores deteriorated in 18.67% of cases.

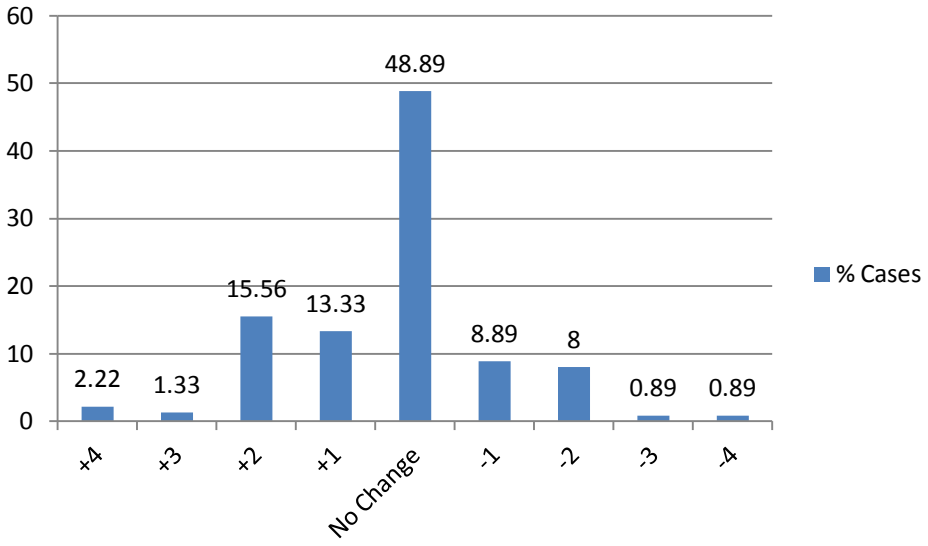


Figure 32: Percentage of case scores by each degree of change in the Environmental Conditions Domain

Further analysis of the instances of 'no change' highlighted above revealed that 96% of all Environmental Conditions Domain components across all these cases were rated as strengths (+1, +2) or community norms (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a stressor (-1 to -3) in the pre-intervention assessment (see Figure 33 below).

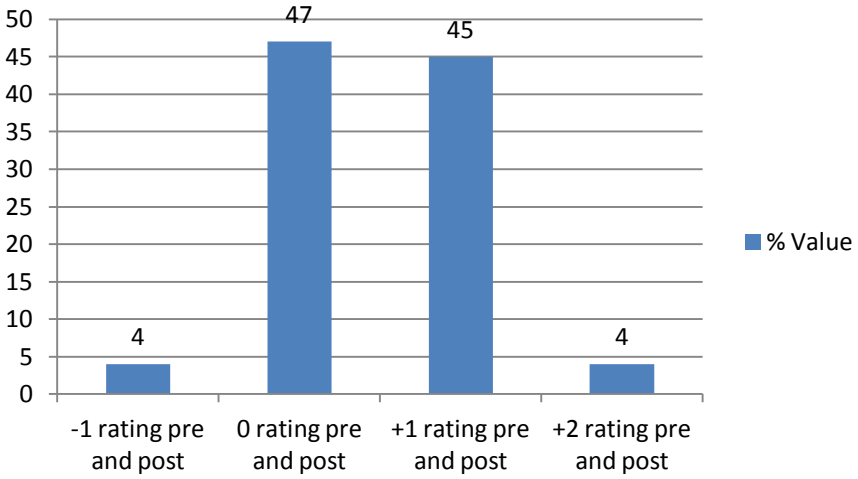


Figure 33: Breakdown of 'no change' cases in Environmental Conditions Domain components

2.3.3.5.2. Social Support

There are four components in the "Social Support" domain. The number of case scores per component ranged from 25 to 26. In total, 101 post-assessment scores from 16 cases were recorded over the 4 social support components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Regular Services" component (improvement in 60.00% of case scores). The

"Emergency Services" component and the "Motivation for Support" component both improved in 32.00% of case scores, while the "Social Relationships" component improved in 30.77% of case scores. Overall, improvement in the "Social Support" domain across all four components was seen in 38.61% of cases. Looking at the degree of change (Figure 34), there was no change between pre- and post-assessment "Social Support" scores in 50.50% of cases, while scores deteriorated in 10.89% of cases.

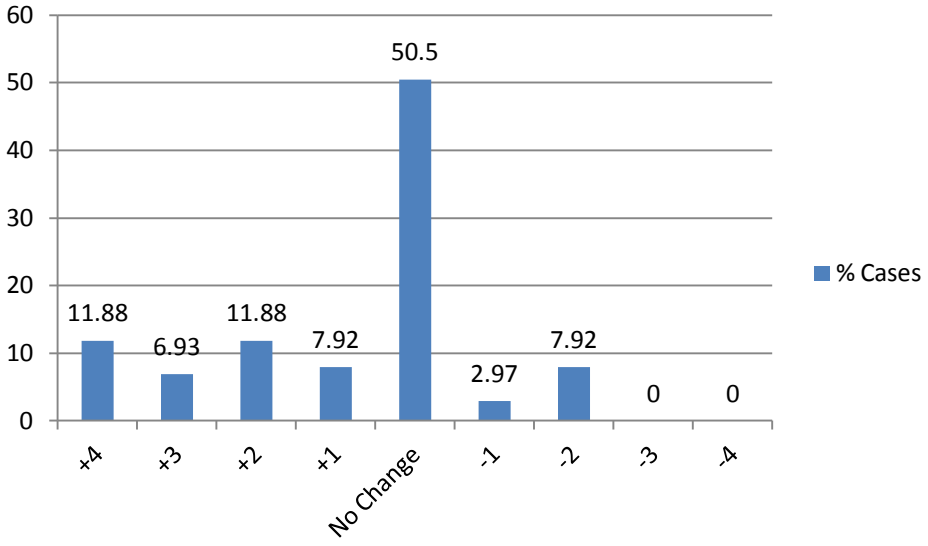


Figure 34: Percentage of Case Scores by each degree of change in the Social Support Domain

Further analysis of the instances of 'no change' highlighted above revealed that 96% of all Social Support Domain components across all these cases were rated as strengths (+1, +2) or community norms (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a stressor (-3) in the pre-intervention assessment (see Figure 35 below).

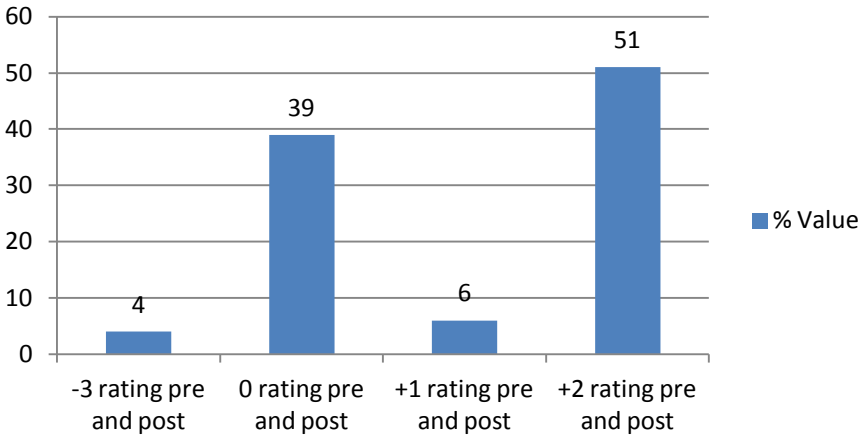


Figure 35: Breakdown of 'no change' cases in Social Support Domain components

2.3.3.5.3. Family Caregiving

There are 11 components in the "Family Caregiving" domain. The number of case scores per component ranged from 24 to 26. In total, 279 post-assessment scores from 16 cases were recorded over the 11 Family Caregiving components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Mutual Support" component (improvement in 83.33% of case scores), the "Parenting Skills" component (improvement in 76.92% of case scores), and the "Adult Supervision" component (improvement in 73.08% of case scores). In contrast, the lowest success was evident in the "Physical Health that affects Parenting" component (improvement in 7.69% of case scores) and the "Alcohol/Drug Abuse that affects Parenting" component and the "Bonding with Children" component (both showed improvement in 23.08% of case scores). Overall, improvement in the "Family Caregiving" domain across all 11 components was seen in 41.63% of case scores. Looking at the degree of change (Figure 36), there was no change between pre- and post-assessment "Family Caregiving" scores in 51.97% of cases, while scores deteriorated in 6.45% of cases.

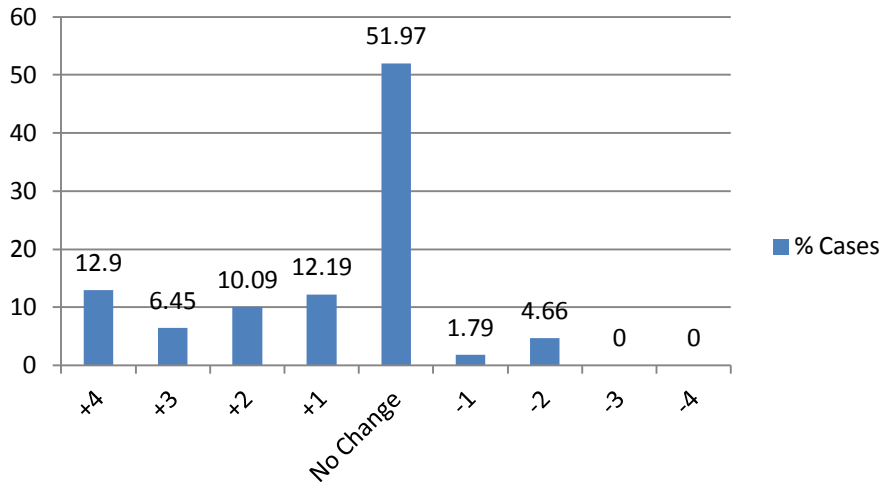


Figure 36: Percentage of case scores by each degree of change in the Family Caregiving Domain

Further analysis of the instances of 'no change' highlighted above revealed that 97% of all Family Caregiving Domain components across all these cases were rated as strengths (+1, +2) or community norms (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a stressor (-1, -2) in the pre-intervention assessment (see Figure 37 below).

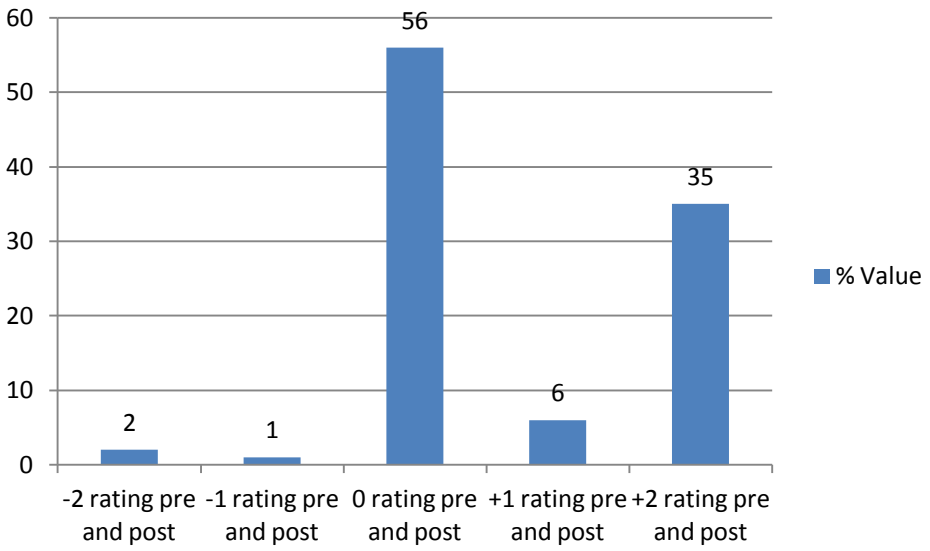


Figure 37: Breakdown of 'no change' cases in Family Caregiving Domain components

2.3.3.5.4. Child Well-Being

There are 12 components in the "Child Well-Being" domain. The number of case scores per component ranged from 5 to 26. In total, 289 post-assessment scores from 16 cases were recorded over the 12 child well-being components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Child's Behaviour" component (improvement in 100% of case scores, *note only 5 cases were applicable*), the "Child's Mental Health" component (improvement in 88.46% of case scores), and the "Relationship with Caregiver" component (improvement in 84.62% of case scores). In contrast, lower success was evident in the "Relation with Sibling" component (improvement in 37.50% of case scores). Low scores were also seen in the risk assessment scores (e.g., Child Sexual abuse = 0% improvement, to "Child Physical Abuse" = 34.62%), however these low improvement scores are exaggerated by the recording of scores when not applicable. It is important to note that this does not mean that these items were not assessed or looked for by workers; they were, but the particular issues were not deemed a stress in the family's life, and/or not an issue of concern for the worker.

Overall, improvement in the "Child Well-Being" domain across all 12 components was seen in 43.95% of cases. Looking at the degree of change (Figure 29), there was no change between pre- and post-assessment "Child Well-Being" scores in 52.25% of cases, while scores deteriorated in 3.11% of cases.

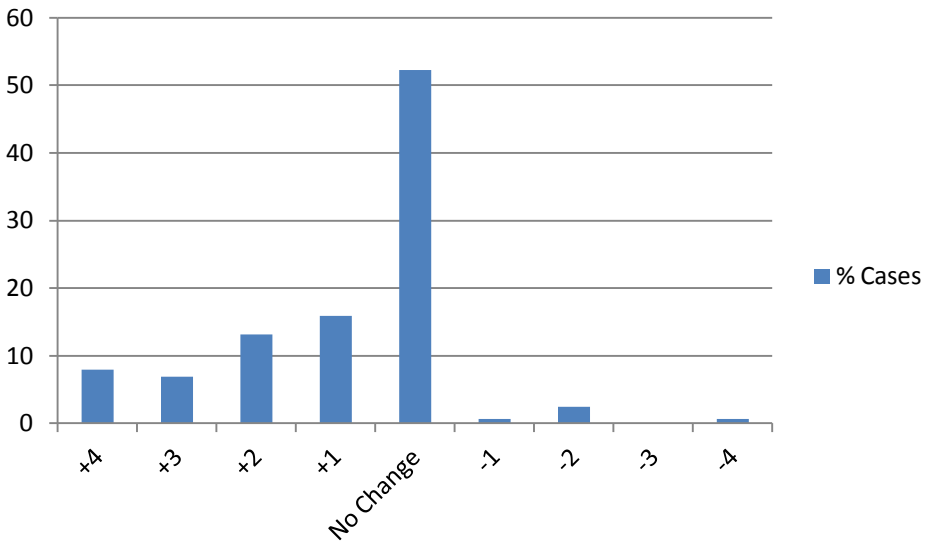


Figure 38: Percentage of case scores by each degree of change in the Child Well-Being Domain

Further analysis of the instances of 'no change' highlighted above revealed that 91% of all Child Well-Being Domain components across all these cases were rated as strengths (+1, +2) or community norms (0) at pre- intervention assessment. This is important to note, as workers were instructed to concentrate only on those elements which were rated as a stressor (-1, -2, -3) in the pre-intervention assessment (see Figure 37 below).

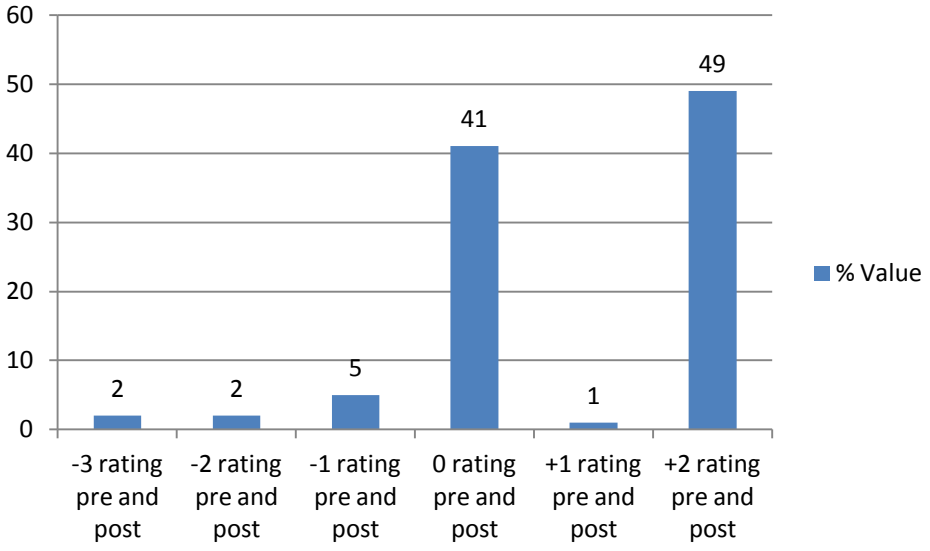


Figure 39: Breakdown of 'no change' cases in Child Well-Being Domain components

2.3.3.5.5. Summary of Strengths & Stressors Assessment

From Figure 30 below, it is clear that the majority of cases that record pre- and post-assessment scores do not report a change. The percentage of cases that recorded no change ranged from 48.89%-52.25%. However, the amount of no change must be

interpreted with caution as the scoring of components as zero (community norms) or as strengths (+1, +2) significantly inflate this figure, as can be seen in previous analysis It must be remembered that workers were instructed to concentrate only on addressing stresses identified by the assessment tool. Items in the assessment rated as "0" (community norm), or as strengths (+1, +2) were not the focus of intervention by workers for families. The small number of cases overall in this analysis is also a point requiring consideration.

The most change between pre- and post-assessment scores was seen in the "Child Well-Being" domain, with 43.95% of cases recording an improvement in scores. The domain that registered the largest proportion of "no change" was also the "Child Well-Being", with 52.06% of cases recording no change. Again, this is likely to be inflated due to the irrelevance of components such as "Sexual Abuse", which recorded "no change" in all cases as there was no sexual abuse recorded in any of the 16 cases. Again, it is important to note that the recording of such abuse does not mean that it was not assessed for.

The largest proportion of cases that showed a deterioration in scores (i.e., negative change) were found in the "Social Support" domain (with 18.67% of cases showing a decrease in post-assessment scores), and the "Environmental Conditions" domain (15.86% of cases showing a decrease). This is relatively high compared to the other domains (Family Caregiving = 6.45%, and Child Well-Being = 3.11% of cases). Overall, while the majority of cases showed no change, a higher proportion of cases recorded improvement across the four domains compared to decreases in scores (see Figure 41).

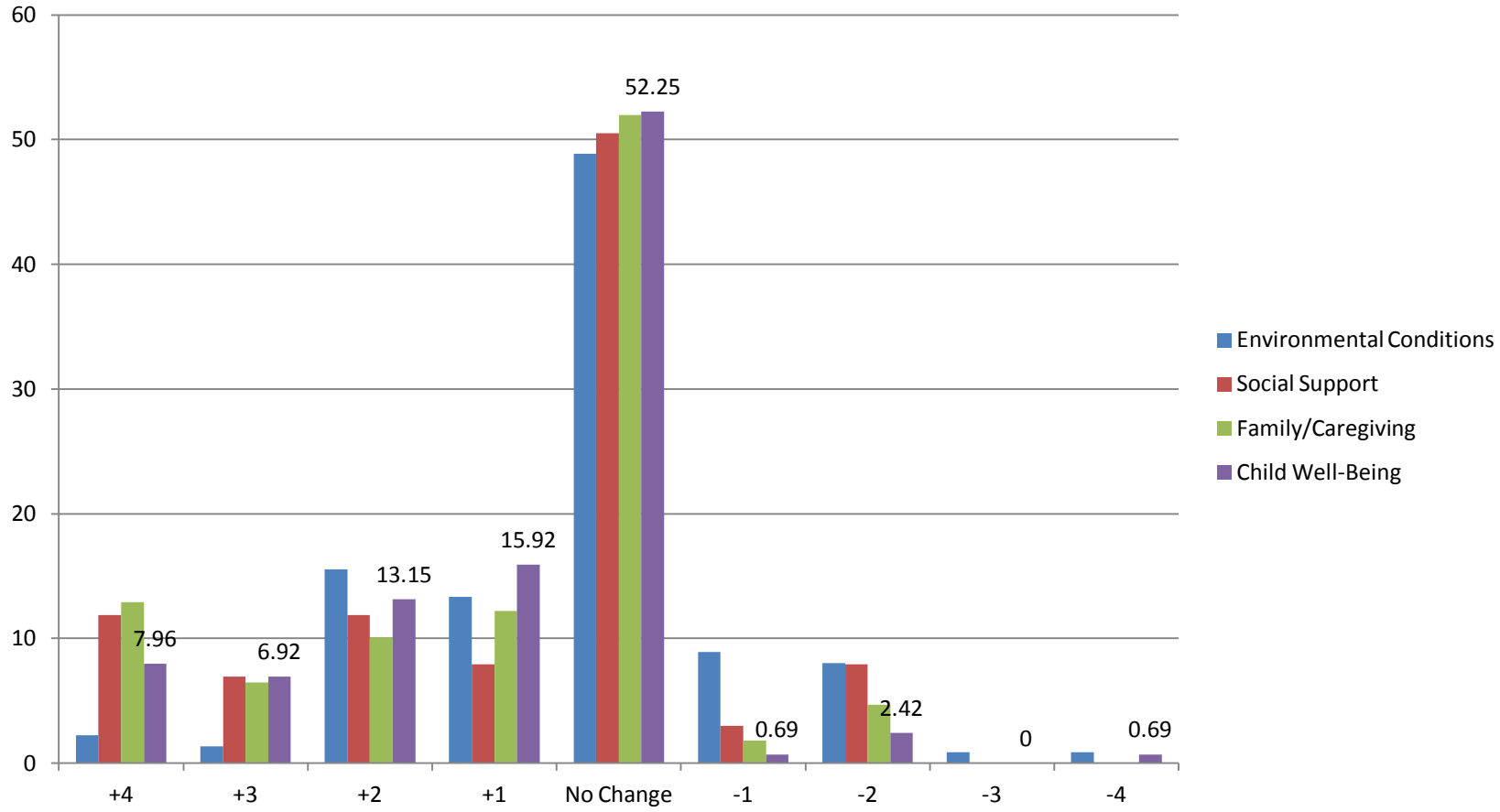


Figure 40: Percentage degree of change in each domain of the Strengths and Stressors Assessment

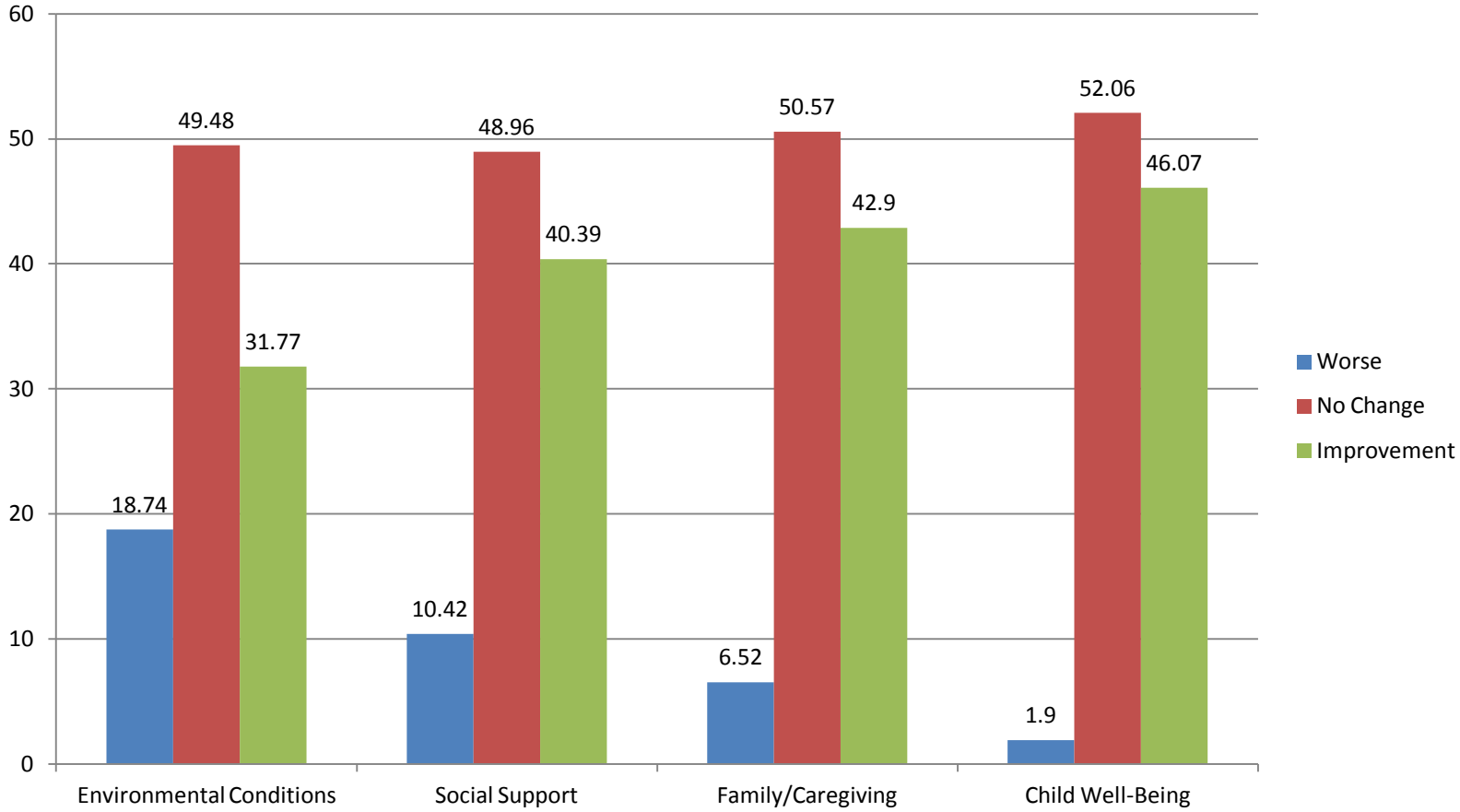


Figure 41: Percentage of cases by change in each domain of the Strengths and Stressors Assessment

2.4. Summary

This Chapter has outlined a very detailed picture of MoI an Óige cases since it began operation in 2007. It has outlined a number of key findings in relation to the cases, such as the number of goals achieved, processes of assessment and information gathering by services, the extent to which cases were deemed successful, and the overall length of intervention. It has also outlined the extent to which statistically significant differences were determined in the pre and post measure scores. However, a note of caution must be issued with these statistical analyses: the numbers are small and the nature of the data is limited. Consideration of other sources of data is required.

CHAPTER THREE: STAFF SURVEY FINDINGS

3.1. Introduction

This Chapter presents follow-up findings of surveys completed by staff implementing Mol an Óige. After this introduction, the second section of this Chapter outlines findings from data of the follow-up survey administered in February 2012. The third section contains standalone data on staff rating of the impact of Mol an Óige skills on their practice. The fourth section identifies staff suggestions for improvement for day to day practice. The fifth section identifies notable survey items for comparison from the baseline and follow-up before the Chapter concludes with a short summary.

3.2. Follow-Up Findings

3.2.1. Demographics

In total, 22 survey responses were received from an eligible sample of 24, representing a response rate of 92%. Nineteen responses were female, while 3 were male. The mean or average age of respondents was 36.55 years, with the median value being 36 years and the mode being 34 years. Respondents had a wide range of experience, from two to 21 years, with the mean being 12.73 years, and both the median and mode being 12 years. The majority (n=13, 59%) described themselves as project workers, with social care workers and child care leaders making up the remainder of the representation. Social care studies was the primary qualification of respondents (n=7, 32%), followed by childcare (n =6, 27%) and youth work (n =5, 23%), and a range of others. All respondents had at least a level eight degree, with a further six possessing a postgraduate degree. The average working week was 30.82 hours, with the median and mode responses being 35 hrs. It should be noted that a number of workers provided additional information to aid understanding of their responses. Two highlighted that they work part time, while three responded that Mol an Óige accounted for only part of their workload.

3.2.2. Work Type and Patterns

The majority of respondents (59%, n =13) reported working both on an individual and group basis, with the remainder working on an individual basis. All respondents reported working with both parents and children. The majority of respondents reported working "with children with chronic or serious problems requiring intensive support in the community", i.e. Hardiker level three, (n=15, 69%), with three respondents reporting working at level four. Two and one respondents reported working at levels one and two respectively.

A number of statistics are presented in Table Two below regarding various aspects of respondents' day-to-day practice. Note these figures are based on 21 responses. One respondent chose not to provide this information.

	Time spent per week planning work	Time spent per week recording work	Time spent per week doing direct face to face work	On average, how many cases are you responsible in a year	Total number of cases closed prematurely in the last 12 months.	Total number of cases closed in the last 12 months.
Mean	6.14	6.81	12.24	15.36	1.90	10.65
Median	6.00	8.00	11.00	10.00	2.00	5.00
Mode	8	8	6	20	2	Multiple modes
Std. Deviation	2.575	3.430	6.434	24.297	2.292	24.926

Table 2: Cases Numbers and Time Averages

Of note here are the high deviation scores relating to some questions. Regarding time spent per week doing face to face work, the deviation of 6.434 is notable in that, while the most entered value was 'six hours', 13 (62%) respondents provided answers ranging from 10-24 hours. Regarding average number of cases responsible per year, the deviation is more pronounced, at 24.297. This is explained in the wide variety of answers, with a range of 1-20 cases, with a single outlier of 120 cases.

Respondents were asked to identify three main theories which they drew on in their work. In total, 62 responses were provided out of a possible 66. These are outlined in Figure 32 below.

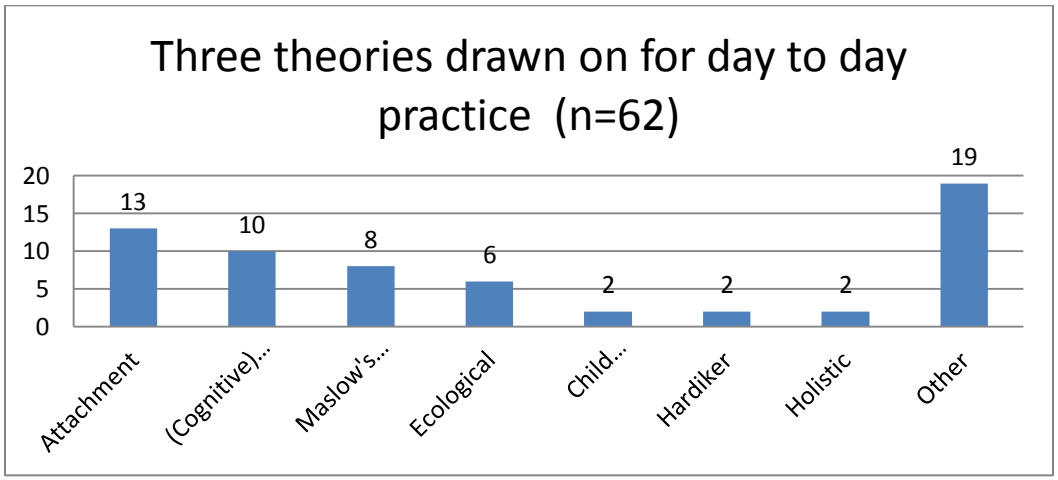


Figure 42: Theories drawn on in practice

Under 'other' a variety of single responses were provided. These included: child safety; resilience; family support; strengths-based; youth focus; children first; family systems theory; MST; anti-discrimination; and family preservation.

Respondents were also asked to indicate whether their organisation worked from a particular model. Six respondents indicated no, while two answered that they did not know. Fourteen respondents answered yes, and provided a range of responses. These are outlined in Figure 33 below.

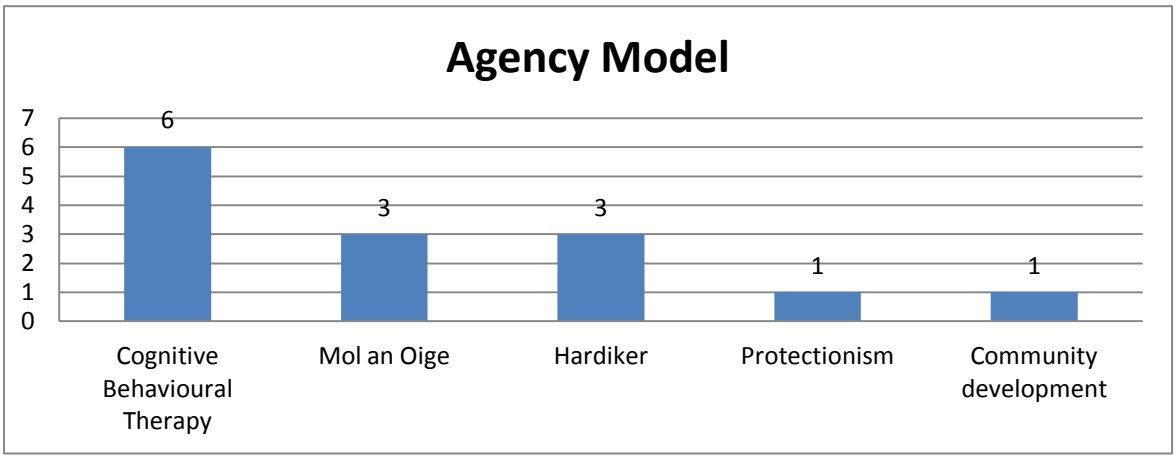


Figure 43: Agency model worked from

3.2.3. (Inter) Organisational Factors in Meeting the Needs of Families

Respondents were asked to rate a number of statements pertaining to their work with families, covering both their own organisation and their work with other agencies.

3.2.3.1. Organisational Factors

Regarding organisational processes and work practices, respondents were broadly positive about the nature of their agency's characteristics and work:

- Almost all agreed or strongly agreed (n =20, 91%) that their agency had a keen understanding of community needs;
- A majority (n=17, 77%) believed there were good planning processes in the agency;
- A similar majority believed their agency had a clear focus on its goal (n=16, 73%), while a smaller majority (n=12, 55%) believed that their agency routinely re-evaluated its goals/missions;
- A majority of respondents (n=16, 73%) believed that people in the agency actively contributed to shaping agency objectives;
- A majority of respondents (n=16, 73%) believed that the agency engaged in high quality needs assessment;

- Only half of respondents (n=11, 50%) believed that the agency was committed to evaluation. Two neither agreed nor disagreed while the remainder (n=8) strongly disagreed or disagreed;

- An overwhelming majority (n=19, 86%) believed that making progress in cases was not simply a matter of resources;

- Regarding answering the statement "we do not have enough case workers to get things done", answers were mixed. Nine respondents (44.83%) neither agreed nor disagreed, while the same number agreed or strongly agreed. Four respondents disagreed with the statement;

- Similarly, in response to the statement "we don't have sufficient funding to achieve our goals", responses were mixed. While nine respondents (45%) agreed or strongly agreed, the same amount neither agreed nor disagreed. Four respondents disagreed with the statement.

Figure 34 on the next page illustrates these values. What emerges in these graphs and values is an overall positive picture of internal organisational processes and practices which contextualise respondents' work. Yet, when issues of access to resources to undertake work, be it staff or funding, are considered, responses are more negative. It is important to note, however, that almost half the responses in these instances were neutral.

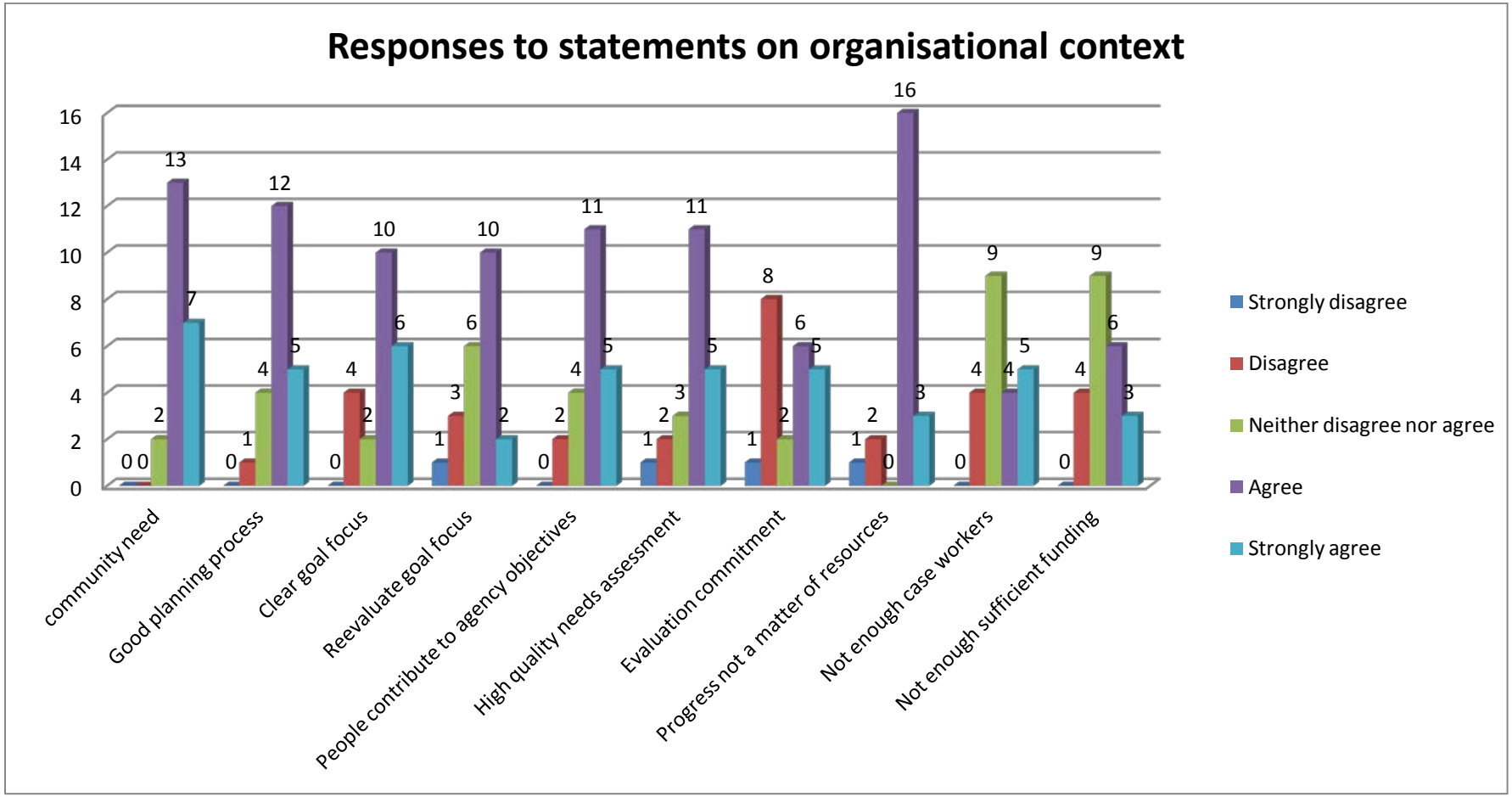


Figure 44: Responses to statements on organisational context

3.2.3.2. Inter-Organisational Factors

As with organisational factors, respondents were broadly positive about their experiences of collaborating with other professionals and organisations in meeting the needs of families:

- Almost all (n =20, 91%) highlighted that their work involved joint working with other agencies, with slightly less (n=18, 82%) indicating that other agencies were happy to share information. Twenty-one respondents agreed or strongly agreed that their manager expects them to be part of interagency work;

- All respondents disagreed or strongly disagreed that their experience of working with other agencies had been unpleasant. All respondents strongly disagreed or disagreed with the statement that they would prefer not to work with other agencies;

- A majority of respondents disagreed or strongly disagreed (n=15, 68%) with the statement that other agencies wanted to take credit for the respondent's work, while two respondents agreed and five respondents were neutral (neither agreed nor disagreed);

- The majority of respondents (n=15, 68%) felt that other agencies were very helpful in their success, while a larger majority (n=20, 91%) disagreed or strongly disagreed with the statement that they would prefer not to work with other agencies. The same majority disagreed or strongly disagreed with the statement that other agencies were hostile to their work;

- The majority of respondents (n =15, 68%) agreed or strongly agreed with the statement that they could not do their job without the assistance of other agencies. Six neither disagreed nor agreed, while one respondent disagreed;

- Almost all (n=21, 95%) strongly disagreed or disagreed with the statement that interagency working makes it harder to meet the needs of clients;

- Almost all (n=21, 95%) value the skills that other disciplines bring to casework, while a majority (n=16, 73%) disagree or strongly disagree with the statement that other disciplines did not respect their role;

- Finally, almost all (n=21, 91%) respondents agreed or strongly agreed with the sense of viewing themselves as part of a multidisciplinary team.

Figure 35 illustrates these values. Respondents are very positive about their experience of interagency working. In the main, they view it as making a positive contribution to their work, and what emerges is an optimistic picture of respondents' day-to-day working with, and attitude towards, other professionals and organisations. Where these positive scores do

recede slightly, in the cases of respect from other professionals and involvement in their work, the overarching scores are still high.

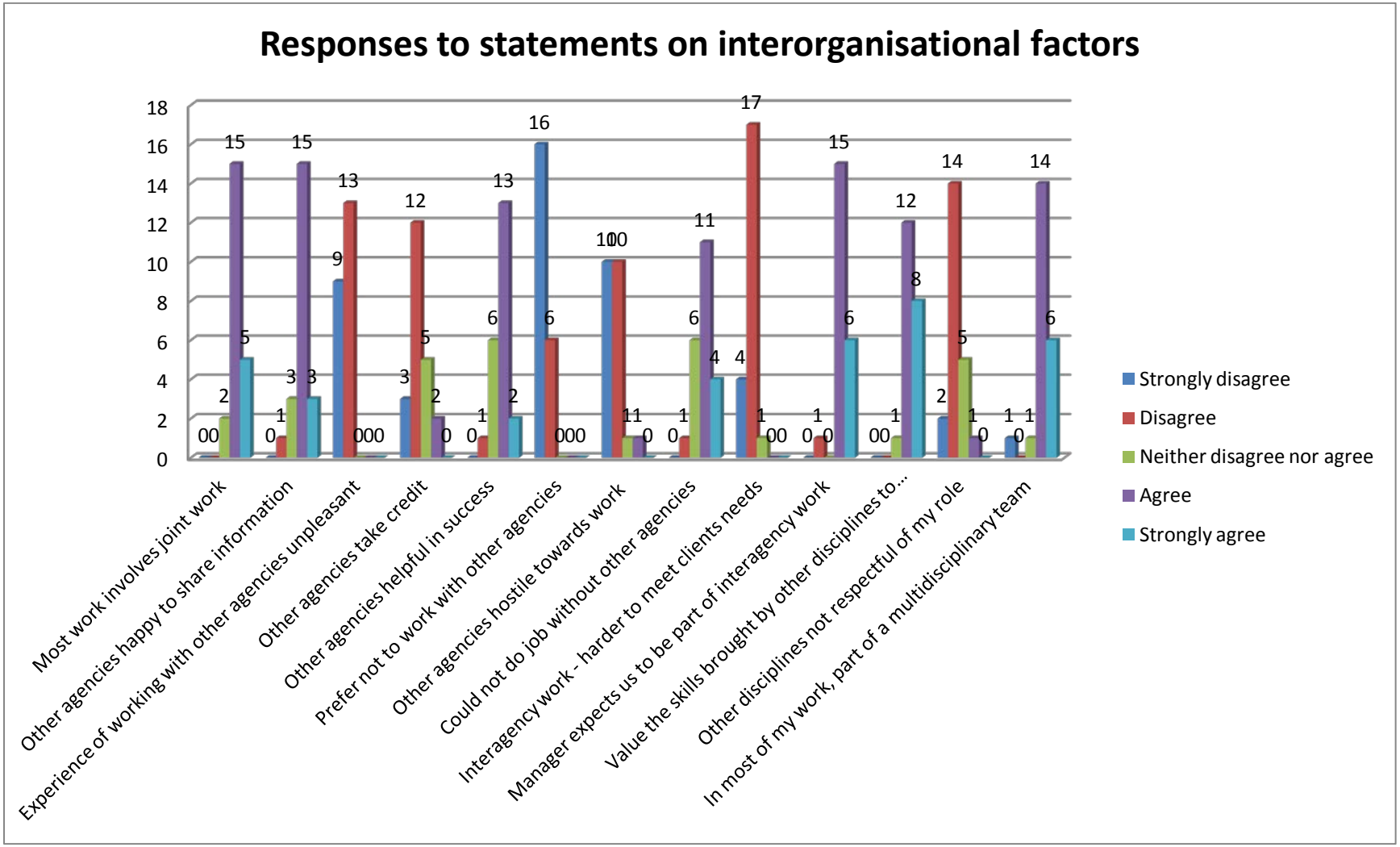


Figure 45: Responses to statements on inter-organisational context

Respondents were also asked to indicate the three key agencies with which they collaborate in their daily work (Figure 36). All respondents provided details on three agencies. The main agency cited was social work, followed by schools and psychology. A range of single answers were provided. These included: NEPS; 'my own agency'; St. Vincent de Paul; Brothers of Charity; 'other HSE'; and Child Guidance.

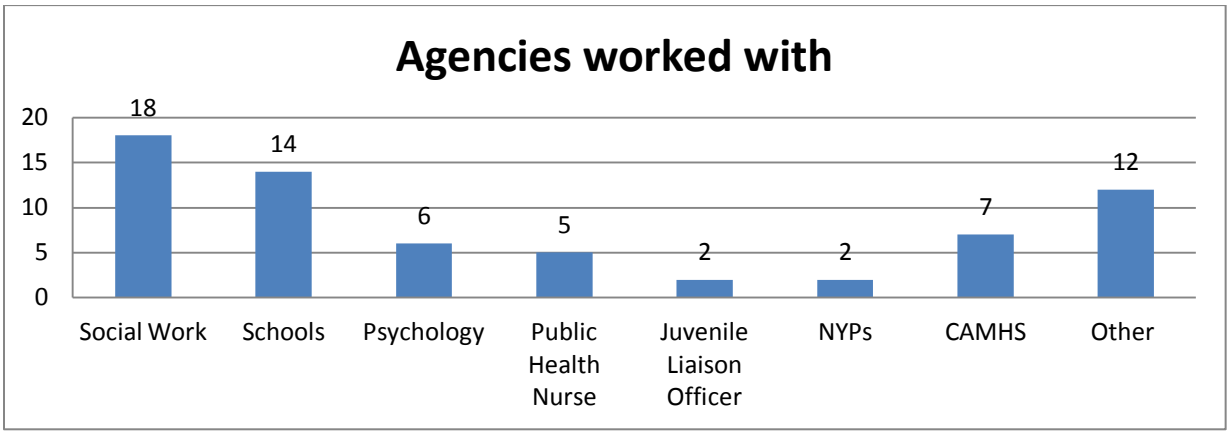


Figure 46: Agencies worked with

3.2.4. Working for Families and its Impact

A majority of respondents (n=17, 77%) disagreed or strongly disagreed with the statement that the children they work with have too many problems to deal with in a community setting. Five respondents neither disagreed nor agreed. All respondents strongly disagreed or disagreed with the statement that the system is too complicated for them to make a difference. However, answers were mixed as to the need for new frameworks or models for working with young people: five disagreed or strongly disagreed for the need; ten neither agreed nor disagreed; and seven agreed or strongly agreed. The majority agreed or strongly agreed (n =15, 68%) that there were adequate resources to achieve their goals. Four respondents disagreed.

Regarding the impact of their work for families, respondents were asked to identify the extent to which they felt goals were achieved in the past five cases they worked. These values are outlined in Figure 37 below (n=93):

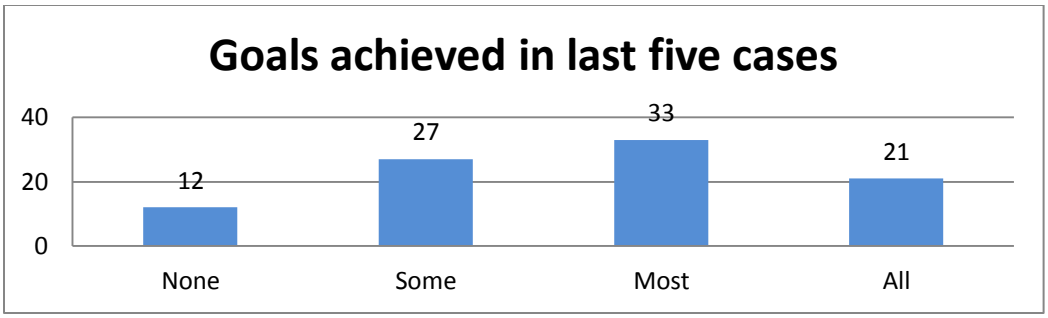


Figure 47: Goals achieved in last five cases

Further to this, all respondents agreed or strongly agreed that they believed they made a difference, while a strong majority (n =18, 82%) agreed or strongly agreed with the statement that their work had a lasting impact, with four respondents neither agreeing nor disagreeing. A similar number (n =19, 86%) agreed or strongly agreed regarding seeing clear evidence of the impact of their work (Figure 38).

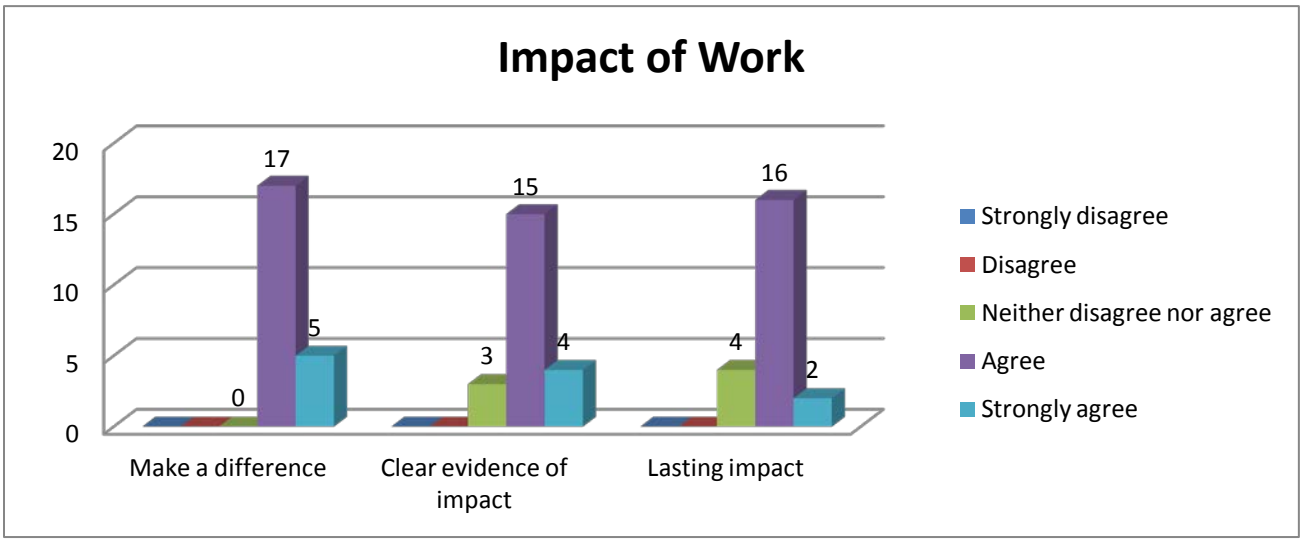


Figure 48: Impact of work

3.2.5. Supervision

A number of questions were asked about staff experiences of supervision. The majority of respondents received monthly supervision (n=16, 73%), while five reported receiving it fortnightly and one weekly.

Eighteen respondents agreed or strongly agreed that they received regular feedback on their performance. Three neither agreed nor disagreed, while one disagreed. A slightly smaller majority (n=16, 73%) agreed or strongly agreed with the statement that they receive recognition for their work, while almost all (n=20, 91%) agreed or strongly agreed that their

supervisor provides backing for their decisions. None explicitly disagreed. A majority agreed or strongly agreed (n=14, 64%) that their agency tries to ensure that they do not have too many cases, while six respondents neither disagreed nor agreed. One respondent strongly disagreed with this statement.

While ten respondents agreed or strongly agreed that their supervisor takes steps to decrease burnout, nine neither agreed nor disagreed, while two disagreed. An overwhelming majority (n =19, 86%) agreed or strongly agreed that the supervision process supported their work; 21 respondents (95%) further agreed or strongly agreed that there was sufficient casework recording in their agency. Respondents were also broadly positive about the space for reflection afforded by their agency: 14 (64%) agreed of strongly agreed that they had such space, while seven neither agreed nor disagreed. Figure 39 illustrating the main values in relation to supervision and related items is outlined below:

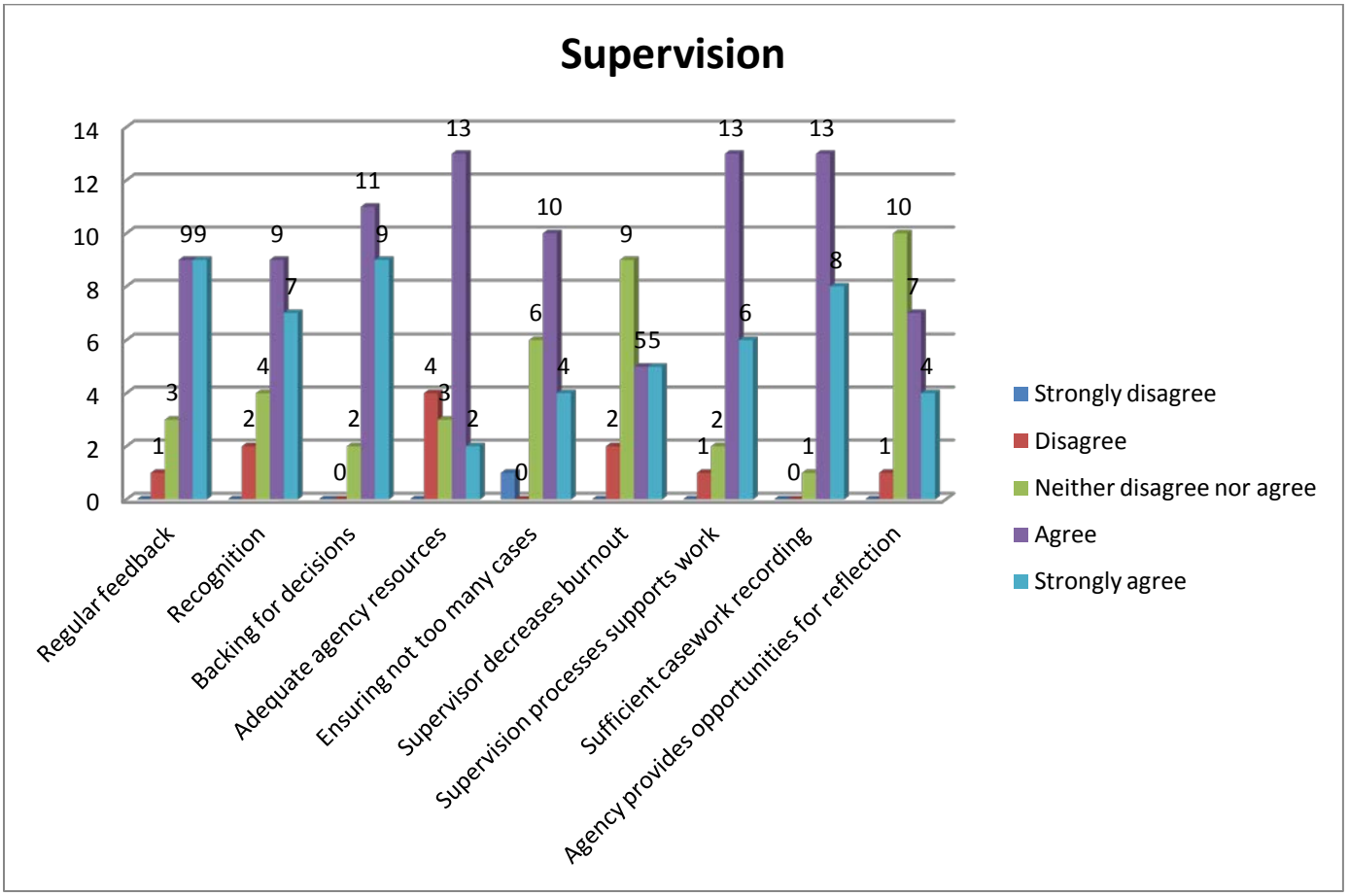


Figure 49: Responses on staff experience of supervision

3.3. Additional Data on Mol an Óige Skills and Approaches

In the follow up survey, staff were asked to rate a series of statements relating to the extent of their knowledge of various aspects of the Boys Town approach or Mol an Óige, both for their own skill set, and in working with families.

Regarding the particular skills of Mol an Óige, the vast majority of respondents perceive their skill base to have increased or greatly increased. In a general sense, all respondents viewed their knowledge of teaching as an intervention to have increased or greatly increased, as had their ability to impart knowledge through teaching skills. This general trend holds for individual skills as well, as outlined in Figure 40 below:

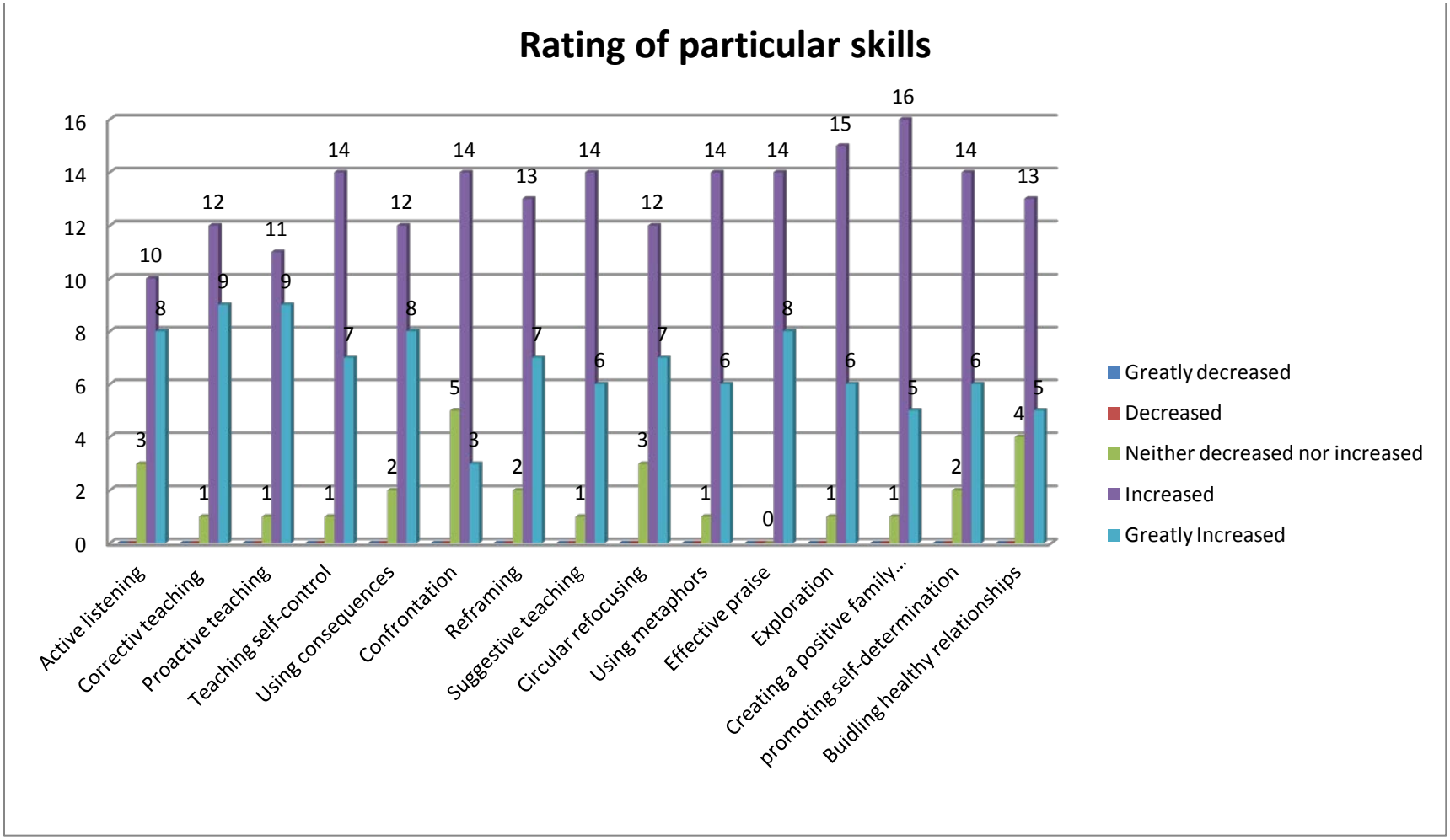


Figure 50: Rating of particular skills

In relation to the other elements of undertaking Mol an Óige work, again the rating scores here were broadly positive. Respondents were asked to rate the change relating to both the overall approach and process elements, including knowledge of or skills in: outcomes work; data-based approaches; using systematic procedures; behavioural approaches; ethical imperative to work; and assessing resources in the community. The scores for these items are outlined in Figure 41 below:

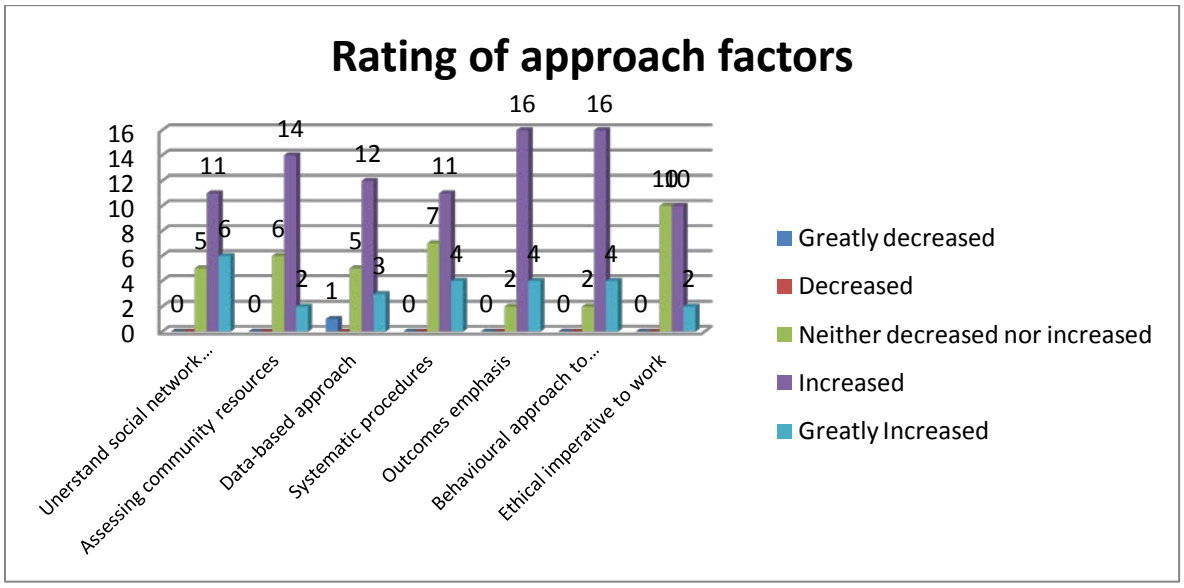


Figure 51: Rating of approach factors

Respondents were also asked to rate the extent of change in their ability to connect with various programme domains. Notably, while the overall rating of ability to connect at various domains was positive, values varied across each domain level. These scores are outlined in Figure 42 below:

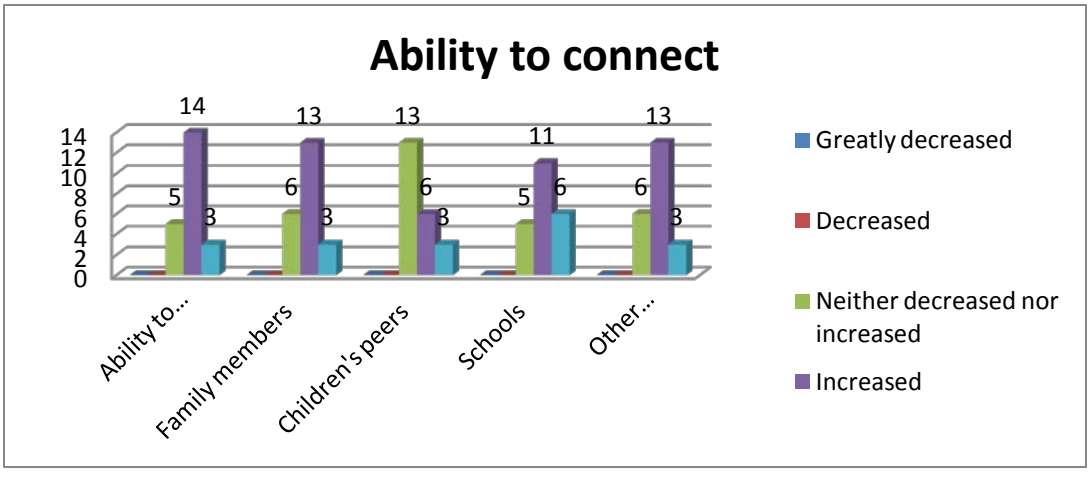


Figure 52: Ability to connect

Respondents were also asked to rate the training and supervisory aspects of the Model. The vast majority (n=19, 86%) felt that programme supervision had increased or greatly increased, while a majority (n=16, 73%) also felt that the orientation of their supervisor towards frontline work had increased of greatly increased. Just over half the respondents (n=12, 55%) felt that staff autonomy had increased or greatly increased, with another nine respondents feeling it had not changed. Almost all (n=21, 95%) felt that skills-based training had increased or greatly increased. These values are set out in Figure 43 below.

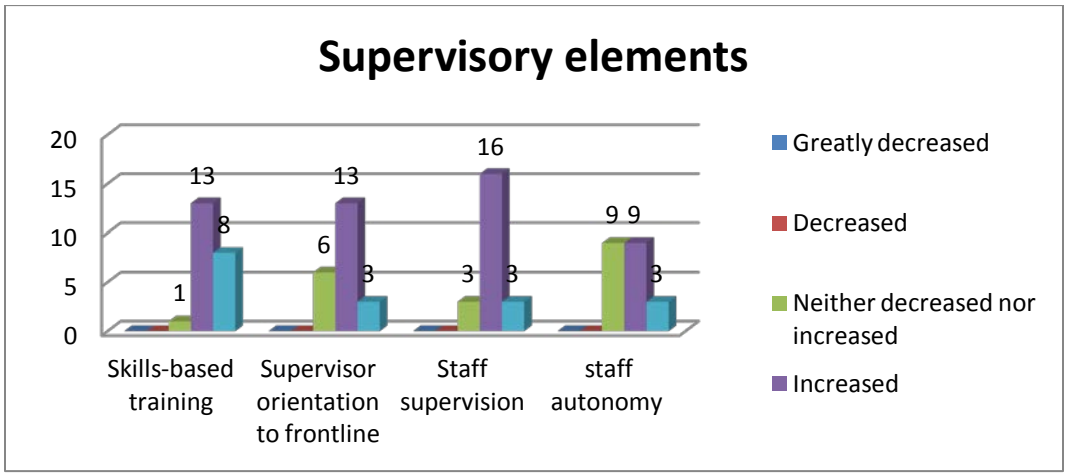


Figure 53: Supervisory elements

3.4. Suggestions for Improving Day-to-Day Practice

Respondents were asked what, if anything, could improve their day-to-day practice. In total, 43 answers were provided across a range of categories. Seventeen respondents provided at least one answer. Table Three outlines the main suggestions and corresponding values. Under other, a number of suggestions were made, including: 'no mileage restrictions', 'tighter structure', 'employment problems', 'recognition by other agencies', 'more information', 'reflective practice', 'recognition of non-Mol an Óige work', 'interagency reviews of the model', and 'expand organisational function'.

Improving day-to-day practice	N=
More training/professional development opportunities	15
More resources	3
Lower caseload	2
More practical supervision	2
More observations	2
Improved referral process	2
More time for family work	2
Having a team	2
Prevention/early intervention focus	2
Greater interagency links	2
Other (each n=1)	9

Table 3: Practice improvement suggestions

3.5. Comparing Baseline and Follow-Up Scores

3.5.1. Overall Trends

In the main, the mean ranking scores for the majority of survey items/statements showed an improvement, while a small number of scores declined. The mean rank scores for all 37 items are outlined in the appendices. For interest, some of the more prominent scores will be now discussed.

3.5.2. Response Comparison on Internal Agency Statements

There was a noticeable increase in respondents' positive perception of their agency's understanding of need, its planning processes and its focus on core goals of the organisation. Of this group of responses, none were statistically significant, although comparisons of baseline and follow up regarding responses to "my agency has a clear focus on its goal" approached significance ($p < .052$). There were also notable increases in the perception of the agency undertaking high quality needs assessments, as well as the belief that making progress is not simply a matter of resources. Regarding the perception of the agency routinely re-evaluating its goals, there was a large increase here, which was statistically significant ($p < .018$). Interestingly, there was a notable increase in the belief that there was not sufficient funding to achieve goals, which was statistically significant ($p < .044$).

There were notable decreases in mean scores here too, including a slight decrease in the belief that people contribute actively to shaping the agency's objectives, as well as more pronounced decrease in the responses regarding the agency's commitment to evaluation. There was a slight decrease in the belief of not having enough case workers to get things done. In an overall sense, when summed together, these factors relating to internal agency issues recorded a slight decrease in median scores.

Question Group	Baseline or Follow up	N	Median
Total Internal Agency	Baseline	19	**32**
	Follow up	22	**31**

Table 4: Summed total of Internal Agency scores

Statistical Significance Test	Total Internal Agency
Mann-Whitney U	200.500
Wilcoxon W	390.500
Z	-2.23
Asymp. Sig (2-tailed)	.824

Table 5: Internal Agency Statistical Significance score

3.5.3. Response Comparison on Inter- Agency Statements

Responses to a number of statements related to interagency working were compared. Here, there were also notable increases and decreases. Notable is the decline in the score relating to the statement "most of my work involves joint work with other agencies", although it is small. There is a more noteworthy decline in the scores for the statement "I could not do my job without the assistance of other agencies", although such a decline could be readily interpreted as a positive thing, pointing to increased capacity of staff. Some of the most noticeable increases included staff seeing themselves as part of a multidisciplinary team, which was statistically significant ($p < .001$), and in the respect respondents perceive to get from other professionals, which was also statistically significant ($p < .001$). Respondents also reported a statistically significant decrease in the amount of unpleasant experiences they had had with other agencies ($p < .002$).

On the other hand, there was an increase in the belief that interagency work makes it harder to meet clients' needs, yet there was also an increase in the preference to work with other agencies, and a decline in the sense of other agencies wanting to take credit for work as well as in perceived hostility from other agencies. When summed together, the mean scores between baseline and follow-up statements relating to interagency working showed a statistically significant improvement ($p < .001$). It is clear that respondents perceive interagency working in a far more positive way after using Mol an Óige than before, although we cannot say that definitively that this is down solely to operating the model.

Question Group	Baseline or Follow up	N	Median
Total Inter Agency	Baseline	21	**44**
	Follow up	21	**49**

Table 6: Summed total of Interagency scores

Statistical Significance Test	Total Inter Agency
Mann-Whitney U	85.000
Wilcoxon W	316.000
Z	-3.423
Asymp. Sig (2-tailed)	.001

Table 7: Interagency statistical significance score

3.5.4. Response Comparison on Supervision Statements

Turning to scores relating to supervision, the mean scores here recorded a notable increase regarding the role and perception of supervision. Notable mean increases occurred in the rating of feedback on performance by supervisors (also statistically significant, $p<.016$), the provision of backing for decision, the undertaking of steps by supervisors to decrease burnout,

and in an overall sense that the supervision process supports respondents' work. The receipt of recognition for work undertaken also increased, although it should be noted that this is not explicitly linked to supervision or supervisors. When the scores for supervision are summed together, we see that there is a significant increase in mean scores, and that this increase is statistically significant.

Question Group	Baseline or Follow up	N	Median
Total Supervision	Baseline	22	**15**
	Follow up	21	**16**

Table 8: Summed total of Supervisions cores

Statistical Significance Test	Total Supervision
Mann-Whitney U	146.500
Wilcoxon W	399.500
Z	-2.068
Asymp. Sig (2-tailed)	.039

Table 9: statistical significance Supervision score

3.5.5. Response Comparison on Capacity Statements

Regarding capacity, again there were important increases here, including the provision of adequate resources to achieve goals and in attempts by the agency to ensure respondents do not have too many cases. Notable increases were also recorded in items including "that there is sufficient casework recording in the agency" (also statistically significant, $P < .007$), and that adequate opportunity is provided for reflection (statistically significant, $p < .019$). Notable decreases were recorded in the desire to have new models or frameworks for services, the perception that children have too many problems to work with in a community setting, and that the system is too complicated to make a difference (statistically significant, $p < .038$). When the scores for capacity are summed together, we see that there is a significant increase in mean scores, and that this increase is statistically significant.

Question Group	Baseline or Follow up	N	Median
Total Capacity	Baseline	20	**16.5**
	Follow up	21	**19**

Table 10: Summed total Capacity scores

Statistical Significance Test	Total Capacity
Mann-Whitney U	124.000
Wilcoxon W	334.000
Z	-2.259
Asymp. Sig (2-tailed)	.024

Table 11: Statistical significance Capacity score

3.5.4. Response Comparison on Impact Statements

Regarding impact, there was a notable decline in respondents' perceived ability to make a difference, but a notable increase in both seeing evidence for work, and perceiving work to have a lasting impact. While this may seem anomalous, none of these changes, however, were statistically significant. When the scores for impact are summed together, we see that there is a slight increase in mean scores, but the increase is not statistically significant.

Question Group	Baseline or Follow up	N	Median
Total Impact	Baseline	22	**12**
	Follow up	22	**12**

Table 12: Summed Total Impact score

Statistical Significance Test	Total Impact
Mann-Whitney U	228.000
Wilcoxon W	481.000
Z	-.339
Asymp. Sig (2-tailed)	.735

Table 13: Impact statistical significance score

3.6. Summary

This Chapter has outlined findings from the follow up staff surveys administered in early 2012 as well as comparative analysis of these with baseline survey findings in 2009 and 2010. There are number of things to note here. Firstly, the trend in the follow up findings is an improved rating of the vast majority of positively stated items, and a general decline in ratings in the negatively stated items. It is clear that staff are generally more positive about their practice than they were when completing the baseline survey. However, when baseline and follow up results are compared there are some very interesting and notable findings. The prevalence of statistical significance in a number of individual and grouped items points to an overall positive regard for the model by staff.

CHAPTER FOUR: STAFF PERSPECTIVES ON MOL AN ÓIGE

4.1. Introduction

This Chapter presents findings from interviews with a range of staff and supervisors who play a role in implementing Mol an Óige. Following this introduction, the Chapter then outlines relevant data relating to the interview participants' roles, quantitative assessment of workloads, length of intervention and reported amount of contact time with each family. The Chapter then proceeds to detail staff perspectives on various aspects of the model. It concludes with a summary.

4.2. Interview Participants' Roles and Workload

The majority of staff operated Mol an Óige alongside a range of other duties, while a few operated it exclusively. For some, their organisation worked to meet various needs and thus they had additional duties to undertake alongside their one-to-one or family work; for others, they provided support to drop-in service users, some of which turned into Mol an Óige cases; and for others again their work role had changed during the period of the evaluation (e.g. undertaking play therapy). It should be noted that a minority have not operated a Mol an Óige case in some time. Yet, all family workers declared having had experience of operating a full Mol an Óige case to conclusion.

Family workers reported carrying on average three to four cases at any one time, although this figure fluctuated dependent on experience of operating Mol an Óige, whether they were fulltime or not, and the extent to which they operated the model exclusively or not. Workers' frequency of contact with families was on average once a week *per individual worked with* in each family. Hence, some workers were with families two to three times per week in different locations (e.g. family homes and schools). On occasion, workers reported being with families up to five times a week, dependent on the level of need and the phase of the work. Other workers reported being with families twice in one day, again dependent on the phase of the model and the nature of the support work being provided (e.g. in the morning to work with a parent and in the evening to observe skill use by the parent). This was supplemented by high amounts of telephone contact, which varied dependent on case (e.g. child and parent or just parent) and stage of the process.

The average length of each visit most frequently reported was one and a half hours, but again this varied dependent on the stage of the work. Many workers reported that during particularly difficult or crisis situations with families, they were in a home for up to three hours. The most significant mediating factor in both frequency and length of visit was the willingness of parents and young people to want the worker in the home, their willingness to engage.

A minority of workers and managers reported that some cases closed after three to four months, while the majority reported the average length of intervention as being between six to nine months. A number of workers spoke of "questioning themselves" if they were still in a home after nine months, some twelve months, while others recognised that while support was still being provided to families, the Mol an Óige component had concluded.

4.3. Aims and Objectives of Mol an Óige

The vast majority identified Mol an Óige specifically as a 'cognitive behavioural' or 'behavioural' approach aimed at supporting families and keeping families together. While many participants' further descriptions of the model varied, a number of common terms were used throughout the interviews. It was described as a "supportive model", "a teaching model", a "strengths-based approach", a "behaviour-change model", a "learning approach", an "empowering model" and a "partnership model". For example:

> "I'd look on it as a very positive framework for working with families, with vulnerable families particularly, supporting them, building up their skills, to protect kids, to keep them at home if that's the safest place for them, [and] supporting parents to ensure that it *is* safe" (IV 6).

> "It's a family-based intervention. It's based on the strengths of the family, where you're going in, you're meeting the needs of the family: it's from their own agenda as well, and grasping at their strengths and using those to try and change things. It includes the parents and the kids, so everyone's involved" (IV 19).

The family's role in identifying its own needs, and their role as experts in the intervention, was viewed as a core aspect of the model, one which contributed to the achievement of the identified goals for the family. In this regard, the objectives of Mol an Óige were perceived largely to be what the family wanted to achieve. The sense of starting work "from where the family are at" resonated strongly in the staff interviews, as did the need for an individualised, flexible approach. For example:

> "The main thing would be that it [Mol an Óige] is in-home work in the family's natural environment. All workers, we endeavour to recognise that the families are the experts in their own lives: they know what works best for them. It is very important that interventions are individualised and flexible and that they are strengths and needs orientated" (IV 28).

> "Its principles [include] 'everything has to be individualised to suit the family'. And that is true to form. It's flexible" (IV 21).

In addition, the model was viewed as fitting with existing policy approaches, be they child protection or family support. Workers and supervisors reported that they felt the model served as a mechanism for 'doing' family support, and through its structures and processes, equally addressed issues of child protection and welfare. While this may ostensibly be an aspect of referrals from social work, it nonetheless featured as an aspect of all workers' cases:

> "I think it does fit under Children First as well [...] because whether you are in the home purposefully or just naturally, you are meeting the child, you are looking for an independent voice, you are recording that. [....] You are assessing what is happening for every part of a child's life, and the parents'" (IV 5).

Finally, other staff felt that Mol an Óige provided an opportunity to work with a focus on prevention and early intervention, if used quickly enough with families:

> "I think prevention, that's an area for development within it, definitely (IV 22).

> "The longer families tend to be in the system the less chance we get of effecting change. So it's early intervention, so the earlier we get in the more chance we have of actually doing that (IV 4).

4.4. The Mol an Óige Process.

4.4.1. Initiating Work with Families: Building Relationships, Quick-and-Early Supports, and Assessment

Staff highlighted that initiating Mol an Óige was mainly through a (self) referral to the service, directly from social work, or from a referral committee to the service. Once assessed as fitting the service or model criteria, staff recounted meeting initially with the family, and other professionals where appropriate and involved, before or alongside initiating work directly with the family.

All staff highlighted the importance of building relationships with families as a core aspect of the model itself, and particularly at the beginning of the work. Meeting with the family, getting to know them and their routines, and talking through their issues initially was viewed as central to developing a base from which to work from. Many staff and some supervisors spoke of the importance of 'actively listening' at this stage so as to enhance their understanding of the situation and hear families' issues. While some staff identified that they would have done this anyway, irrespective of the model, it nonetheless served as an important step in early work with families:

> "I'm very conscious not to come across too overly jovial or condescending either. [...] You have to be quite sensitive to see exactly where they are at so, I try to ask very open-

ended questions; they have the time to talk and I have the time to listen. That's the key bit for me" (IV 22).

Again, while supervisors identified the strong sense of listening in their staff's skill set already, some identified the model as requiring staff to listen more. For example:

> "Active listening would have been a very good one (skill) to have focussed on because some of the workers talked a lot and they've become more mindful now, taking the pauses and sitting back and letting the family have their speak more" (IV 28).

The importance of exploring issues with families through this process was viewed as a significant step in identifying issues. This was particularly the case where referral reasons from another agency were very general (e.g. parenting) or did not align with what the worker's experience of the family was after talking with them. Assessment played an important role in this regard, as did the 'quick and early' support since it was introduced in 2010.

Described invariably as a mechanism to further enhance buy-in from families, the quick and early is a once-off instance of support which can be delivered in a quick and straightforward manner. Numerous examples of 'quick and early' supports were provided by staff in the interviews, ranging from telephone numbers for particular services in the community to particular items or specialisms sourced through the agency or other agencies in the community. Many staff highlighted that while generating buy-in was an explicit aspect of the model, they also felt that quick and early supports added to the sense of partnership with the family through identifying what practical issues needed addressing immediately. They also identified, however, that they often provided quick-and-early type supports prior to 2010. In the main, staff recounted that these supports were provided in the first few visits, although a small number of staff commented that they did not provide them immediately due to the potential for them to be construed as "a bribe".

All staff highlighted the importance of assessment as part of the initial work with families. While some staff were of the view that they assessed all the time through their interactions with families, the formal assessment process was a key aspect of the model's work. Linking the assessment into resulting goals of the family plan was remarked upon frequently in staff interviews. Strengths and Stressors, in particular, was identified as being a compact assessment tool, one which was relatively straightforward and quick to administer, and which in some cases fostered discussion between worker and family on differences of opinion on how particular statements were scored. For many, discussing these differences openly was central to the model:

> "Because you have it in front of you with the family, and you know, it opened the discussion [...] you scored a minus three where the family had themselves at two, and you were able to discuss that, and outline your reasons" (IV 30).

Others highlighted that the Strengths and Stressors assessment allowed them to ask more difficult questions, particularly by styling it as a questionnaire to families, as well as bringing focus to initial engagement with families, almost a prompt. For example:

> "Some staff would be saying "I am not really sure about asking about sexual abuse" and you are saying "no, this is a child protection concern", so you can ask those things again [with the assessment] and review it again, and it's a concrete scale to see if things are moving on or are they not" (IV 5).

> "If you were sitting down having a conversation you mightn't be able to get all the questions that you need to ask on it asked" (IV 10).

Once assessments were undertaken and scored, workers reported that goals were identified and finalised for the first draft of the family service plan, which was then agreed or "signed off" by the family. In the main, workers identified that the process of developing family plans and implementing them was quicker due to the new Strengths and Stressors assessment; however, staff did stress the individual nature of each family and that in some cases assessments were completed quicker with some than with others.

4.4.2. Working with Families to Meet their Needs

Workers outlined a huge range of tasks which they undertook in meeting the needs of families when implementing Mol an Óige. The vast majority of workers identified skills pertaining to the implementation of the model, such as various forms of teaching (e.g. corrective, proactive), modelling, and exploring issues which have arisen since the last visit. Many workers identified the idea of Mol an Óige being a tool kit, or a set of resources, which can be picked from as and when required. For example:

> "You do the effective praise, consequences, rationales, proactive teaching rationales; they're kind of standard for all the families we're working with. It depends then on the needs of the parents [….]. The sets of skills are there, it's like your tool box and you're looking at what does this family need. And it's picking them out […], the core parenting skills I do with all my families that I work with and then it might be picking out that they might need extra help in teaching self control, extra help in staying calm themselves, extra help in being consistent in the implementation. Young people, again from your tool box your social skills, what do they need in order to meet their goals and meet the goals the parents have for them?" (IV 24).

Central to the activity was the family plan and being specific in the activities undertaken, which were linked to the desired goals and outcomes specified in it. In this regard, the plan was viewed positively as giving a structure or focus to family work. Even when, as almost all staff identified, new things arose, both in the context of day-to-day family functioning, and in relation to the plan, the sense of flexibility and focus that the model and plan brought was viewed as a positive. For example:

> "And that's the way the family support service plan works, it guides you, like, you're so focused, you know what you're going [into do], but it's not to say that I could go and think "today I'm going to do preventative teaching" but Mam is bawling crying because herself and her partner have had an argument. I can stop, my preventative teaching has gone on hold, I can go through the moment, and then get back to it; so that's flexibility" (IV 11).

> "Say there's been some crisis over the weekend that you need to deal with and focus on. So [the plan] is pushed aside to the following visit or maybe you'll get it in in the middle of the visit. [So that happening] pre Mol an Óige would have thrown you because you're like, 'I want to go in and do this, I need to get this done but actually now there's been a major blow up over the weekend so what am I going to do here?' We know exactly what to do now. Where once that would have thrown us [….] it's just automatic at this stage" (IV 12).

Hence, family plans were reviewed regularly (every month to six weeks) as both goals were worked on and achieved, and/or when new needs were identified as work was being undertaken. The sense of using the plan as a mechanism to incorporate the family as an active partner in its implementation was viewed as a strong empowerment feature of the model. For example:

> "And then for that plan what they can actually do for themselves, what they can do for the children in the house, what they can do then outside of that themselves; or if they don't feel competent enough what I can do with them in the community whether that's going to the various other organisations that may be either statutory or voluntary that can support the family. They're making links and hopefully they're learning from what you're doing. You're modelling for them in terms of what they can do for themselves" (IV 9).

Others spoke of supporting parents to parent, about getting involved in family life and undertaking whatever activities or tasks are required so as to maintain relationships and progress the work towards the goals. While some felt that this was not necessarily core Mol an Óige work per se, others identified that anything which went towards building and maintaining

relationships and trust was instrumental to it. Underlining many of various activities are the characteristics of the model and the sense of modelling and teaching:

> "I have helped clean a kitchen, changed a baby [..]. You're doing all the elements of the model from the teaching bits to the joining in on family life, whatever is done. I have gone for walks with a teenager while doing corrective teaching, I have done charts with a mum, I have helped cook while doing a teaching element or discussion [....] I suppose the element is that we're clear [...]:we're teaching, we're modelling, we're not going out just cooking dinner for them" (IV 29).

Many staff highlighted that they undertook this work outside of regular working hours with some of their cases. Being in a home very early in the morning to help with or observe a breakfast/school routine, and/or being there at night to support a bedtime routine were referred to by staff as such examples. Weekend and bank holiday support, directly in some cases, and over the phone in many, was also highlighted by some staff, as these tended to be times when families experienced crises or flashpoints occurred.

4.4.3. Phasing out Mol an Óige Support and Closing Cases

Many staff spoke about fading or phasing out, or moving to stage three, where they began reducing the number of times they met families. Such a decision was based on staff themselves observing that skills were being used with confidence and consistency by parents and young people in their home. This was viewed as an important part of the process as it asked families to take on and maintain independently the various skills and approaches which had been modelled for them previously in the work. This was viewed as relatively short process in some cases for some:

> "The fading out, say for example most of the goals have been achieved, we'd review it then. See how the family feels about it, start to fade back, suggest that we'd meet every fortnight with a view to closing and we'd probably have a projected end date at that point obviously if things are going well, that's where it would end" (IV 26).

Again, the notion of empowering families to address the issues themselves was common in staff comments on this aspect of the Model. While some families were reportedly satisfied to conclude the work, for others issues of confidence and ability of parents arose which require the worker to step in. For others again, examples of 'slips' or cases which had regressed when thought to be closing were recounted. In such cases, the workers were required to step in and reaffirm skills, redouble efforts, and in many cases reassure parents that they could deal with the particular issues in question. Notably, some workers identified that in certain cases, a "lighter" or "less intense" form of support outside of Mol an Óige was required to address ongoing issues, or referral on to other services in the community needed. Some workers spoke

of cases being "closed to Mol an Óige" but still open due to a reduced level of need, with families receiving some form of support.

4.4.4. Supervision and Observation

Fundamental to the operation of Mol an Óige are the elements of supervision and observation. Reported frequency of both varied dependent on the experience of family workers, additional non-Mol an Óige work and whether they were full-time or part-time. However, supervisors and many family workers reported that on average Mol an Óige supervision occurred approximately every four weeks. Observations occurred approximately once a month (although some reported less), and more so in the case of new or less experienced workers. With an increase in staff familiarity, some supervisors reported undertaking two small observations of approximately twenty minutes and one full observation every six months. This full observation coincided with a complete file audit of a case to ensure all case notes and additional paperwork were being maintained.

In the main, the package of supervision, observation and file audit was recognised by all participants as constructive elements of the model and viewed as offering something positive in addition to regular supervision. For example:

> "The [way the] Mol an Óige supervision process operates is quite different from what would be considered conventional or regular supervision. For example, supervision is more frequent in that I would see staff once or twice a month. [….] I would go out and observe staff and then feedback on those observations, so that's an element of supervision that is completely new. It's one of the aspects […] which I think is particularly valuable in terms of finding out how people are getting on, supporting staff directly through visits, working in conjunction with them. [….] It's not nit-picking or fault finding, its support" (IV 6).

This sense of supervision being a joint problem-solving exercise resonated in interviews. For the most part, despite some staff recounting instances of where they were instructed to do something with a family, the majority felt that this supervisory process did not encroach on their discretion or autonomy, but rather supported it. That supervision offered a space to raise issues pertaining to families and discuss approaches was a very common response. For example:

> Talking through the meeting with the family and [the supervisor] would say how the teaching went, I say how it went, and maybe discuss where to go with a family the next time. Feedback from both of us as well to how we felt about it. It's a two-way process" (IV 2).

In this regard, it was mentioned that supervision (in conjunction with observation) was often a mechanism where delays in progressing cases were readily identified and resolved, either through changing strategies with families, or deciding to discontinue service provision. It was also as mechanism to ensure that files were up to date. For example:

> "If there is some area that a worker may find that they are struggling with, for example maintaining records or documentation, like it would be me then prompting them to give time to it, allocate time in the week [….] and then me following up with my file audit" (IV).

Many family workers spoke specifically about supervision being a challenge in the beginning, particularly given that it was focused on cases and the process of doing Mol an Óige. In particular, developing and revising family plans in the early stages of implementation became a focus of supervision for some workers, who found it beneficial:

> "I thought they would stand back and you'd say "OK, get that now". But the to-ing and fro-ing with the service statements […] they'd come back and say "no, change that around". Very beneficial, definitely, definitely" (IV 23).

Others found that it brought a focus or structure to their supervision experience, and while some family workers did comment that their early experiences of supervision was a rigid, fidelity – focused process, many did report that it had become more "relaxed" or open to broader discussions about wider work issues, not just cases. A minority of staff who had experience of being supervised by two different supervisors viewed it as a positive thing, something which was energising and which brought a fresh perspective.

However, it should be noted that not all were as positive about the experience of supervision. Some family workers felt that they could get more out of supervision, and that in some cases it was still very much a model driven process. Some staff were specific in cautioning against supervision not becoming a paper or tick-box exercise. Others again spoke of the need for supervision to speak a little more of the model, in terms of effective praise and recognition of work done. A small number again highlighted that model supervision had fallen off due to what they felt were capacity issues.

For the most part, however, the overwhelming majority of family workers were very positive about the supervision experience and the role it played in their practice. Being more accountable was a common theme highlighted, as well as the structure it brought and it being core to practice support. A number of examples are cited below:

> "I didn't feel I was accountable, because just the nature of [the work]. So accountability comes with supervision, in terms of caseload, what I'm doing, the family plan that

comes with me to supervision, so I feel my work practice has been, I am more accountable and that is important for me" (IV 11).

"In terms of supervision and observation, really good in terms of the accountability. Mol an Óige gives you that where other models don't. And I think that's crucial to it […] that families know "this one isn't just batting balls in the dark" (IV 27).

"You are only as good as how your supervision is. If your supervision is pretty solid and effective, chances are you are going to be a pretty solid and effective worker" (IV 4).

Observation was also spoken about specifically by family workers in their interviews. Again, while initial challenges were outlined, in particular around having somebody coming in to "check on you", the presence of having another person in the house while you work with a family, and the issue of boundaries between families and supervisors initially, it was viewed as contributing to the joint problem solving approach of the model. For example:

"I can be a bit daunting at first, having someone observing you. Especially when you've built up a strong relationship with the family they're used to just you, but it's been great […] just ideas I wouldn't have picked up on myself" (IV 6).

"I suppose observation is to ensure that the worker is competent and willing and able to deliver the work that they are meant to do. It's to support that. Also, there's a part that's reflective, you know that you are looking and your observing how your working and I think that very important [….] looking at how you did things and how you work" (IV 27).

The majority of workers spoke about the impact observation had, specifically in bringing a sharper focus to their work with families, highlighting opportunities to bring in particular skills from the model, and more generally in progressing cases along. This sense of progress and task-orientated working, alongside fidelity-related comments in observation feedbacks, was common in the interviews:

"Like, I could get very off-track otherwise. If I go in about a particular issue and get [sidetracked], when [my supervisor] is there, "task, task, task, you said you'd do X" and I'd go, "oh yeah, I did", I better do that so. So it does keep me on task" (IV 14).

Observations also provided reassurance to workers and supervisors. Supervisors could see families firsthand and observe in many cases the difficulties which workers were encountering regularly and where a decision to discontinue service provision was required:

"And there are lots of families, they may disengage where you never get them to engage at all and even having [the supervisor] to be there and be able to say 'well, look you've done everything, it's not your fault, it's not the model's fault that things haven't got off the ground, it's things beyond our control" (IV 12).

> "Observation visits to observe me, which I think is great, I get the feedback, I get everything. I'd say to [my supervisor] "look, is there anything I can do differently, am I missing something here?" […] But you know, [the supervisor would] know after a few visits, [.....] "God, are we wasting our time here?" (IV 21).

Other workers again highlighted the importance of observation as a positive for families, to offer them a reassurance of work being undertaken with them. For example:

> "I think it reassures […] I've said 'look my manager will come out [...] and just do an observation and they'll only be here, […] 20 minutes, half an hour maximum. Just to sit there and all they're doing is observing me interacting with you to ensure that you're getting what you deserve to get and if you have any issues you can speak to the manager'. […]. Maybe it was just me but I thought it was reassuring for them, for the client" (IV 9).

File audits were spoken about by supervisors and managers but less by workers than both supervision and observation. In the main they were seen as part of the supervision and observation cycle, with supervisors using them as part of fidelity checks. In many cases it was viewed as part of a comprehensive overview of a case and the work involved, and served to highlight issues in the round:

> "You might dig out a file and you might go through it as a file audit and things that maybe you didn't see earlier on, sometimes when you read a file as a whole piece things kind of come out at you whereas when you're checking it with the worker aren't as apparent" (IV 16).

For a small number of workers, having the file audit is also a core part of their work, particularly in keeping files up-to-date:

> "And with file audits you can't let your case notes slip, these things happen because I mean at certain times if something comes up in a case it's very easy to go, haven't got time to record that. You have to. I feel like it keeps me in check as a worker" (IV 26).

> "I suppose if you're not doing up your case notes you're not accountable. Like if you don't have your stuff on paper, you didn't do it. So I suppose like if… with the file audits and that, if your files aren't there, you know, not good" (IV 19).

4.5. Implementing the Model: Facilitators and Barriers

Staff were asked to identify any barriers they experienced in implementing the model – both initially and as implementation progressed – and if and how they were overcome. Responses were fluid, but mainly fell into two categories: practice and organisation.

4.5.1. Practice Level

Singular amongst the issues identified in the initial phase of the model's implementation was the amount of time it took for workers to familiarise themselves with the model's content and processes. Learning how to develop and revise a family service plan, learning elements of the different aspects of the model, such as effective praise or corrective teaching and service planning, and becoming accustomed to the practice of observation and feedback were all frequently cited as challenges. Implicit in many responses was the notion of taking on a new way of working and the challenge that presented to existing practice:

> "The information overload, the paper work, was nearly – it had to be done – but it was nearly the barrier to implementing the model because we were constantly thinking "what am I supposed to do now" […]. It was like "am I supposed to be doing proactive teaching", "what did I say just there?" "What will I write down in my cases notes"? That was the biggest barrier to implementing it" (IV 12).

Others felt that their practice was challenged in additional ways. For example, observation was a significant challenge for many staff. Changes to individual practice, such as the requirement to challenge families more directly, or follow up closely with families on particular strategies devised to deal with particular issues were also cited here. Many staff spoke of an initial fear of being turned into robots, of working with families only in one way. However, most staff spoke of the sense of new skills becoming innate, of observation, supervision and fidelity monitoring being supportive, as well as becoming more relaxed in general. Of significance also was the role of more experienced staff in supporting less experienced ones through early implementation problems.

Many staff highlighted that learning the model really only came through practice. The ability to work through cases with support was important in translating knowledge into service delivery; in essence, practice. Numerous staff also spoke about taking the model resources themselves and re-working them for their own use, simplifying language, and developing their own manuals to support their practice. For a small number of staff, support received from Boys Town staff on subsequent visits was also an important driver in implementing the model post training. This support took the form of site visits, problem solving meetings and email and phone support on particular cases. Workers reported that space was created for their own personalities to imbue practice, while still being faithful to the model. Others spoke of building on their experience, of incidental learning acquired from each case and applied in the follow case.

Staff spoke at various lengths about the challenge of assessments, specifically the original Family-Based Ecological Assessment (FBEA). Described in broadly negative terms, the FBEA

was viewed by family workers and supervisors as challenge, particularly in not producing enough relevant information for the intervention. For example:

> "The ecological assessment was too long winded and it was too laborious and tedious and it was really questionable what was coming out of it in terms of concrete issues to deal with" (IV 13).
>
> "The ecological assessment tool was very long winded and over elaborate and very repetitive and I didn't get anything really from it [...] and that changed, so I welcomed that" (IV 22).
>
> "And the other one [FBEA] was really cumbersome to be honest, and I don't actually feel that when I look back on it now, we didn't really go back to look at this thing as often as we would go back looking at the 'strengths and stressors', to look at an area or a question" (IV 25).

Data from Boys Town also highlighted the difficulties with the FBEA it was documenting from its various sites across the United States the reasons for introducing changes to the assessment process:

> "So we went back and asked 'how can we know what kind of assessments we are doing are impacting the services we are giving a family'. So we went out and looked for assessment tools that not necessarily were great tools [for research], but tools for practice and intervention and service planning and an assistance for the workers and family. So we went out and found tools that would assist and define how to engage families and what would include the family as part of the assessment process, not something that a worker kind of did a semi interview with the family and then interpreted it later in their office or car. So we wanted to include the family in the assessment process and get their opinion on how life is going for them and areas that are stressful to them and also identify strengths so we used the Strengths and Stressor assessment" (IV Boys Town).

A small number of staff reported being uncertain about what changes in the assessment process meant for the model itself, and its future use. However, as at practice tool there was almost unanimity amongst all those who had experience of it about the improvements in the assessment process through the introduction of Strengths and Stressors and the removal of the FBEA form.

Views on the Social Network Map were far more divergent. While some staff viewed it as a useful tool to talk through with families, many staff highlighted the potential for it to do more damage if they felt that a parent and/or child were isolated already. Staff reported that they used it very much on a case-by-case basis, and even if it was used, such use was, in instances,

some time into the first phase of the intervention. A small number of staff reported that, where they did undertake such mapping, an alternative version was used.

In addition, other changes were reported, including for some the discontinuing of categorising work in stages, and domains, changes to the family service plan development process (removal of hypotheses construction), and the introduction of quick-and-early supports. While some of these changes were adopted immediately, others were not. The majority of staff reported moving to the new assessment procedures and family service plans, however they reported still working through stages implicitly in their own practice, while they viewed domains[4] as being akin to an ecological working and thus still highly relevant. Interview data from Boys Town supported this view.

4.5.2. Organisational Level

Staff familiar with the early phase of implementation spoke about the challenge of Mol an Óige being perceived as the "only game in town" or the "one best way", and the sense of pressure they felt to operate the model with a family. Related to this was the challenge cited by a small number of staff from other professionals who were sceptical of the model and staff's perceived willingness to taking it on. Of note here was the sense in some staff interviews that, while individual services operated the model, there was potentially an absence of full organisational buy-in to it.

Responses to these situations differed. In some cases staff were given time to feel their way through the model, for it to bed down through learning and experience; others took it on alongside existing duties and accessed various forms of support. However, for some developing familiarity with the model was complicated by a number of inappropriate referrals being taken on initially and cases quickly failing. A lack of clarity about how many cases each worker should have (with and without additional responsibilities) was felt to be a further complication in the early stages of implementation.

Many staff spoke of an organisational pressure to become trained in the model, of the model being advertised as being the "be all and end all" and thus a challenge to existing practice, particularly for those who had accumulated a lot of experience who could potentially feel that it was being devalued. While some managers felt that this was to be expected given the newness of the approach, others did question whether, in retrospect, practice concerns particularly about the model's suitability for some families, were not listened to carefully enough. While referral processes were broadly deemed satisfactory, the notion of joint referrals was spoken of as a further requirement given the possibility of some families re-

[4] The five domains [individual, family, school, peer, and community] constituted part of the Mol an Óige approach but were formally removed from the service process in 2010. However, the majority of workers familiar with them reported still using them as guides in their work.

entering Mol an Óige at different service points. For a small number, there was a feeling that referrals could be increased.

Where there was resistance, some managers/supervisors commented that such resistance by-and-large had dissipated through experience of operating the model and observing its impacts. This was also corroborated in them main by perspectives on the impact of the model for work and practice (see below). Interestingly, staff spoke about the extent to which they sourced formal and informal support from each other, as well as elsewhere in the organisation, through this period as an important factor in the model bedding down for them.

A number of other challenges were also outlined in the interviews: particular organisational challenges such as changing service, changing groups worked with, or changing the type of work undertaken; and the challenge of staff and supervisors in some cases learning together, which problematised the observation and supervision experience for some in the initial stages. However, it should be noted that other staff saw this conjoint learning amongst early operators as a strength, not a challenge as it permitted senior managers to identify what aspects were and were not working in the Irish context. Leadership shown from managers and senior managers in both counties thus was viewed as a facilitator. In particular, the role of senior managers being closely involved, undertaking observations and being familiar with families, while challenging initially, was a positive aspect of the implementation phase.

Capacity was the single most significant factor identified as affecting implementation throughout the period in question, both at the level of the organisation, and at practice. Some staff reported that reduced capacity amongst some services after initial implementation, as well as other organisational priorities at particular times, affected implementation, case numbers and overall fidelity to the model. While maternity leave, absence of cover, and changing work priorities were all factors in fidelity and operation being affected, shifting organisational pressures as a result of other priorities were deemed to be the single greatest factor impeding further implementation in some situations. The absence of senior managers at different times through retirement and long-term sick leave, along with a sharp increase in referrals, was perceived as affecting the use of Mol an Óige. Some staff felt that they were under pressure to begin work on a high number of cases, all requiring attention. In the absence of supervision and observation, some staff reverted back to older practices. More recently, staff expressed concern about the negative impact potential restrictions on mileage could have on their work in meeting the needs of families, while concern was also expressed over the uncertainty regarding the move to the new agency and the future use of the model.

4.6. Resources Used by Staff in Implementing the Model

All staff were asked what resources they had access to and used in implementing the model. Setting aside the role identified for families themselves as active players or resources in resolving their own issues, a range of responses were provided. Prominent amongst the responses from all staff was the role formal and informal peer support plays in implementing Mol an Óige and meeting the needs of families. Talking through particular situations, sharing experiences of previous cases and specific strategies used, offering constructive criticism and more generally "offloading" about particular situations were all highlighted by staff as being important supports to them in their work. For example:

> "I suppose just to have someone there to actively listen to you, or I suppose what I get great awareness from is constructive criticism, which I find very helpful; and I suppose as well sometimes if you come out of a family and you felt all this work has gone in and you feel defeated and to go back and talk to someone, it kind of motivates you again. It's very helpful (IV 19).

Some staff spoke of meeting every three months in the past to share experiences of the model and particular cases, although this had since ceased. Other staff spoke of not being co-located with other colleagues as a challenge to accessing this type of support.

Related to this was the supportive environment the overwhelming majority of workers felt was created by the supervision process. Many staff spoke of their supervisors as being supports in both implementing the model with families and supports to them. The nature of this support was often spoken about as being outside of the formal supervision process, as a case of keeping the supervisor up to date, as seeking reassurance, as being accountable, and problem solving. A small minority of workers did however report that the supervision process was not a significant support for them. This was largely due to what was felt to be a lack of familiarity with cases and a sense of supervision as a box ticking exercise.

Outside of a family worker's immediate working environment, dedicated psychological support was the most prominent answer *for those who had access to it as part of the model*. The psychologist played a number of key roles. Firstly, the delivery of a weekly clinic to some services was perceived to be a very significant positive support. It offered a problem-solving environment where staff can bring issues about cases – either starting them or discussing specific issues which have arisen over the course of working with them. In this role the availability of psychological support on the phone between clinics is viewed as critical by staff. For example:

> "Maybe even before I'd even meet the family, I'd run it by him to see what his thoughts are on it […] He'd give you a little bit of advice on what you need to guide yourself and

> your own assessment. You meet the family a couple of times, you might actually ring and say "listen […] I want to run it by you again", he'd say "no problem"" (IV 4).

Where family issues were particular problematic, many staff highlighted the willingness of the dedicated psychologist to meet with families directly as another element of this support, although this was not available to all services that had the support. The ability to undertake assessments (and undertaking them quickly) was an additional element cited, as was the support provided in adapting or "simplifying" elements of the model where required for particular families. In many ways, the significant role psychology played in the operation of the model for some services was underlined by the readiness of other services to identify their limited or no access to such a support as a gap.

Outside of those already mentioned, a range of other agency supports were mentioned. These included: financial supports provided by the agency, both for quick and early pieces of work and for additional things; workers' own expertise and skill set developed over years of practice (see below on supplementing the model); other non-Mol an Óige workers in the agency (e.g. play therapists, home management, other family support workers); social work (and individual social workers); CAMHS; PHNs; Child Guidance; CWOs; other Psychology personnel; and the collation of a range of accessible resources, Mol an Óige specific and not, both in hardcopy and through shared computer drives.

A range of other resources and supports were identified by all workers outside of their own agency. For those not working directly with the HSE, HSE-related supports, services and professionals were identified as being important. Beyond this, a range of other services were mentioned: These included: community (development) projects and other community workers; Foróige; ISPCC; MABS; SVP; Gardai/JLOs; Teachers; Education Welfare officers; NEPS; GPs; local authorities; CIC; addiction services; and Brothers of Charity. The nature of the support tended to be mainly informational, although a small number of staff did highlight that they accessed this support to link families in to other services at stage three, or were contacted by professionals working with families in the course of the work. Some staff did also mention particular individuals whom they knew through personal networks and from whom they sourced support and advice on a case-dependent basis. In a small number of cases, workers commented that they also sourced support from families' own networks, but again this was very much dependent on the family and the set of circumstances.

4.7. Training

All staff were asked about their experiences of training. In the main, staff used phrases such as "overwhelming", "information overload", "stressful" and "very intense". Many felt that they did not learn much new in the training from a skills perspective, while others felt it should have

been more about the actual process of working through a case, delivering the model and implementing all the elements involved, rather than solely skills focused. For example:

> "I think the delivery of the model is quite different to the training. They are not that well aligned. The training that is delivered, right – it goes through the skills, [….] that's fine. But I think when you actually go out and deliver the model, your interpretation of that is quite different […] I thought the training was excellent but I think there needed to be a lot more around the delivery of the service, delivery of the model" (IV 25).

This absence of a focus on the implementation of the model was a very common feature of training cited by staff. Others commented that the training was not focused enough on exploring the model itself, its background and how it operated. For example:

> "They should have done a little relationship building with us, a little buy-in with us. They should have given us a sense of "this is the way the model works", rather than "off ye go, you are told to do this" [….]. None of us were clear on how to do service planning after it, you know"(IV 23).

Many staff did also highlight that the follow-up training in Swinford was problematic, in particular due to a perceived lack of communication or clarity about why changes to the model (assessment and service planning in particular) were made. Staff were also critical about the fact that such changes were introduced relatively late in the actual training session itself. A number of staff did highlight that, with hindsight, training in CSP first would have been a good entry point for Mol an Óige training and family work.

4.8. Family characteristics and Mol an Óige

The vast majority of staff identified a set of common factors which they felt impacted on a family's ability to take on the intervention. The key necessary factor was motivation. Given the *active* role for the family in implementing the intervention, motivation was viewed as essential for the intervention to have any chance of succeeding and promoting change in family life. In particular, the motivation of all involved was deemed to be important. For example:

> "I suppose it's got to do with buy-in. if you have both parents willing to work together and address the issues for the child, and you have the child at least wanting to change the behaviour and making some form of effort in it, […] that's a good place to be" (IV 22).

> "[If they] don't want to commit to the intensity of it, […are] quite happy for you to in there once a week at a maximum, even less sometimes, or to come to you, that's not good […]. And other parents who were referred just said they didn't need it, that everything was fine, and they have subsequently come back in via other routes now" (IV 8).

Interestingly, while staff spoke about motivation of families, many also spoke specifically about their role in the programme as fostering motivation through "meeting the family at their level", engaging in various activities, using the quick and early, and trying to meet other smaller needs quickly. However, the vast majority indicated that in some cases these techniques did not work. Ultimately, engaging in the intervention was voluntary. Those staff who had experience of working with families referred by social work as part of a required piece of work had mixed views on the motivation of these families. While some staff felt that they had an advantage of being successful in promoting change in a family because they were "not social work", others felt that some families agreed to the intervention because it was a last resort, and in reality, when social work staff were not present, the family tended not to engage.

A range of other factors were also identified as impacting on the ability of families to take on the intervention. Prominent among these was the issue of addiction and its impact on the capacity of parents to implement a routine, let alone take on any of the skills. Staff felt strongly that all such issues needed to be addressed before the model could be used. Another prominent factor prevalent in staff responses was the issue of learning capacity to take on the skills. There was some uncertainty amongst staff regarding the continuing relevance of a minimum IQ level for the intervention to work. However, the majority of staff felt that even with efforts to adapt the model or simplify it as much as possible, learning was often not sustained and change not maintained. For example:

> "I think learning ability, IQ, is a huge factor. Whether or not they can learn, can sustain the learning and then process it and make it their own, that's a huge one [factor]" (IV 1).

Staff spoke about the importance of ensuring that Mol an Óige is right for the child or family is important:

> "I have always believed that the model is for the child, not the child for the model [....] the model is for the child, the model is for the workers" (IV 32)

In this regard, many staff cited that no model was necessarily going to resolve every type of family issue, and required supplementing and supporting with different skills.

Staff also spoke about families with problems which were too severe, or "too far gone" for the intervention to have a realistic chance of working. Issues of 'calling it' (i.e. closing a case) were often cited here, as reported elsewhere in this Chapter. However, the sense of ethos, of working to a vocation, and of being a public service requiring needs to be met as best they could was common in the interviews.

4.9. Supplementing Mol an Óige

Staff felt the model contained a number of gaps which they identified in their interviews. The single most prominent gap identified by the majority of staff was the model's inability to address issues pertaining to attachment. Staff spoke of the model's inability to deal with "emotional issues", with "family history", or with the need to "look back". This was a very common response amongst a number of staff. In particular, staff highlighted the importance of attachment as an issue which could prevent any behaviour-related work taking place. For example:

> "There'll never be anything in this model that will make that feeling turn on in [the parent], that will activate the attachment in [the parent], that the young person's trying to activate in [the parent] all the time" (IV 7).

> "Where I've seen more of an attachment issue [….and the model] doesn't really talk about attachment. Huge issues that sometimes parents need to look at first before they can look at their child's behavior" (IV 14).

Again, for those who have access to dedicated psychological support as part of their service, this gap was readily overcome with the provision of specialised case support being viewed as critical to the resolution of many family problems, as well as general talks and team meetings as part of the operation of the model more generally. For others without access, information was sourced informally with psychology in some instances, and through other means (e.g. attachment training from previous practice).

Other issues mentioned included the perceived abrupt ending of the intervention for families, an absence of integrating with other services, the challenges in working at some of the levels of the model (peer group in particular) and other case-specific needs. Engaging hard to reach groups was identified as a challenge as well.

To supplement these gaps, staff reported using other skills drawn from their previous education, training, practice and supports available to them in implementing the model. In particular, the sense as cited above that Mol an Óige was actually a framework where old and new skills complemented each other was common amongst staff. For example:

> "We bring in additional [skills], whatever we can that can help and we can easily bring it in under the goals and objectives and intervention strategies. That hasn't been an issue for us. We see this as being our framework. You can then bring in things to it" (IV 28).

> "I'm using the Mol an Óige "framework", but I'd be pulling bits maybe from [a number of programmes are mentioned], maybe from other things that I've picked up along the way that would be useful but they'd be done within a framework" (IV 27).

Personality is also viewed as being important. For example:

> "[…] in terms of their personalities, in terms of their interpersonal skills, in terms of what they bring. There's still a bit of scope for people to bring in some stuff of their own [….] but the model is very clear; there's a blueprint and there's an overall structure that has to be delivered. But within that, there's scope" (IV 13).

Other gaps or limitations of the model were highlighted by staff as well, but to a far less degree than the issue of attachment. These included: the absence of ongoing training for workers and a related issue of there being no space for workers across different services to meet and share experiences about Mol an Óige, and more generally about practice. In particular, ongoing training or refresher training was suggested, particularly for those whose use of the model had lapsed. Other gaps included the process-driven supervision, with a lack of anything personal for the worker.

4.10. Mol an Óige and Common Sense Parenting

All staff spoke specifically about Boys Town's Common Sense Parenting (CSP) programme, a parenting programme developed from many of the same principles and practices as Mol an Óige. Generally, all staff spoke positively about the universal nature of the programme as implemented in both counties, and its roll in being a fundamental aspect of the organisation's work to support parents. In relation to Mol an Óige, CSP was cited as a support to the implementation of Mol an Óige. It was also perceived as a useful complement to worker's one-to-one, in-home intervention work, with elements of CSP being provided on a direct basis in the home. CSP's usefulness as a step-down support for families with whom in-home work had concluded was highlighted by many, although it was also reported to be used in the middle of a few cases, as well as at the beginning.

Many staff were strongly of the view that, while CSP was a useful mechanism, the group aspect was a challenge for many parents – particularly in trying to use it at the beginning of an intervention, but also more generally - while for others the intensity of CSP was a difficulty:

> "CSP is a lovely programme but I think it can be too much for people, the group aspect" (IV 23).

> "I'm willing to go in there and do some on-to-one work but not necessarily push them into the coalface of this 'group' because they're not going to keep going, they're not going to attend and it means in the eyes of [other services] then that they'll fail and be non-compliant when they are not non-compliant" (IV 17).

Literacy was also cited as a barrier to CSP working for some families, as was the ability to grasp the skills and maintain them. Many staff spoke of elements of CSP simply going "over parent's heads". For others again, the cost for families of some of the materials was a barrier.

The language of CSP was viewed as being instrumental in two ways. Firstly, staff identified it as a good entry point for Mol an Óige and recommended that it be used as a first step for anyone being trained up in Mol an Óige. Secondly, its language was important in fostering connections with other professionals trained in it. Again, Foroige was mentioned here, but more prominently perhaps the role of Public Health Nurses (PHNs), and their ability to identify and share views on the use of particular skills in a home with workers.

4.11. Linking with Other Services in the Community

That the model promotes an ecological way of working, emphasising interagency linkages, was perceived by many workers as important in this regard. While many felt that they worked with a number of different organisations already, it was felt Mol an Óige caused greater collaboration in some cases, especially but not solely with schools. For example:

> "I think the Boys Town model had brought us even further in together, definitely. We always were […] interagency, but I think it's making it stronger and better and making better use of the services in the community (IV 14).

> "That was something that came out of Children First, that there wasn't a whole lot of collaboration in the past. [.....] There's an awful lot more of that since we're doing the Mol na Oige because we're working more with schools, psychology, different other professionals and agencies in the community" (IV 26).

Staff were asked specifically if other agencies or professionals were taking on the model, implementing elements of it or expressing an interest in it. While some staff cited examples of Foróige and PHNs, in the main staff spoke about their experience of working with individual professionals in individual cases. Schools featured prominently in responses, and in particular the willingness of individual teachers, principals and SNAs to take on elements of the work. A common feature of this aspect mentioned by some staff was the use of weekly positive comment or report cards for young people being worked with in schools. For example:

> "A lot of teachers said "it is actually refocusing me on seeing the good in [the young person]". When small change happens, they now buy into it. " (IV 3).

> "We have had quite a number of cases where we would go into the school and teach the year head or the SNA the specific skills that we were using in the home […] so they're getting the same message from school and at home" (IV 12).

Other staff spoke about how when they were involved it served to improve communication between home and school, while other staff reported providing pieces of information to schools about the model, and how it worked. Many staff highlighted the importance of individual personalities in giving examples of this work, while others cited examples of schools

being challenging to work with, and in some cases being unable to do so. Notably, in an isolated case, a staff member perceived that local Gardai were using elements of the model – teaching by suggestion and effective praise - in a manner which reinforced their work with the family.

For the most part, however, staff reported that while there may have been an awareness of the model amongst professionals, they felt that for the most part such professionals did not have a specific knowledge of the all elements of the model. Staff identified a number of reasons for this, including: that organisations were busy with their own work; organisations had their own way of working; some professionals were required only for some (small) aspects of individual family work; and that some professionals adopted a 'need-to-know' attitude. Notably, many staff highlighted that they met with different organizations to inform them about the model and also provided information to other professionals and organizations elsewhere in the Country. However, many felt that this could be something which was worked on in a more formal sense in the future.

4.12. Perceived Overall Impact for Families

For many staff, the evidence on which they assessed the impact of the model was drawn from their own experience with families; in short, they witnessed changed themselves. Many workers identified particular families where changes were achieved, and maintained, where changes were achieved with a less intense support required to maintain them, and where the intervention did not work.

While many staff identified cases where no further intervention was required, perspectives were mixed regarding the extent to which all cases could result in a total end to service provision. Some staff - as cited above – spoke of cases being "closed to Mol an Óige" or "closed to family pres" but with cases still being open to a less intense form of family support. While some staff were clear about the specific nature of their service (i.e. only Mol an Óige), others believed that while Mol an Óige could be used to some degree, with some goals achieved, longer, less intense intervention was sometimes required in a small number of cases. In some cases again, families had not achieved their goals, but it has served to highlight that needs were too great, and that alternative care was required:

> "Some families have gone into foster care because the model has been there, has seen the woods from the trees very quickly, that things are not going to change" (IV 5).

For some staff, they felt that Mol an Óige offered a better solution for families to resolve problems compared to previous ways of working. For example:

> "Families would depend on you for the 6 months that you'd be there but I don't think they'd take the step further where they'd be able to do it for themselves particularly around the young person's behaviour (IV 7).

That it's strengths-based as perceived as a strong factor in its success with families. For others again, the language of Mol an Óige was viewed as offering a non-judgmental way of addressing issues around parenting which families themselves want addressed. Many staff identified the structured, goal-orientated aspect of the model as being a core aspect of why they felt families liked it, which they felt had a knock-on effect for its success. For example:

> "I feel it works really well because I think it focuses the family on what goals they can achieve, and they can actually see progress [….], when they make little changes it gives them a great boost of confidence. […] The family support plan, they can see it is achievable, it clearly outlines how they can get to where they want to get, and what support there going to get from us. It increases their confidence and they become empowered to make those changes" (IV 20)

That Mol an Óige gave families a process to work through themselves was cited by many staff as a significant factor ("it's not wishy washy"), as was including all the family, parents and young people. For example:

> "We're very much about keeping parents in the loop about what we are doing with the young person. They like that, like having a say in what's been worked on. So, its very foscused, you're not going out there waffling about the young person's behavoiur. It's like "this is what's happened, and this is what we're going to do to manage it". It's about being very clear on the specific skills or plans to manage it" (IV 24).

4.13. Impact for Work

The overwhelming majority of staff said Mol an Óige brought structure to their work. It gave them a structure which, in the majority of cases, they felt they did not have before. For example:

> "I feel positive about it and I genuinely mean it that because it has given me and the work that I do a great structure which I would not have had before, and I think that offers accountability, transparency, the whole lot" (IV 6).

> "[It] has created space for them to work intensively with a smaller number of families [.....]. It has given them a framework, has given them a sense of direction, a sense of control, a sense of achievement, that they are starting at point A and working through to point Z" (IV 32).

This sense of having a structure which promoted accountability resonated almost universally with interview participants. Additionally, the accountability aspect of Mol an Óige was viewed as promoting good practice with children and families. It gave clarity to all about what was expected: family, worker, supervisor. For example:

> "It's improved it (my practice). It's probably made it more efficient, made it clearer, easier for me and made it clearer for families about what it is I am looking for and what it is I am actually going to do. And everybody knows what the expectations are […]. So its improved the work definitely (IV 18).

> "I just feel there's much more clear direction in cases and better outcomes for families; when I was [working in another service organisation] I was feeling a bit stuck and adrift with cases whereas I don't feel that as much anymore with this (IV 16).

For many, again the sense of seeing improvements in families was the core indicator of the model. That families could, for the most part, move on independently after six or nine months was central to their perception of the model The sense of having a process was common amongst all responses. The family service plan, the assessments, and the supervision and observation – despite initial challenges, all contributed to a positive way of working for workers and supervisors. The sense of measurement and assessing progress being brought to the model was also identified as a positive impact of the model:

> "It is family support but with very specific objectives and goals in it [....], that you have a beginning, middle and hopefully, the end, but it is much more specific than what we were doing" (IV 14).

> "For me the biggest impact is putting a structure on what we do, seeing the differences, seeing the family service plan on paper. You look back after 6 months or a year working with the family, you see it's all mapped" (IV 17).

> "So if you're assessing it constantly as well then, you are looking for movement. That's one of the key things, you're looking for movement and you can measure movement with this" (IV 22).

> "This is very definite. We know what we are trying to achieve. It is reviewed. "This has been achieved, this hasn't. why not?"" (IV 5).

Many other positives were identified by workers, including the sense of the model giving a common language to workers and a consistency of service in individual services, and in some cases across services; that while it was intensive in the beginning, with some pressure, the way of working had become innate in their practice; for some services it gave a sense of identity by bringing clarity to what that service did and did not do. For those who used the model regularly, there was almost unanimity that, while it was not without its problems nor was it all completely new, it was a preferred as a way of working to previous experience. Many workers who had a significant amount of non-Mol an Óige work, or had not worked a complete Mol an

Óige case in some time, highlighted that they brought in Mol an Óige elements to their non-Mol an Óige cases, and very much viewed the value in it as a way of working.

4.14. Summary

This Chapter has outlined detailed findings from in-depth interviews with all staff operating the Mol an Óige model in both counties. Use of the model has varied in recent times due to different reasons, and implementation has not been without its challenges for practice and the organisations. However, the model is seen is an optimistic light, with its particular elements viewed as bringing structure and accountability to practice. For some, however, the sense of dislocation still resonates, and the desire to have some training or other mechanism to share experiences is present.

CHAPTER FIVE: FINDINGS FROM INTERVIEWS WITH FAMILIES

5.1. Introduction

This chapter outlines the findings from interviews undertaken with families that have used the Mol and Óige model. Following this introduction, the Chapter outlines the service characteristics of families. It then proceeds to outline participants' views on a number of themes: how families became involved with the model; families' experiences of the model, its constituent parts and the worker elements; linking with other domains – extended family, peers, school and community; benefits received by service users; families' overall assessments of the service and their recommendations for the future development of the service. It concludes with a short summary.

5.2. Service Status of Families

In total, 35 parents and 12 young people were interviewed across 30 cases over the course of the evaluation. Seven cases were open, two were in the process of closing at time of interview and the remainder, twenty one, were closed.

5.3. Frequency of visits

Families' recollections of the length of time that the intervention lasted were often very vague but the reported time scale ranged between 2 months and 24 months with 12 months being the mode. Where workers engaged with parents alone the frequency of visits started at once or twice per week in the initial stage, then going to once per week and less often as the family reached the end of the programme.

In typical cases where the whole family was involved the worker could visit the parent twice per week and the young person once per week in the initial phases. Visits would typically last from 30 minutes to 2 hours with one hour being the typical length of visit once the programme established. There were though many occasions in the early stages when workers spent many hours working with the family or young person and in dealing with schools and a range of other organisations on the family's behalf.

5.4. Factors/Circumstances which Families into the Service

There was a wide range of circumstances that brought families to the service but for all families there was a sense that they were in a situation that had become overwhelming for them. They used comments such as, *'I was at my wits end', 'I felt depressed'* and *'I couldn't go on'*. Some families had experienced challenging life events that had severe impacts on them which contributed to their engagement with services. Moreover, in general parents in this cohort had come to lack confidence in their parenting skills. For example:

> "Yeah a lot seemed to have happened. It was the aftershock of that you know. A lot of it was, [child] and me wouldn't spend a lot of time together, even though we were together but we'd be in different rooms… stuff like that" (P2).

> "'I was lost. I was giving in to situations" (P15).

In the main, the motivating factor for involvement with the service was the difficult behaviour of one or more of the children. The most difficult behaviours were exhibited by teenagers. This encompassed a wide range of challenging and, in some instances, violent and threatening behaviour. Parents talked of the young people challenging their authority, not adhering to house rules, not returning home for days, school absenteeism, stealing, drinking excessively, taking drugs, using verbal abuse and violent behaviour, coming into contact with the Gardai, and in one case, attempting suicide.

Some of the younger children demonstrated difficult behaviour by refusing to help with household chores, refusing to go to bed on time and aggression towards siblings and parents. Two young people had been diagnosed with ADHD and parents found it hard to cope with the aggressive behaviours they exhibited. Young people talked about how they were before the intervention. Many talked about difficulties with anger issues and recognised that they had been difficult to live with. For example:

> "I was a hell raiser. I'd fight with [sibling], with my mum and not come home for days, take drugs, too much alcohol and I'd no relationship with Mum … well it was a bad one" (C15).

> "At the start I just said f***. off, just leave me alone, if I want a joint I'll take it a joint, if I want to stick a naggin down my throat I'll do it, if I want to stay out on the street I'll do it, if I want to wake up in hospital then I guess I'll do it" (C14).

> "I had a bit of a temper problem" (C5)**.**

5.5. Involvement with Other Services Prior to Use

In all but three cases families were already involved with some other service before using the Mol an Óige model. Where children and parents were the focus of the intervention, children were engaged with a variety of services including child guidance, psychological services, school guidance counselling, social work, community based family support services and Foróige's 'Big Brother Big Sister' programme. Where adults were the main focus a range of services/professionals were referenced by participants and these included psychology, counselling, community based family support services, GPs and school principals.

5.6. Experiences of the Model

Families' experiences of the service differed in some respects based on what they desired to get out of the engagement and the workers' adaption of the service to the needs of the family. Workers were able to explain the objectives of the programme in the language that would appeal to the parent as in this example given by a father:

> "It was huge support. What [the worker] always stressed from the very outset, what really drew me to the project, [they were] going to give us the tools, give me the tools how to deal with the issues that would arise in the home with the children" (P7).

5.6.1. Phase One: Relationships, Goals and Plans

The early stage of intervention comprised meetings to establish the issues for families, to establish the possible causes for these and to develop a relationship. In many of these initial meetings the worker used the Mol an Óige 'Initial Assessment Guide' in order to assess families and, in collaboration, identify the family's risk and protective factors. Some of these initial sessions were very lengthy and for one family it lasted three and half hours because there were so many issues to discuss.

In the majority of cases where they were working with parents and children, the worker would spend a lot of time with the young people getting to know them, their issues and the root causes. Parents and young people agreed that this could be a challenging experience. Young people talked about trying to evade meetings and cancelling meetings but the workers were persistent and turned up for the meetings as had been agreed. In general, there was surprise that despite their initial resistance, they began to trust the workers:

> "Initially there were a lot of tears, a lot of storming out but [the worker] never gave up and [they] gave *me* the strength not to give up" (P15).

> "He trusted [the worker] one hundred percent; he had to be sure he could trust [them]."(P5)

When bonds had been built, parents stated that the next steps involved the identification of goals and objectives. This next stage comprised of meetings for some parents only and for others with the child (ren) to discuss the goals for the family in order to create the family plan. Assessment was spoken about by some, as going through questionnaires and talking about questions and issues. The work on the social mapping ('family tree') which was to help highlight social networks and sources of support (or lack thereof) was seen as very useful by several parents. For example:

> "It was like a family tree sort of thing, it was strong, very strong" (P13).

Throughout this process, the sense of partnership working or working in tandem was a common feature for many parents. For example:

> "Yeah, a plan. What his behaviour was and what we'd work on and how we'd work on it together and how [the worker would] work on it then with [child] without me being there, talking to him, getting him to see his side and taking into consideration in some things that, what he wanted as well" (P1).

Some parents had detailed charts and folders containing 'the plan' which they showed to the evaluation team, while others recalled the goals from memory. Strategies or plans were devised that were specific to the family or young person and in general were in response to the particular issues identified. They included obeying household rules, staying in school, reducing aggression, staying safe, counteracting impulsive behaviour and reducing risky behaviours such as self harm and drug taking.

Throughout the interviews examples of family goals included: improving listening skills; a range of goals relating to school such as routines, academic improvement and attendance; improving boundaries; learning to pre-empt situations; keeping safe when socialising; getting bedtime routine consistent; everyone helping with the household chores; staying calm; anger management; problem solving; no shouting; no aggression; improved communication; improved relationships; more mealtimes together; and planning and household bills (organising the household).

In addition to mentioning many of the goals described above, young people were able to reflect and have some insight on the journey that they had taken. They remembered the goals that mattered most to them:

> "Yes I did what I wanted to accomplish. I wanted to get closer to my mum instead of losing my head. I wanted to talk to her and learn to control my temper" (C5).

> "I wanted to achieve the no shouting one [in the home]" (C6).

> 'I just want to be able to, when I turn eighteen be a lot more civilised' (C14).

5.6.2. Phase Two: Implementing the Plan and Learning Skills

Once the family objectives or goals had been identified the worker used appropriate programme learning and techniques and worked with parents to devise strategies that could be used with the individual young people. Here, parents noted that there was a positive response early on. They became both surprised and encouraged by the good reactions to the techniques that they used. The perceived early aspects of the work reportedly gained the respect and interest of many of the young people too.

> "He was very interested; [young person] never missed a week" (P5).

During this phase parents noted that they were learning skills and the worker supported the parent to reinforce the learning around consequences, rewards and problem solving. At each session parent and worker would review progress and discuss additional strategies for working with the family. For some parents the teaching element was very important.

> "[The worker] spent the first few weeks teaching me. [They] showed me the charts, educated me and explained *how* to do it. Explained about how my approach to [the young person] should be firm…explained about consequences and rewards. In the beginning [the young person] just laughed at me… was controlling me but I learned to be in control. [The worker] taught me to turn it around slowly and calmly and don't respond to his answers" (P5).

For other parents, the sense of taking a different look at things was instrumental:

> "…Slow and gradual really But [the worker] was always reinforcing, loved simple things. ...sometimes you would be having such a battle, [I'd say] 'the child just hates me. [The worker] would say "Ah no [the young person] doesn't. [They are] always looking for you to pick up a bit of leadership or kind of make a decision or [they are] trying to make you happy, you know." When you look at it from that kind of angle then you see sometimes that yeah, [young person] gets frustrated with me, it wasn't all [them]. At the beginning I thought I'd a demon child" (P2).

Learning about listening skills and communication skills featured widely in interviews with parents. They learned to rephrase demands into requests; how to choose a good moment to raise issues; and more generally develop techniques. One parent talked about a technique he developed himself with agreement of the worker. For example:

> " I told [young person] the next time they have a problem I am going to introduce the window [window of opportunity] and it is where we sit down for an hour or two hours and we discuss whatever the problem is. And once the two hours are up we agree we won't talk about it if it's resolved and that's it. We park it there until the next time we have a window. And stop [it] being discussed breakfast, dinner, tea. So [the worker] was in full support of that" (P7).

During this phase many parents spoke about learning to "pick their battles wisely". For example:

> "You know if [the young person] didn't brush her hair in the morning before they went to school it wasn't going to be the end of the world kind of thing. It's [they] that is going

> to have messy hair. A lot of stuff like that. It isn't until someone says that yeah, what's the point in World War Three over something like that? If [they] want to go to school like that, let them suffer. One hundred and one daft things like that, if you just stop fighting, there was no battle" (P2).

Parents started to note changes in their children and in the family dynamic as they began to see the techniques working. *'I noticed in myself I was more relaxed and so was [child] and we were getting close'* (P9). There were beginning to be less arguments and aggression and behaviour was beginning to improve. Other siblings were also beginning to respond to discipline techniques and parents became more assured in using them and feel more confident in their parenting abilities.

Where strategies were not working the parent and the worker returned to the family's goals, reviewed them and agreed another approach. Sometimes it could take a long time to reach the goals set for the young person. For example:

> "[Child] is aggressive and has anger issues..I was afraid for him and for other people. He had to learn how to deal with it and get it out and other tactics. Punching bags, tearing up newspapers wasn't helpful. Now he'll throw a cushion not toys. He has to be throwing something or hitting. After a few months the tactics worked but it took near enough a year to change his behaviour……He could only go into school an hour at the start and now he is in all day" (P9).

> "[The worker] kept me going when [child] was testing me" (P9).

Many parents found that the handbooks and programme documentation were very helpful. They were a useful reference when parents were on their own and they noted that they referred to them often and still find them useful.

Many of the *specific activities* undertaken with families were in response to the identified family service plan and goals. Parents mentioned a wide array of tools that were used to reinforce the learning around consequences and rewards. These were specifically designed to suit individual children and included stair charts, star charts, 'the joy box and the job box' and effective praise amongst others. Anger management, techniques included deep breathing, leaving the room, counting to ten, 'Scale Project', hitting cushions, tearing newspapers and children talking with the worker and parents. Where a need was identified young people received sessions on body language, alcohol awareness (using the 'beer goggles') and sexual awareness and contraception. The 'worry box' was one technique devised to help a young person deal with anxiety and stress behaviour. The effectiveness of particular techniques was reviewed at each weekly meeting and where a particular technique did not work the worker would suggest an alternative.

The activities undertaken with parents included discussion, goal setting and review sessions. In addition parents mentioned the use of videos, role play and particular skills such as corrective teaching, which helped them to gain perspective on situations that could arise in the home. In relation to improving family communication, parents talked about learning listening skills, using eye contact and putting time aside to talk with their children. They mentioned the scheduling of family time for meals and social activities together. This had a reportedly good impact on communication and bonding within the family.

In relation to developing parenting skills some parents mentioned the usefulness of the DVDs and role play. For example:

> *"Well it done an awful lot for me over the past year, [the worker] was very helpful, showed me how to do the parenting properly and we done the DVDs that I needed to do and there was a lot of teaching to do. It was hard at first but I finally got through it" (P13).*

However, for others the role play was a challenge, initially and for some throughout. For exam*ple:*

> "I felt uncomfortable with the role playing scenario… it's hard for me. I felt uncomfortable being watched by (the worker) with the kids but they did it in a kind and supportive way. [The worker] was kind and praised me"(P12).

5.6.3. Phase Three: Achieving Goals

The length of time that families were in the programme varied. The shortest period was 8 weeks and some families were still in contact with the project workers after 2 years. Those families that had completed the programme described the final phase of work comprising the workers continuing to meet regularly with families. At this stage many parents were introduced to other services and they talked about a whole range of organisations and activities that the worker had supported them to join or take part in. All but two parents have enlarged their social networks beyond the contact that they had with Mol an Óige. For example:

> "For myself if I compare when I came here first, I'd no links. I have family, my mother is here, I have quite a few brothers living in the area. My sisters live away. But in the local area I remember I wasn't involved in anything. Then they were looking for people to join [a local organisation] and I just went to the meeting one night and I ended up becoming secretary. I made a lot of friends and I am really very driven by getting everything done[...] I'm also involved in [a different local organisation]…and that has all come about…getting involved with [a third local organisation] … it was [the worker] who referred me onto them" (C7).

Parents mention that the numbers of meetings with the worker began to reduce towards the end as families were beginning to achieve the goals that had been set for the family, the young person and the parent. There was also a reduced need for telephone contact at this stage. Typically meetings tailed off from a high of two or three times per week (for some families) with phone calls in between meetings to once a fortnight or once every three/four weeks with irregular need for phone calls. This was a fluid phase whereby the workers responded to families' needs. Sometimes there was a crisis where there was an increased need for support but generally families were beginning to feel that they were getting better at coping and communicating, young people's behaviour was improving and stabilising and the family was achieving the goals in their family plan.

Parents and children were prepared by the workers for the ending of their time in the programme but even so, for many it came as a wrench to say goodbye to their worker. *"I cried and so did my mum"* (C15). Some parents found the ending too abrupt and one parent was still confused as to whether contact had formally ceased or whether they could continue to contact their project worker when they wished. For example:

> "[Project workers'] supervisor came out here and they went through kind of a little bit [of a conversation] and that was seen as the end of the project. It was a bit of a shock when it was at the end and you didn't know it was the end coming up. And I think both of us felt that for a while but it kind of seemed to end a bit suddenly. But maybe we were becoming too aligned with being [with] a mediator that was not necessary. I don't know, there was a while where I thought 'ohhhh. Is it over now?' kind of thing" (P2).

Many parents expressed the wish that they would like to be able to keep up contact with the project worker or have some form of step down support. For example:

> "When [the worker] finished, I was sad or disappointed. But I was always assured by [the worker] that [they were] always there if we needed [them]. But I would have loved even if it was once every six weeks we had a meeting [..] just to keep things in line. I would have been delighted with that. But it wasn't a part of their policy. I suppose there are so many families that need her time and that's one major thing I'd have loved, even up to today. Just to check in, even if it's just for half an hour" (P7).

> **"**Like once its finished I would like if the door isn't closed..just to know that I can pick up the phone" (P5).

> "They could give more time, it's very short with [project worker] I would love it to be on-going until I feel myself ready to go and until all is sorted with my older son" (P8).

However, one parent thought that if the service went on too long that she would become dependent on the support:

> "[The worker] was so good..if it went on too long I would get to rely on [them]. I'd go over and over scenarios with her like the bullying in the school yard. I was always looking for the answers and [they were] so helpful." (P12).

5.7. Working Ecologically: Family, School, Peer, Community.

Respondents were asked about their and their child's links with siblings and family, with school, with friends and with the wider Community.

5.7.1. Family

For parents, the greatest impact of the programme was around the closeness that they had achieved with their children. The closer bonds meant a lot to them and they also noted the closer ties that the young people had with their siblings. In the past many of the family members operated as individuals; instead they now scheduled family activities such as jointly cooking special meals, walks, films and family outings as rewards and playing games instead of watching TV. Scheduling talk time with young people was seen as an important feature for many parents.

> "It's a lot happier, kids are an awful lot more happier, their relationship wise, to me it actually brings tears to my eyes to see how well the kids are getting on with each other because it was difficult for them and I think that [young person], the way he was, so much anger, it was very very hard for him to express any other way than that" (P4).

> "It's much easier – I fight with [sibling] obviously .. were sisters! We love each other but before [the service] I wasn't sure of that" (C15).

> "Her relationship with (sibling) is more normal and [with me] she is more open, we can discuss and spend time together"(P15).

In relation to wider family networks, a small minority of families noted that they did not have closer ties with their extended families for geographic or other reasons and they either did not chose to seek support from their extended families or this support was not available to them.

5.7.2. School

For many families, difficulties in school were a significant focus of the work with the project worker and so a primary goal for the young person was improvement in school experience. Each of the young people interviewed was asked about their experience of school. Where there were initial difficulties, in all but two of the cases children's school experience had improved. In some instances, young people had decided to return to education. Workers were reported to have engaged in a variety of activities directly with schools, such as: coordinating with teachers

on attendance of young people: addressing bullying issues; and in some cases addressing issues of suspension and supporting a process of re-entry to school. For example:

> "I had serious issues in school and didn't intend going back.. I hated the idea…but with the skills that [project worker] gave me.. helped me to think using problem solving and anger management and with [project workers] logical head I know that it's not a bed of roses.. but I'm going back to do the leaving" (C15).

> **"**I'm in [a different school now] and its better than [the old school]. It's a new chance and new teachers … they're lovely people. [Teacher] is one of the nicest men in my life and I love the music course because I'm into music" (C5) **.**

> "The biggest change in [young person] is in school, the way he is actually doing his work now..He was really misbehaving in school ..with the help of project worker and social worker we had a meeting with the principal and agreed on a daily report card from the teacher…[non attendance and not doing homework] …that has all stopped because of the daily report card. And we get one at the end of the week as well. An overall weekly thing. So his grades have started to come up again and at least he's doing his homework so that was fantastic" (P14).

5.7.3. Peers

Parents and young people were asked about the contacts that they have with peers. Across all the interviews, responses were mixed: some parents noted that the young person had made new friends, and were familiar with their new friends, although this was not always the case. For other parents this was not the case at all. While some young people reported not changing their friends, but their behaviour, others noted that they had chosen to change their peer group. For example:

> ***"****I have a couple of new mates. I'm friends with people I never thought I'd be friends with and some [of my old friends] I haven't spoken to in a while and I don't want to"* (C5).

> *"I moved on from a lot of friends that weren't good for me. The wild side is fun but I know it's not right"* (C15).

5.7.4. Community

There was a noticeable increase in the range and level of involvement for families after contact with the Mol an Óige programme. Families were referred and/or introduced to a wide range of community, voluntary, state sector and professional organisations. These were specifically selected to match the identified needs and interests of the family.

As a result of the programme parents had reported participating in parenting and other courses, such as arts and crafts, healthy cooking and Weightwatchers. They had been referred

to Family Resource Centres, Social Services, and MABS amongst a range of organisations. Children had been referred on to the Child Mental Health Service, Foróige, BBBS, NYP, Brownies, Rainbows, youth cafes, sports, horse riding, drama, boxing and a wide range of other sports and services. A small minority of parents noted that although their child was involved in activities, their own involvement in the community had not increased and they felt isolated. To some degree this was a personal choice as they had been encouraged to avail of particular local services or groups by the worker.

5.8. Benefits of Mol an Óige for the Family

Parents and children identified a wide range of benefits that they had gained from participation with Mol and Óige. The most common benefit identified by all parents and often by children was that the home was a calmer, safer and happier place. Parents were more confident, relaxed and less worried than before intervention. *'I used to get up knowing that it won't be a good day'* (P9). Parents noted that there were better routines in the family and children were helping with chores around the house. Generally parents felt more confident in their parenting. Parents also noted that they had closer bonds with their children, and the children with their siblings, and they were seeking more support from outside the family:

> "He wouldn't get involved in anything….I learned through the project..I learned through [the worker] and got a beautiful, beautiful bond with him" (P9).

Parents identified a wide range of skills that they had been taught that included, problem solving, pre-empting situations, anger management, listening skills, clearer communication, using programme 'tools' and establishing their own personal goals. Others also said it had improved communication, in one case particularly between parents.

Parents noted that the biggest changes for young people were around behaviour with the impact that the children were happier, calmer, more contented and more open to communication. Children also noted that they learned skills including problem solving, anger management and improved communication. They also noted that their own behaviour had improved and that they were happy that communication was better in the home and they were closer to parents and siblings.

> "I've learnt to listen and to accept consequences and I've learnt to appreciate mum and accept when she gives out to me and I've learnt not to be so impulsive… I don't self harm now and don't drink or take drugs and I stay safe" (C15).

Many of the children initially presented with anger issues and this was addressed with the worker during the work. A wide range of anger management techniques were tried with

families and achieved good success as where one technique failed, another was tried and its effectiveness reviewed.

> "[The worker] taught [young person] to sit for longer times, he was very impatient. His anger now is very seldom and he has a lot more respect. He learned to deal with things and is better now at not going into a rage. He has more respect for his brothers …very protective of the younger one. He takes life as it comes ……he can come to me now even with something bad. The biggest thing is I don't fear for his life now" (P5).

> "There's a huge, huge change in [young person]..I'm very proud of him..he's more independent in himself and he's very popular in school - he didn't used to be - and he talks more and he's very respectful[...] no cheek and he's loving and caring [...]and I can bring him to a restaurant or cinema now." (P9).

Some families identified that it was not all 'plain sailing' and there were sometimes lapses but generally the young people's behaviour and family life were very much improved. One family identified the positive improvements but also that there was some way to go:

> "Improvements, definitely. But there still is a long way to go, I don't think [young person] would be in the home only for [project worker and social worker]. That's a miracle in itself" (P14).

Notably, a small number of parents did identify that they still had problems with consistency in parenting and in some cases had reverted to previous parenting approaches for various reasons. They had stopped using the tools and would like more time with the project worker.

5.9. Benefits of the Worker

Respondents were asked about the impacts derived from working with the worker. Some parents identified that the worker's approach was very gentle:

> "Someone who was on your level [...], someone who was there to help you and not someone you felt that was dictating to you even though in her own way[they]would be telling you what to do but it wasn't like you should. You didn't feel like a child. You felt like one to one" (P1)

> "She praised what I was doing right. Reminded me of things I was doing well" (P12).

> "I think it is brilliant. I suppose [project worker] admitted that [they] promised me that [they] would get [young person] back into the home and get [them] sorted and in

[worker's] own mind. I didn't know whether they could do that but they have done it. I'd say without [worker] in his life, things would be an awful lot different" (P14).

It was the personal support of the worker that was the most important aspect for most parents who were able to share personal information and avail of advice. However, the focus on the work at hand and achievement of goals in a personable manner was cited by many parents:

"'There's need for more people like [the worker] if everyone is trained to the same level as (the worker). They were wonderful, solid and listens to so much but still has got the steps done amidst everything else" (P15).

"[The worker] was very helpful and anything [they] told us we took on board and it helped a lot. I don't know how we would have managed without [them]. Another little while with [them] would help" (P11).

This personal aspect was strong in the interviews, as was the in-home nature of it. For a small number of families, it was preferable to other services and approaches:

"I learnt more from [the worker] I think than I did from the [other professionals]. I couldn't [do the parenting course...]. Some people can go into a course and talk like that but I'm no good at it, I was useless. I was so nervous, meeting a load of people sitting around and asking questions [..], I found that awful hard. When you're in your own house you can ask questions and you can say 'I've done this' or whatever. But if you were in a course there would be questions you would want to ask but I'm not going asking them because everybody will laugh or think that's daft. And that's what it is in a course. There's lots of things that you would like to say but you're afraid to say anything" (P22).

The availability of the worker to the family was a featured remarked upon by many parents. For example:

"You could call [them] any time… [they] didn't take any fluffing" (p15).

"[The worker] stayed late nights with me and one night until eleven pm to help discipline [...]...in getting the child to bed" (P6).

All young people mentioned in interviews that they got on well with the worker, learned to trust them and they appreciated that the worker spent time with them, listened to them, was clear with them and was firm. They responded to being treated on an equal basis. For example:

> "[The worker] talked to me like an adult instead of talking down to me like a child and I respected it more. I just think it's a great, great programme" (C15).

> "Well, [they'd get] me to realise the bigger picture… Like there is nothing I could complain about cos [they] just gave it to me straight and sure that's what you want, you want to be told straight you don't want someone pickin' at the bush, you want them to go straight into it"(C14).

The words of one parent captured the sense of frustration about family life and the role of the worker in helping to identify the main issues and work to resolve them:

> "People are blind; we don't see what's going on. They explain it to you. My kids were very angry, especially my son, was very angry towards what had happened [...] the whole lot. It made life very difficult in the house. And from the start {the worker] came in and helped us, made life so much, I cannot get over it, I cannot express [how] much life has changed. It has, words can't express how much a change it has made in the house and that's being honest" (P4).

A small number of families who had experience of other health professionals noted the difference between Mol an Óige workers and these other professionals. The particular differences remarked about were a sense of comfort with the Mol an Óige worker, regularity of interaction, and the consistency of having the same worker.

5.10. Other Issues

Parents and young people were asked if they would like to make any other comments. In the main, nothing was offered. One parent remarked that there was a waiting list locally for participation on the programme which meant that she waited six months for participation after the initial contact:

> **"**When I came first it was a few weeks before [the worker] could work with me. I was waiting from October to May…a long time. They did say call me or come in if you need [help] and they gave me a few pointers [for while I was waiting]" (P12).

One family were living in an isolated area and felt that there should be a service based nearer to them. One parent found the parenting DVD difficult to watch because she found it hard to relate to the actors.

> "The only thing, that when we used to watch the common sense DVD's you know the parenting DVD's oh they used to, I hated watching them, you know if they are doing an Irish one, it's better to have Irish actors because those American DVD's were just, they were just hideous, and you'd sit there, and sure we'd be laughing, you know, that's the only

thing, I mean I couldn't fault anything else but just the DVD's were, like just the way they talk and the way they call stuff, you know, it's not like, I think if you were watching an Irish thing you could nearly you know gel with it more but it actually made you want to stop watching it that's how bad I found them" (P10).

The majority of participants noted that they were not aware of the service before referral and that it should be more widely publicised and more widely available to other families in need. For example:

> *"It's hard for (the worker) to get people to tell them about the service. There needs to be some way of promoting the service better"* (P12).

> "It is support for people that need it. And that there are some people that are unaware there is a thing there for them, you know" (P22).

One parent highlighted that despite searching for support for the family for several years they only in the last year heard about Mol an Óige and they identified issues around the visibility of the service which could have entailed earlier intervention for their child.

5.11. Overall Assessment of the Service

In general respondents and parents were very happy with their participation with the programme and were enthusiastic in their descriptions of how the intervention had improved their daily family experience. Parents and young people highlighted different ways in which the programme had an overall impact on their family.

> "It was very much facilitative and empowering" (P10).

> "What I liked most was the support. It was very gentle but you had to work at it. There was no preaching and it's very appropriate for families in difficult situations…no sense of "you have messed up here, we're here to fix it" (P15)

> "I like the way they came into my home and turned things around and made us have a relationship with each other that we can actually get along and that the house is so much happier. It's a peaceful house. I don't know, it's hard to describe in words how much of an effect it had on the family but definitely had great success I have to say. I hope that it does continue for other families out there" (P5)

Many young people interviewed identified positive aspects of the service from their own perspective. For example:

"It's helped a lot, coz everyone knows there's a big difference in me coz [I've] been known as a lad that was [...] down the play ground asleep on the bench [...],drunk off my head a lot, threatening people [..], giving cheek to the guards, [...] …. But like I don't do any of that now and it's noticed that about me"(C14).

Others see the potential value of the initiative for other young people:

"Honestly its good, it's done great.. It should be available much more widely and open to families with issues especially teenagers" (C15).

5.12. Conclusion

This Chapter has outlined findings from interviews held with parents and children who have gone through or are currently going through the Mol an Óige programme. In the main, the findings highlight the overall positive picture of the intervention, as experience by parents and young people. While not all are necessarily familiar with the specific language of the programme, they nonetheless are aware of how it operates and works 'for them', in their own homes, their lives and their relationships. The self-reported impact of the programme, and the role the worker plays in achieving that impact, are both very positive.

CHAPTER SIX: FIDELITY

6.1. Introduction

This Chapter presents details of fidelity data provided to the services and the evaluation team by Boys Town USA. Following this introduction, the next section outlines information of the overall level of fidelity monitoring since 2007 before proceeding to present fidelity data based on the Family-Based Ecological Assessment (FBEA) which featured from 2007-2010, and individual domains therein. The next section then outlines data pertaining to the In-Home Family Service (IHFS) Observation Form scores, mirroring changes to the model, from 2010 onwards. The following section examines elements of fidelity across the entire period before the Chapter concludes with a short summary.

6.2. Overall Fidelity Monitoring

Model fidelity reports were completed by Boys Town based on family worker observations completed by supervising staff on visits with family workers to homes. Each supervisor was required to score the project worker on the particular items that they witnessed the worker engaging in with the family. Figure 44 below outlines the overall fidelity monitoring instances for the period 2007-2012. In total, 228 worker reports were submitted to Boys Town for analysis across both the FBEA and IHFS monitoring mechanisms. It is clear from the graph below that fidelity monitoring significantly reduced in 2010, even allowing for the change over to the new fidelity forms. It should be noted also that fidelity was only recorded in three of the six services using the IHFS form.

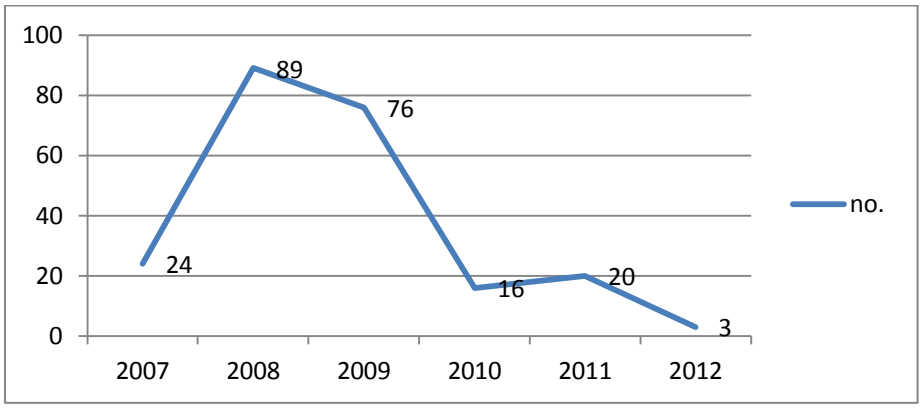


Figure 54: Fidelity monitoring reports 2007-2012

It is important to note also that some scores across both the IHFS and FBEA fidelity reports are based on a significantly smaller number of observations (within each worker report) than others; the n value for particular scores is less than others. There can be a number of reasons for this, including that the worker was not engaging in particular activities with a family when they were being observed;, that some items were not applicable in certain cases; and that there

was a reduction in the number of observations due to issues of capacity arising out of staff and organisational pressures.

6.2.1. Family Based Ecological Assessment Scores

The FBEA form is a 56 item fidelity measure. Each FBEA form and fidelity report contains five sections:

- Teaching components (20 items);
- Relationship Building (12 items);
- Professionalism and Safety (4 items);
- And Natural Therapy Systems (NTS) focusing on work affecting the five domains of individual, family, peer, school and community (4 items in each of the five domains).

Additionally, there are five levels of fidelity with associated scores for each:

1. No/incorrect: No visible signs of implementation or completely incorrect;
2. Below average: some signs of implementation, but is not complete;
3. Average: basic implementation occurs correctly;
4. Above average: Implementation is becoming more natural/spontaneous; and
5. Excellent: Implementation is natural, consistent and spontaneous.

The total number of reports submitted for analysis from 2007-2011 was 201, with the majority being submitted in 2008 and 2009. However, nine reports were submitted in 2010 and three in 2011.

In the ***Teaching Components*** section, of the 20 different items, 18 recorded a steady increase through years 2007 to 2009. Of these, progress was made on nine but scores remained below average (incomplete implementation), while another nine progressed to average, (basic implementation occurring correctly) (see Table 14 below). In two items (*suggestive teaching* and *active listening*), scores decreased from average to below average. This is notable because of the large n score in both when the final score for 2009 was calculated.

Progress but below average	Progress to above average
Family behaviour addressed based on treatment needs	Teaching consequences
Preventive prompts and social cues	Using exploration
Proactive teaching for clear behavioural expectations	Using metaphors
Effective praise	De-escalation
General praise	Reframing
Using mediation for mutual decision making	Challenging
Using rationales	Modelling
Role-play	Assignments for practice and goal attainment
Circular refocusing	Variety of appropriate teaching methods

Table 14: Fidelity progress of Teaching component items

Overall, the Teaching Component average score increased to average (basic implementation occurring correctly) by 2009, and maintained this into 2010, albeit under a reduced number of fidelity reports. The overarching message here, however, is that basic implementation occurred correctly.

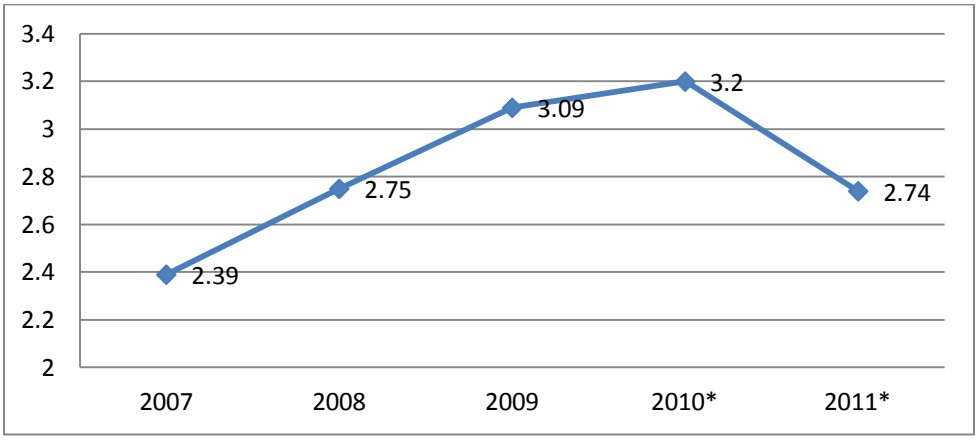


Figure 55: Teaching component average scores

Under ***Relationship Building***, eight of the twelve items progressed to average. They are listed in the Table 15 below. One item –*maintains quality components* – maintained an average score. Two items progressed but remained below average. These were *demonstrating respect for family tradition* and *encouraging the family's normal routine*. Finally, one item – *sharing examples or experiences appropriately* – decreased to slightly below average.

Progress to above average – Relationship Building
Addresses the family agenda
Includes relevant family members in the intervention
Allows families to express their views
Provides concrete services
Uses humor appropriately
Recognises families as experts
Attempts to join the family communication style
Building relationships through spending time

Table 15: Fidelity progress of Relationship Building items

In an overall sense, fidelity towards the Relationship Building aspect of the model progressed comfortably towards average (basic implementation occurring correctly) by 2009, and maintained it in 2010, albeit under a lower number of reports.

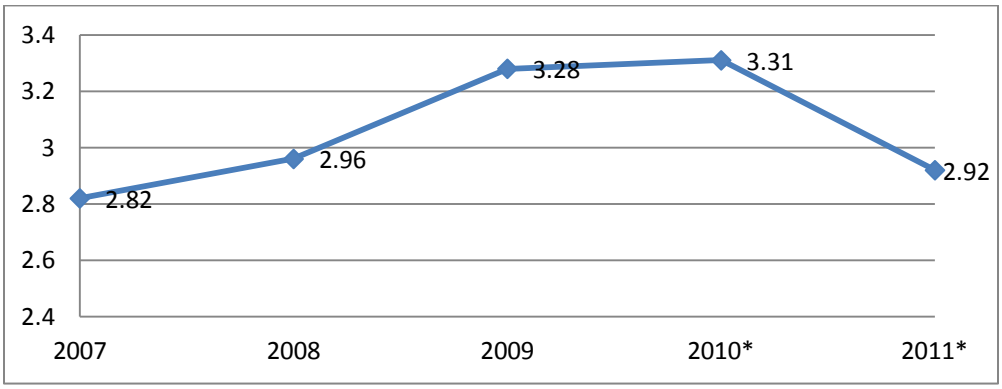


Figure 56: Relationship Building average scores

Of the four items contained under ***Professionalism and Safety***, two maintained an 'average' score across the period in question. These were *demonstrates appropriate roles and boundaries* and *ensures safety of self*. Another one – *ensure safety of family members* – progressed to average. The fourth item – *engages in appropriate professional behaviours* - was given as a percentage score, and this remained stable at just above 90% across the period 2007-2011.

Overall, fidelity to basic implementation was achieved relatively early in the implementation process compared to other items in other groups, and was maintained and built on over the period up to 2010.

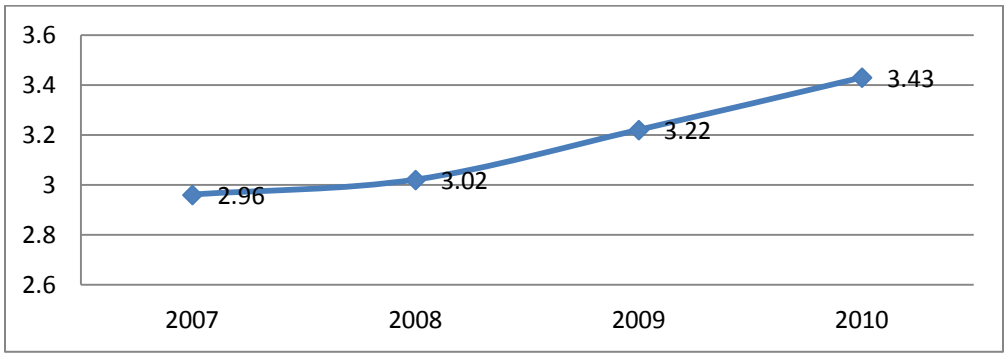
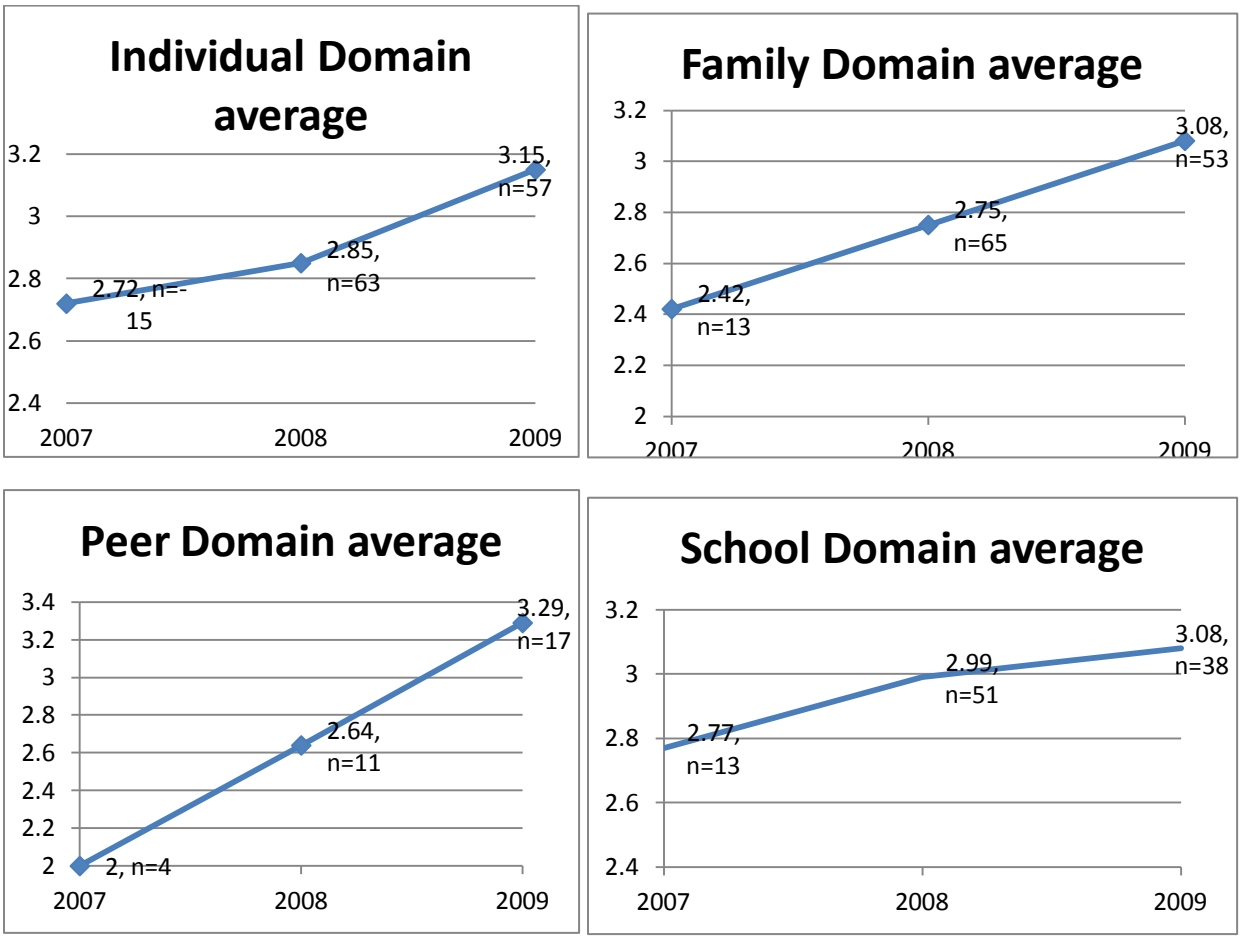


Figure 57: Professionalism and Safety average scores

Evaluating fidelity scores for the five category, twenty item Natural Therapy Systems Domains section is problematic. While other sections contain significant n values (for the most part above 66% of total n values for each section), n values under this section vary widely. For

example, under the item *making existing environment more effective by realigning appropriate existing resources*, 62 out of 89 (70%) fidelity reports scored this in 2008, but only 23 out of 76 (30%) scored it in 2009. In the family domain, the item *increases accessibility to resources* was not scored at all in 2008, and but was scored 15 times in 2009 (19.7%). This is particularly the case with the four items under the Family Domain. In both 2007 and 2009, two of these four items were not scored at all. Hence, these scores need to be treated with caution. Figures for 2010 are discounted given the small number of reports in total, and the calculation of some items on a small number of assessments (n=1 in some cases).

Under each heading, general progress is noticeable through 2007 and 2008 to achieve an average rating by 2009. However, while the total n values are high in the individual and family levels, and reasonably high in the school domain level, they are noticeably less so in peer and community levels. Scores in all these domains are presented in Figure 48 below:



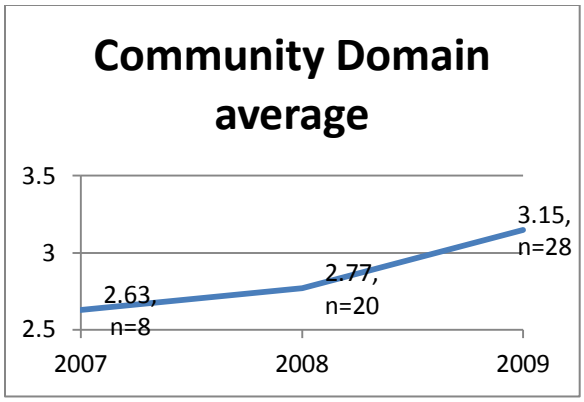


Figure 58: FBEA Domain average scores

6.2.2. In-Home Family Service Fidelity Scores

As outlined above, the fidelity assessment form changed in 2010, with most supervisors switching to it in this year. In total, seven reports were submitted in 2010, 17 in 2010, and three in 2012. The IHFS fidelity measure is a 42 item measure. The form has six parts:

1. Relationship Building and Engagement (8 items);
2. Teaching Components (11 items);
3. Safety (5 items);
4. Resources and Supports (4 items);
5. Assessment and Exploration (6 items); and
6. Documentation Review (8 items).

The five levels of fidelity are the same as with the FBEA.

There are eight items assessed under *Relationship Building and Engagement*. When scores for 2010 and 2011 are considered alone:

- Three items increased within the category of consistent and effective implementation: *includes relevant family members in intervention; provides and quick and early solution;* and *promotes the family's empowerment and self-determination.*
- Three items decreased *within* the category of consistent and effective implementation: re*spect for the family's traditions, values and beliefs; demonstrates appropriate professional behaviours;* and *attempts to join the family's communication style.*
- One item decreased from natural and spontaneous implementation to consistent and effective: *maintains quality components*; and
- One item decreased from consistent and effective to average implementation: *allows youth and families to express their views and opinions.*

Under *Teaching Components*, seven items increased within the category of consistent and effective implementation (see Table 16 below):

- Two items increased category from effective implementation to effective and consistent implementation: *ensuring role-play* and *use of specific praise to reinforce appropriate behaviour*;
- One item maintained the same score within the category of effective and consistent implementation: *teaching application of consequences*; and
- One item decreased within the category of effective and consistent implementation: *preventive prompts*.

Items increased within the category of effective and consistent implementation
Addresses the family issues based on needs in service plan
Recognises opportunities to teach skills
Uses rationales effectively
Accurately teaches skills and strategies
Ability to convey skills, resources, supports and assist family in how to utilise them
Uses assignments to keep families focused on using skills
Uses a variety of techniques

Table 16: Teaching Component items increased with category of effective and consistent implementation

Out of five items under *Safety*:

- One increased within the category of effective and consistent implementation: *de-escalates crisis situations*;
- One maintained the same score within the category of effective and consistent implementation: *promotes appropriate and effective monitoring of children*;
- Two decreased within the category of effective and consistent implementation: *addresses physical and environmental safety issues* and *promotes safety of family members*; and
- One decreased from spontaneous and natural implementation to effective and consistent implementation: *addresses safety of self*.

Out of four items under *Resources and Support*:

- One item increased within the category of effective and consistent implementation: *identifies needed resources which align with the family's service plan*; and

- Three of the four items decreased within the category of effective and consistent implementation: *provides concrete services; links the family to appropriate formal systems and services;* and *helps the family to identify and utilise informal supports*.

Out of five items under *Assessment and Exploration*:

- One item increased within the category of effective and consistent implementation: *correctly uses established protocols for formal family assessment*;
- Three items decreased within the category consistent and effective implementation: *actively listening; addresses the issues that families want to change;* and *the use of exploration effectively;*
- Two items decreased from consistent and effective implementation to effective implementation: *prioritises family problems and intervention strategies to be addressed;* and *identifying ongoing and new family issues and concerns which emerge during treatment.*

Out of eight items under *Documentation and Review*:

- One item increased from effective implementation to effective and consistent implementation: *documentation demonstrates initial and ongoing assessment of the family's strengths, stressors and needs*;
- Three items increased within the category consistent and effective implementation: *service plan identifying important resources to meet family needs; service plan identifies formal and informal supports to address family's needs;* and *case notes clearly document implementation of interventions and family progress;*
- Two items maintained scores: *plan includes identified skills for family members to learn;* and *plan contains individualized interventions;* and
- Two items decreased within the category of effective and consistent implementation: *use of quick and early documented;* and *documented attention to environmental and interpersonal safety issues.*

An overview of all these changes across the six sections of the IHFS form is outlined in Figure 49.

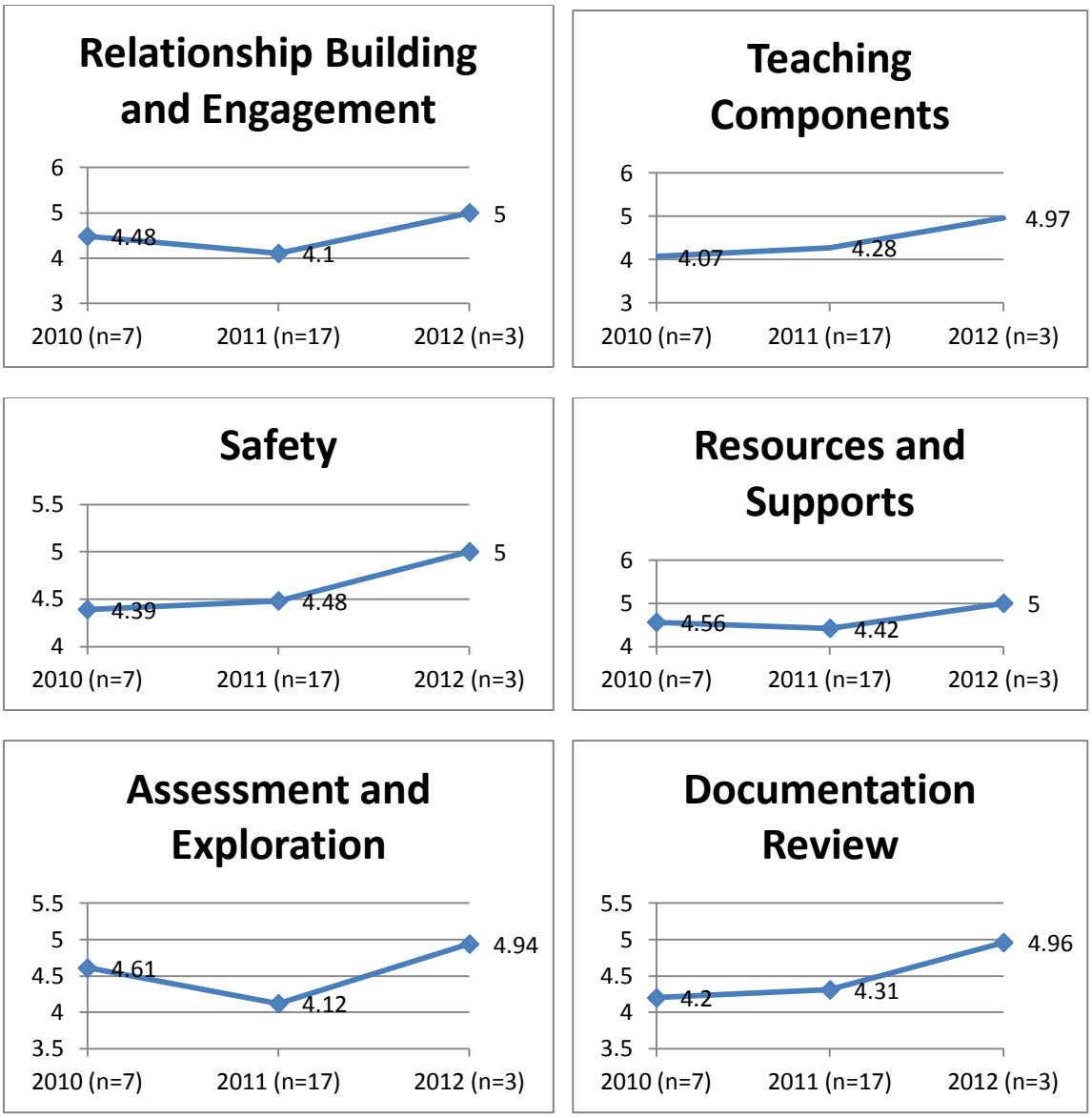


Figure 59: Strengths and Stressors average fidelity scores

6.2.3. Tracking Change across Fidelity Measures[5]

Twenty-two items are directly comparable across both sets of fidelity measures. This figure is relatively low due to many of the teaching component and Natural Therapy Systems fidelity items in the FBEA being collapsed into cumulative scores in the IHFS fidelity form. When analysed together, these scores mainly display progress towards effective implementation and in some cases effective and consistent implementation.

[5] See Appendix E for a full account of comparable scores between the two fidelity forms

Across the seven items which could be reasonably characterised under *Relationship and Engagement*, the trend has been towards effective implementation. The overall trend for these items is displayed in Figure 50 below:

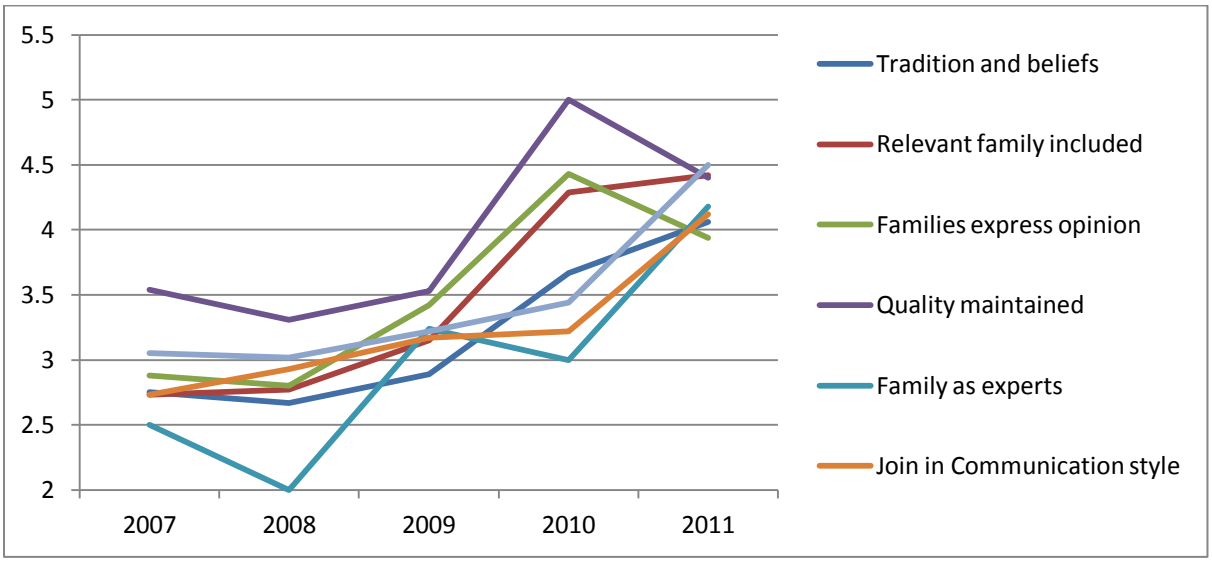


Figure 60: Overall trend in Relationship and Engagement scores

Under Teaching Components, again the trend is generally upward. While the rating of adequate practice of skills dipped significantly between 2009 and 2010, the reduced number of fidelity observations should be taken into account here (29 in 2009 versus 4 in 2010).

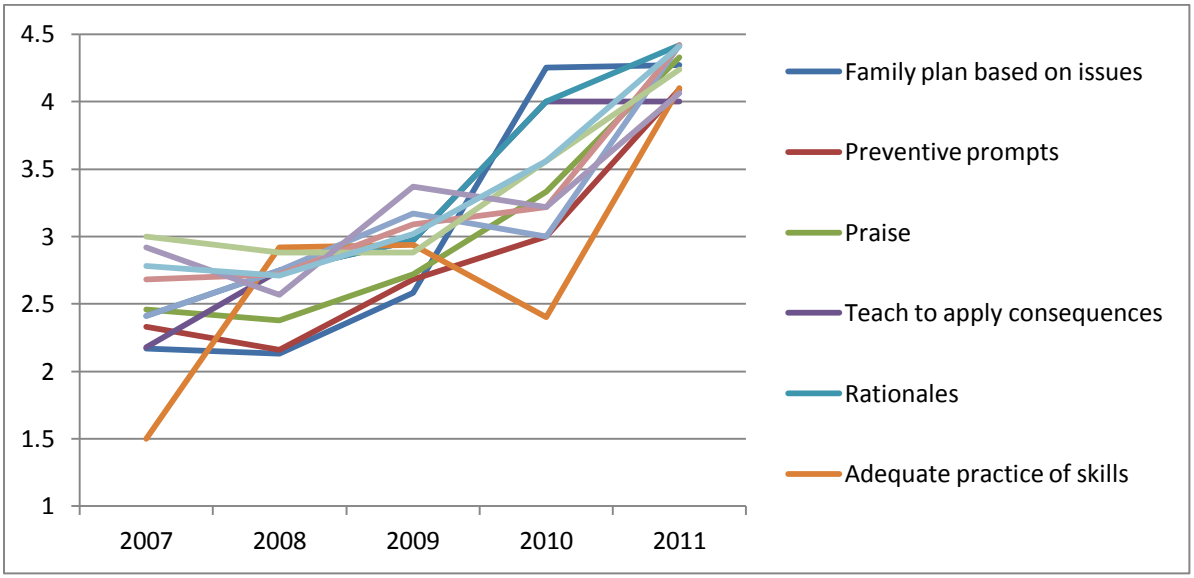


Figure 61: Overall trend in Teaching scores

Under *Safety*, as with the other categories there is a notable increase to an average rating of three, denoting effective implementation. In particular, while the safety of the family and the

professional was a constant from the beginning, the ability to intervene and de-escalate crises significantly rose over the early period of observations.

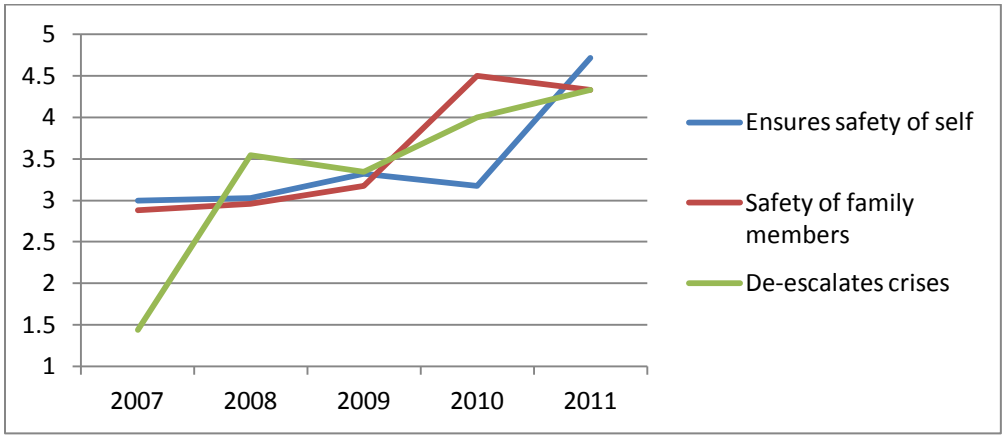


Figure 62: Overall trend in Safety scores

Finally, the provision of concrete supports rose steadily from 2008 onwards, almost reaching natural implementation in 2011, before falling back slightly but well within the range of consistent and effective implementation in 2011, where there was a higher amount of observations undertaken.

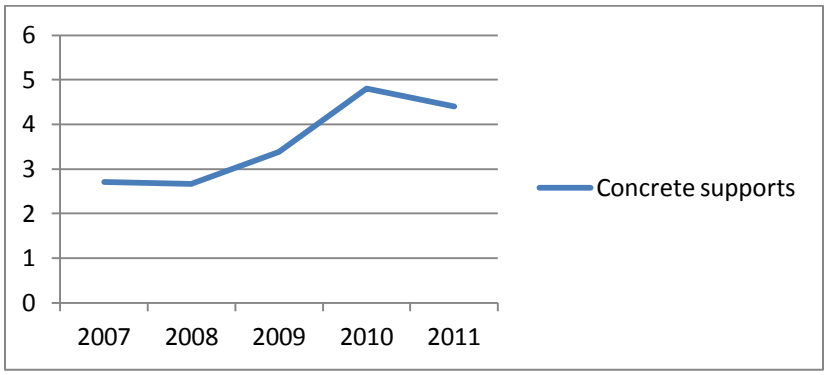


Figure 63: overall trend in Concrete Support scores

6.3. Summary

This Chapter has presented findings from fidelity information gathered by the services and analysed by Boys Town. Overall, it displays a generally positive picture of programme implementation, with the majority of scores being within the 'effective implementation' range. Progress towards consistent and effective implementation was achieved in 2010 and 2011, although the significantly lower observation scores need to be borne in mind here.

CHAPTER SEVEN: WIDER STAKEHOLDER PERSPECTIVES ON MOL AN ÓIGE

7.1. Introduction

This short Chapter presents findings from a small number of interviews with a range of professionals involved with family workers using Mol an Óige with families. In total, ten professionals not associated with Mol an Óige or Boys Town were interviewed from both Mayo and Roscommon, ranging from school staff (2), social workers (3), a public health nurse, a disability worker, a family support worker, a counsellor and a psychologist. Following this introduction, the Chapter proceeds to outline these stakeholders' involvement in working with particular family workers operating the model, their knowledge of Mol an Óige, examples of working with family workers in situations, and their overall perspective on it. The Chapter then concludes with a short summary.

7.2. Stakeholders' Involvement with Family Workers and Knowledge of Mol an Óige

There was great variation amongst professionals regarding their involvement with workers who used Mol an Óige. Notably, over half the professionals had links to the various workers they spoke about which predated the introduction of the model. For most of these, personal contact, or working in the same organisation or sector explained these longstanding links. While some considered themselves to be quite involved with workers, others spoke of being involved in a single case, and on two occasions only in particular parts of the case – where professional specialisms were required. One respondent was adamant that, while they and the family worker had worked with the same families, they did not work together due to the confidential nature of family work. Contact with family workers generally mirrored the extent of involvement. Some spoke of meeting up regularly to discuss family issues (this was particularly the case with social and family support workers), while others spoke of phone contact and being kept informed of what work was being done with the family, but spoke of not getting too involved, or of not "crossing boundaries". One respondent again spoke of working to support each other professionally but not on the same cases.

Half the respondents were not explicitly familiar with Mol an Óige work, while the other half were. Proximity to the family worker, both sector wise and organisationally, accounted for this difference, with some being very knowledgeable of the particular elements involved - such as teaching, consequences, rewards and phases like relationship building. Family workers and some social workers in particular were familiar with it, and many described it as a "particular form of family support" or a "useful way of doing family support". Others, who were not familiar with it or knowledgeable of it by name, spoke of recognising the worker operating from

a strengths-based or positive perspective. The majority, whether familiar or not, spoke of sharing this perspective, of operating from a broadly similar set of principles.

7.3. Examples of Working with Family Workers to Meet Needs.

All respondents were able to provide at least one example of how they worked with or alongside family workers in meeting the needs of families, and understandably there was great variation in this. For example, two professionals worked with family workers to support families at difficult times due to illness, and where in one case the young person present was "acting out" because of it. These professionals supported the parent(s) with particular needs while the family worker addressed the child's behaviour. They had weekly contact to update each other on the case and this was found to be a useful support for the professionals. In particular, they felt that having an understanding of the underlying principles of the worker's approach was useful to their work.

Others spoke about reinforcing the particular approach being used by the family worker, or particular elements of the work being undertaken with the family, whether it was implementing a staying calm plan in a different setting, or using the same language around managing behaviours or supporting parenting. In these instances professionals were very clear about the benefits of adopting a common approach:

> "Often times [the worker] might ring me about a particular family, and invariably we'd be singing off the same hymn sheet [to that family] (WS 5).
>
> We'd talk about things, [...] It'd be a conscious attempt to try and say the same thing to the young person, that we're on the same page" (WS 7).

While for some it was a conscious or intentional aspect of their work, for others it was more a result of having a common set of skills, irrespective of Mol an Óige:

> "Both of us continued to offer support and give the same messages regarding behaviour management, consistency, routine etc [...] we were working alongside and singing off the same hymn sheet, but we didn't have a conversation about it, it wasn't conscious" (WS4).

This sense of working from a similar position resonated in some responses, but in the main, this set of professionals spoke of working for families, but within their own professional boundaries. Each had their own specific piece of work to do, which tended to complement the family worker's work, but was not led by the family worker. They were they asked to undertake specific tasks relating to the family plan.

Other professionals spoke of referring into family workers, and in the case of social workers particularly, working closely with these workers to support families. Such work involved sitting with families, reviewing progress, planning a programme of work, alternating visits and maintain contact about cases. Many spoke about examples of cases in the social work system in which family workers operating Mol an Óige were involved. In some of these cases, after Mol an Óige was introduced and operated, families were closed to social work after different lengths of time with different outcomes. For example:

> "Good conclusion, because parents could take it on and the worker was good, persevered. [.....] Mother was committed and turned it around. Another case, [family] worker went in, tried to help, but after three weeks we quickly realised that this wouldn't work, no way" (WS 9).

All respondents were asked whether they had taken on any of the elements of Mol an Óige or its approach. As referred to above, the majority spoke of working from a similar perspective and thus felt they already worked in this way, with most of the respondents commenting that they had not taken on particular skills from their experience of working with family workers operating the model. However, there were two cases where respondents did indicate that particular skills were adopted, including problem-solving strategies with young people, communication skills, and being more inquisitive in dissecting particular incidents.

7.4. Overall Perspectives on Mol an Óige

For those respondents who were aware of Mol an Óige or Family Preservation, they were very positive about its potential, based on the experience they had of it. This was particularly the case amongst social and family support workers, who perceived it to have particular benefits for their service. Such benefits included a structure, a plan, and measurement, a way of "not getting bogged down in general conversations", something which was perceived could affect all types of family work. For example:

> "It's a particularly useful way of doing family support: there's support for the family and support for the worker. [in this case], improvement was tracked, progress was made and it worked [....]. For case notes the plan is excellent. It's clear, it's out there, it's organised, rather than "we're putting in this support, the best of luck with it". It's "this is what we expect, this is what we are going to work towards". It helps with accountability" (WS 8).

Others familiar with it spoke of the importance of building relationships as key to its success, and that the role of the worker in this regard was key in bringing creativity and flexibility to the engagement with families. For example:

> "It's quite a powerful tool, the plan, the lot [...] there's a great need for flexibility, creativity in how to engage people, spend time, meet them where they are at, but having a model, a framework and linking what you are doing to that is good" (WS 10).

Many highlighted that in some cases it was not a matter of a quick fix, and this was particularly the case amongst social and family support workers. While some have seen Mol an Óige work for families which have no further problems, others view it as an intensive support which may in some cases require less intensive service provision afterwards. The importance of suitability was also highlighted by a small number of respondents. Addiction, lack of motivation and other problems were viewed as impediments to the approach working. The importance of using the right intervention at the right time was often highlighted.

For those not familiar with the model, they were nevertheless positive about the workers and the way they worked. All spoke about the particular characteristics of the workers, their good communication style with both them and families, and that the work appeared to them to be planned. Others spoke in particular about communication style being clear, direct and to the point when it needed to, whether it was with a young person or adult. Amongst almost all respondents, they felt they have referred or would refer into the particular worker more since their initial experience. Notably, for three particular respondents, they were not aware of the service at all until they came into contact with the worker. These respondents advocated greater awareness in the area about what the services do. Others spoke of the preventative aspect of the work, highlighting that it could be useful for resolving issues earlier.

7.5. Summary

This Chapter has outlined findings from a small number of interviews with wider stakeholders engaged with Mol an Óige workers in meeting the needs of families. The findings are mixed regarding the extent of familiarity with the Mol an Óige approach – some were and some were not – with the majority recognising the underlying characteristics as being similar to their own professional approaches. Despite this mixed level of familiarity, the majority of respondents were positive about the way in which the family workers worked, and for those with a specific knowledge they recognised its potential for undertaking structured family work. The role and particular skills of the worker were important in this regard.

CHAPTER EIGHT: DISCUSSION AND RECOMMENDATIONS

8.1. Introduction

Originally adopted from Boys Town USA as a result of service contact between it and the Child and Family Services in both counties in 2006, the Mol an Óige Family Preservation Service was introduced as a way of working in six services from 2007 onwards. Characterised as an ecological, strengths-based way of working with families to achieve positive change, the model adopts a behavioural approach through direct support work by a family worker in the family home. Core to its operation is the teaching of effective parenting skills, with an underlying emphasis on family self-determination, healthy relationships between worker and family and the creation of a positive family environment. This direct work is supported by an infrastructure of leadership, training, regular supervision, detailed case note/file maintenance, observation and fidelity monitoring.

The aim of this study has been to evaluate the implementation and impact of the model for families and staff. To this end a number of overarching objectives have guided the study:

- Assess the implementation of the model in relation to a number of key areas including:
    - referral criteria and processes;
    - direct work with children and families;
    - staffing;
    - training support; and
    - fidelity to the underpinning theoretical models;
- Assess the outcomes for participating children and families;
- Assess the impact of the model on work practices;
- Reflect the views of stakeholders on the programme;
- Assist the project in collating and interpreting internal project data; and
- Assess wider impacts of the programme in areas such as skill development and collaboration.

In order to meet these objectives, a mixed methods research strategy was used to generate data from a range of sources. When the data from this range of sources are taken into consideration, a number of themes emerge to guide the discussion. These are:

- The role of Mol an Óige in family support: working with families for outcomes;
- The role of Mol an Óige as practice support: working for staff;
- Implementing Mol an Óige;
- Fidelity; and
- Working ecologically: linking with other services and supports in the community.

These points are now discussed in turn.

8.2. The Role of Mol an Óige in Family Support: Working with Families for Outcomes

In analysing outcomes in any intervention, the quality and validity of data must be considered. As outlined in the methodology, outcomes data was gathered in four different ways. All services were asked to complete basic templates on all Mol an Óige cases, indicating, among other things, the goals in each case, whether these goals were achieved, and their overall assessment as to whether the case closed successfully or not. Secondly, services were asked to complete more detailed templates of case files of families who consented to have their information used in the evaluation study. These files contained detailed anonymised information on issues such as source of referral, goals, whether they were achieved, and where present, pre and post intervention assessment forms. Thirdly, parents and young people who had come through the intervention were interviewed about their experiences of the process and their current situations. Fourthly, staff were asked about their perceptions of the intervention's impact on families, and examples of where the intervention did and did not work.

Issues of validity arise here regarding mechanisms of collecting data, in particular the collation of service level data. However, as outlined in Chapter One, the evaluation team is satisfied that the information provided was an accurate account of what was contained in case files. The clearest indication of this is the willingness of services to identify goals which were not achieved and cases which were not successful, as well as the range of reasons for cases being deemed not successful. Regular interaction with services during the data collection process also served to assure the evaluation team of the validity of the data.

Analysis of data from all cases reveals that three core goals were central to work with families in Mol an Óige: parenting support; young person's behaviour; and school support. The former two account for 51% of all goals identified in all case files, and individually their totals dwarf a range of other goals which featured in the file analysis. Other goals worked towards included family relationship issues, service access, drug and alcohol issues (of young people mainly), keeping a child at home and returning a child home. From this data alone, it appears that Mol an Óige is addressing needs central to the rationale for its incorporation into child and family services in both counties.

8.2.1. Data from all Cases

When cases are examined based on whether they were successful or not, an interesting initial picture emerges. In total, 60% of cases are deemed to have been successful, with 40% being deemed unsuccessful. Amongst the 60% of successful cases, the vast majority of goals were achieved, with parenting, behaviour (including criminal) and school-related goals accounting for 68% of all goals achieved. Conversely, when unsuccessful cases were examined, the vast

majority of goals were not achieved, with parenting, behaviour (including criminal) and school-related goals accounting for 61% of all goals not achieved. That drug and alcohol, family relationship and return a child home-related goals accounted for a further 30% of goals not achieved is of note here. Also of note is the average length of intervention in unsuccessful cases: 7.5 months.

A number of reasons were provided regarding cases being unsuccessful. In 15% of these cases, goals were deemed to have been simply not achieved, with no further reasons given. In other cases, families moved away, cases were transferred to more appropriate services, or children were (almost immediately) taken into care. However, the single most common reason provided within this group for cases being unsuccessful is 'disengaged', accounting for 51 out of 91 total cases. Of interest here is the amount of time spent by services trying to engage with these families: 6.5 months. Two factors are apparent in disengaged cases: the young person or parent explicitly refused to engage; and children were already in the care of the State or open to social work. However, it requires saying here that there were also cases where children in the care of the State were returned home successfully through Mol an Óige and did not require the intervention further. More generally, it is worth noting that successful cases in Mol an Óige came from services in this evaluation which work with families at levels two, three and four of the Hardiker scale. There were successful cases in all services, as well as unsuccessful cases.

8.2.2. Outcomes Measures Data

Consent for full file analysis, including pre and post assessment measures, was received from 58 families. Of these 58, ten were ongoing cases and thus had no post assessment form completed, while another twenty had either no pre or post assessment form completed. This left 28 cases where some form of pre and post assessment was undertaken, with smaller numbers again present for different types of assessment. Clearly, this is a very small sample size and is further limited by the non-representative nature of it, across both the Mol an Óige population as a whole and across the six services.

When assessment items relating to parenting are examined, slight overall improvements are noted in the Strengths and Difficulties Questionnaire (SDQ) total scores, but the majority of cases did not change category. Similarly with the Parent-Child Relationship Inventory, there were slight improvements in scores. Neither of these measures showed any statistically significant change, but this is not surprising given the small number of cases. Results were more promising in the two main forms used by staff, the Ecological-Based Family Assessment (EBFA) and the Strengths and Stressors assessment. Between 73 and 77% of cases recorded overall improvement in parenting items, with approximately 25% showing no change. When the young person's behaviour is considered, again the rates of improvement were high, almost

77% in the EBFA and 100% in Strengths and Stressors, although this was based on a very small case number. Of note here was the amount of improvement in child SDQ scores, and statistically significant improvement in pro-social and hyperactivity scores. There was also statistically significant improvement in Adolescent Wellbeing scores. When school related assessment items are examined, rates of improvement are less pronounced. 54% of cases of school behaviour improved under Strengths and Stressors, while the EBFA noted a score of 31% under this item, and a 44% improvement in school attendance, with large amounts of no change under this heading, as well as others.

8.2.3. Family and Staff Interview Data

Thirty families consented to interview on their experience of Mol an Óige. A variety of families participated in the interview process: some had successfully closed, some were closing and others were still working with family workers at the time. Despite numerous attempts by services, no families who disengaged from the process or for whom the process was not successful could be recruited into this aspect of the evaluation.

Families spoke of not accessing services until they were almost at crisis point in their lives, with some families highlighting that they were not aware of such services until a particular contact put them in touch. However, once service provision began, participants were positive about the Mol an Óige process they experienced. In particular, the skills of the workers were cited prominently amongst parents and young people. Among those cases which had closed, or were closing, both parents and young people were very positive about the impact the work had on their lives, individually and as a family. Where relevant, improvements in school relationships were noted in the vast majority, and participation in wider community activities was also common. However, change at the peer level was notably less. For some families, there was a lack of clarity about when the service actually ended, or whether they were free to source additional, less intense support from services if required.

Staff also commented on the ability of the intervention to improve outcomes for families. In the main, they reported that there was great potential for it to impact positively on families, having witnessed changes in families they had worked with. For staff, the key determining factor in the intervention achieving outcomes was the motivation of families to change their behaviours and persevere through the work. The structured, goal-orientated aspect of the model was also viewed as a significant factor in families persevering, as it allowed them to see progress. While staff remarked on a number of perceived gaps in the model's underlying approach, such as a focus on attachment, they felt competent enough to fill such gaps with their own expertise, practice knowledge and resources available. The testimony from both parents and young people highlighted the improve relationships and subsequent improved bonding which had occurred as a result of the worker's engagement. While limited, such data

highlighted the ability of the worker to combine initially the programme's focus on relationships with existing skills and available resources to improve connections between parents and children, to ultimately address attachment. However, at the family level, capacity to take on the skills in the model and sustain them, as well as other mediating factors such as addiction and the timeliness of the intervention were cited as playing a significant part in determining whether the intervention was or could be successful for families.

8.2.4. Outcome Overview

The overall case data indicate that, at one level, Mol an Óige as an intervention appears to have succeeded for the majority of families with different levels of need. Of note here is the relatively low number of families which services are aware of which have re-entered the intervention. Thus we can say that as an intervention, it shows promise. However, there is a sizable proportion in these figures which, for whatever reason, it has not worked. Examining unsuccessful case figures more closely is not possible given the limitations of the data. Regarding cases where goals simply were not achieved, the fundamental question is why. Data from staff is useful here. Was a lack of parent capacity to take on the skills a factor in these cases? Were addiction issues at play, or was it something else? Is it possible that the level of need for some of these families may have been too high for Mol an Óige to work in the manner in which it did in other cases? Is it possible that the amount and frequency of support provided was a factor? The predominantly voluntary nature of this intervention is underlined in these figures and in the staff interview data. When families are adamant about not engaging after lengthy attempts to build relationships with them, there is little workers and services can do but to try and understand why. Generating an understanding of why individual families disengage should be a focus of each service's work. Thus, information gathered in a systematic, timely manner is crucial to any further analysis.

A recent systematic review on hard-to-reach families in a range of service sectors (Boag-Munroe and Evangelou, 2012, p.233-34) highlighted that families who lack the will or motivation to engage with services "through passive disengagement, service resistance, refusal to cooperate or through incompatibility with the service or the staff [….] might be the hardest to reach and will need time and persistence [to engage]". Importantly, they highlight that the usual mechanisms to engage other hard-to-reach families will often not work with this group. A number of lessons from this review are identified by the authors in reaching these families: increased visibility of service, shifting the locus of the service, provision of a wider service, and the identification of factors which make families unwilling to disengage and the development of strategies to overcome those factors. Some of these points warrant consideration in trying to respond to and meet the needs of disengaging or refusing-to-engage families.

Turning to the assessment measures data, several issues emerge. Assessment items relating to the main goals outlined above show improvement, and thus show significant promise for the intervention. In particular, high rates of improvement in parenting domains are noteworthy. Furthermore, it is very promising that some standardised assessments relating to behaviour and wellbeing of young people show statistically significant improvement. However, any interpretation of this data must be treated with caution given the very small number of cases for which there is information.

The use and usefulness of the assessment instruments is of note here. There is a large amount of 'no change' recorded in the two main assessment forms: the EBFA and the Strengths and Stressors. While 'no change' is at face value self explanatory, the high percentage scores are partly explained by the programme's instruction to workers to only concentrate on the assessment items or questions which scored negatively (i.e. those which were stresses). Many items in both assessments were scored '0', while others were scored positively. Such items were understandably not the focus of intervention by workers, but served to produce a large amount of no change when post intervention assessments were examined for impact. While the ability of the worker to act at the individual and family levels is clear, their skills to affect, for example, the availability of religious institutions or the prevalence of drug addiction in a neighbourhood is less so. This difficulty is less prominent with the Strengths and Stressors than with the EBFA, but also applies. Relevance of particular assessment items is an issue in considering this data, but it should also be acknowledged that working the full ecology of parenting is difficult, particularly for one worker in one service.

The assessment data also highlights another issue, however: the loss or absence of a large amount of post-assessment data. Any future analysis of the efficacy of the intervention should be dependent on the systematic gathering of pre, post and follow up assessment data for all cases, ideally as part of a quasi-experimental research design. To this end, services should consider assessing for outcomes as a matter of course, using internationally recognised measures such as the Strengths and Difficulties Questionnaire (adult, child and school), the Parent-Relationship Inventory and the Adolescent Wellbeing Scale, or a combination of these as appropriate to each case. Management should examine this issue and ensure that such outcome assessment occurs.

In considering the data from families, it is clear that for many of those involved, goals have been achieved and family lives are enhanced. Homes are happier, calmer places where parent's capacity has increased, behaviour has improved and, where relevant, school attendance has increased. For those families in this research whose Mol an Óige experience was ongoing, they spoke of challenging times and cited the support they received from the worker as being important. However, for some families there is a lack of clarity about how the

service ends and for others a clear desire to access some form of less intense support from time to time should the need arise. Considering these points, it may be useful for services to consider how the final phase of the intervention concludes and, in some cases, consider the provision of a lesser form of family support for some families to aid the family in consistency of approach or to overcome particular issues. This would be best assessed on an individual basis. While Common Sense Parenting may be a useful step-down support for some parents, group programmes or settings do not suit all.

8.3. The Role of Mol an Óige in Practice Support: Working for Staff to Support Families.

Mol an Óige introduced some new elements to the working processes of staff and the organisations operating them, while also reforming or reinvigorating others. Core to the operation of the model is the use of a particular skill set, a structured form of case supervision, observation, file auditing and an overall assessment of workload. In addition, working in an outcome-orientated manner, with a clear but evolving family plan to work from, is central to the model. In introducing this new way of working to practice, recognition of a reduction in caseload is implied, given the additional intensity required in family work and increased paperwork associated with it (e.g. revisions to family plans).

Staff reported many challenges initially in adopting the Mol an Óige model as a way of working. In particular, many staff reported the significant challenge in taking on new model skills and applying them with fidelity, and more generally in familiarising themselves with the model in an overall sense. As highlighted in the interim report, the variation in time spent undertaking different types of work (face-to-face contact, administration, travel, telephone, out of hours and professional contact) was marked, and appeared very much dependent on the nature of the case itself: the level of need, the stage of the case, and the geographical location of the case. It is clear that this structured model required more focused engagement with a smaller number of families, but also required more paperwork and additional duties at particular times. Others spoke of the challenge of observation initially, the accompanying feedback which followed and potential affront this was to their then practice and experience. Associated with this, the nature of supervision being purely based on cases was highlighted by some as an initial and ongoing challenge. In addition to this, particular organisational characteristics, such as whether a worker was practicing exclusively in a Mol an Óige way or had additional different workloads, and individual pressures, all made taking on this model challenging.

Despite these challenges, a number of positives emerge in the findings. For the vast majority, it fits with national policy frameworks, in particular a family support perspective, in that the work is led by the families' issues as well as incorporating referrer concerns, plans are developed around these to achieve particular goals and is implemented in a strengths-based

and flexible manner. However, it is also recognised that it is effective in ensuring child protection concerns are detected and acted upon when required. Some workers recognised its potential to contribute to a broader prevention and early intervention approach.

It is clear from both the interview and survey baseline and follow up findings from staff that in a general sense they are very positive about this way of working. Survey findings highlight that staff competencies relating to particular Mol an Óige skills and the overall approach increased since they began operating the model. This is not that surprising, but when these are combined with interview findings they do indicate that many staff feel comfortable and experienced in operating the model. Indeed, for many staff, they simply report it as being their way of working rather than a new way of working; in short, it has become innate to their practice. This is not to say that it is not without its perceived problems or gaps, for example some staff not having a case in some time. However, from a practice point of view, it has not encroached on their sense of autonomy, nor has it prevented additional skills being incorporated into their work. The citing of attachment as the most prevalent theory drawn on for day to day practice in the survey, as well as the use of additional knowledge and expertise supports reinforces this point. More generally, staff feel that in the main Mol an Óige is more a framework, a way of working, rather than a prescriptive model. It permits them to be creative, within an overall framework or structure which works for them.

Related to this is the increased perception of capacity to work for families. Given the statistically significant increase in capacity scores in the survey data, this further emphasises the sense of agency which workers currently feel in working in an environment which permits them to support families in a particularly way. This is corroborated by staff's reported increase in their perception of have a lasting impact and seeing evidence for their work and a slight increase in their overall perceptions of the organisation in which they work. Staff are clear that particular elements of the approach, such as the family plan, provides great definition to family work and serves to further improve the relationships with families with which they are working. The importance of good relationships was also commented on by families, as was the willingness of staff to challenge them about particular things. This sense of working together with families is viewed positively by staff.

More specifically, staff are clear about the benefits which the Mol an Óige way of working provides to their practice. Regarding *supervision*, while there was initial concern amongst some about the proposed nature of it, staff view it now as a core support to their work, as an opportunity to joint problem solve, and in the main, as a reassurance to their work and their practice approach. This is borne out in the staff surveys, where improvements in attitudes to supervision greatly increased after experience of working the model. In particular, that overall supervision scores saw a statistically significant increase is very important. Compared to the

baseline responses, Staff are more positively predisposed to supervision as a supportive process than prior to implementing Mol an Óige. Related to this is the observations and file audit processes which are part of the supervision package. They are viewed as constructive to practice, and contributing, along with supervision, to improved working. While attention should be paid to comments that supervision does not become solely a case process -driven exercise, is clear that this overall supervisory element of the model is valued greatly by staff.

While staff view supervision as a resource, they also draw on a number of resources in implementing their work. Colleagues are key supports in delivering the model. They provide an opportunity to share knowledge, discuss particular practice issues with the model, and contribute to a worker's overall practice experience of the model. For those who are not coterminous, or located in the same building as colleagues, the absence of this resource is felt. In addition, more experienced staff were viewed as a positive support by staff less experienced in the model. The role of dedicated psychology personnel for some services is a strong, beneficial feature of the operation of the model, and a vital, problem-solving support to staff who have access to it. A range of other supports, particularly other professionals and services, are accessed by the workers. The data reveals, however, that staff are concerned about potential cuts in mileage allowances which may hamper their ability to work with families in the future.

There is much to be learned for practice from Mol an Óige. It is important to acknowledge that the work processes and structures required are intensive for all involved: family, worker and supervisor. There is a transaction cost involved in developing practice through Mol an Óige, but this is not unusual when adopting and implementing any new approach. However, the sense of structure given to family support work by Mol an Óige is prominent. This outcome-orientated approach, linked to a family plan which is agreed with families as the focus of the work is a key element; it gives clarity, a process, a beginning, middle and end. Intervention work is documented clearly and quickly; progress, or lack of, is readily identifiable, and occurs within an organisational boundary of structured supervision, observation and file audit which are supportive. More importantly perhaps, is the sense of accountability (for the service and the family) and transparency which the model offers. Its strength for practice is most plainly seen in staff views on it: for those who have experience of working pre Mol an Óige, either in their service or in a previous iteration thereof, it has become a preferred way of working when they compare it to their previous experience. For those who are not currently or exclusively doing a Mol an Óige case, that they incorporate elements of the approach into their other practice – such as the plan and/or the outcome-orientated work - is testament to its value to practice. However there are current staff needs. For those whose skills have lapsed, retraining may be required, while ongoing training and development was the highest ranked support for practice

in the survey findings. The opportunity for workers to come together to share experiences would also be useful in reducing isolation felt by some and support practice.

At a policy level, there is also much to gleaned from the Mol an Óige experience. The arena of children and family policies and services in Ireland has witnessed significant change in the last decade. The introduction of the *Agenda for Children's Services* in 2007 highlighted the importance of outcome-focussed work, and the role it can play in enhancing the wellbeing of families. Broader developments in child and family services have also occurred, with new programmes and approaches currently being implemented and evaluated across the country. Such developments are both in response to national drivers – like the Department of Children and Youth Affairs' Prevention and Early Implementation Programme with Atlantic Philanthropies, or the HSE's trialling of different approaches to child protection, such as the Differential Response Model – and as a result of local policy-service entrepreneurship, such as the implementation of various parent and family support initiatives like Triple P in Longford/Westmeath and the Incredible Early Years in Galway City. Together, such developments aim to contribute to a greater understanding of how services work, and seek to improve the experiences of families who use them. All this is, of course, occurring against the backdrop of the forthcoming establishment of the Child and Family Support Agency in January 2013.

In this regard, Mol an Óige firmly contributes to the changing landscape. Its emphasis on working in an outcomes-focused way fits neatly with policy's emphasis on achieving good outcomes for children, as outlined in *The Agenda*, but also more recently in the Health Information and Quality Authority's (HIQA) (2012) *National Standards for the Protection and Welfare of Children.* The evidence compiled in this report highlights Mol an Óige's ability to protect, promote and support the welfare of children and families 'at-risk' in the community, as well as children who are in the care of the State. It aims to, and does, include the voices of parents and young people in decision-making about them throughout the process of engagement. Child protection, welfare and safety are core principles underpinning its operation. It emphasises leadership, management and accountability of services through its structures, especially its supervisory elements – case supervision, observation of practice and file auditing - and brings service supervisors into direct contact with families on an ongoing basis. It seeks to harness the resources of the family, agency and community to best meet the individual needs of children and parents. These are important themes and principles which underpin work in the Children and Family Domain in Ireland now, and into the future. Thus, local management in both counties should consider disseminating their experience of Mol an Óige to a wider audience and seek to contribute their important knowledge about the programme, and its effects, to ongoing debates about child and family services in Ireland.

8.4. Implementing Mol an Óige at Three Levels

In analysing the implementation of any new programme or intervention, a number of influences operating at different levels need to be considered (Fixen et al, 2005). At the core, issues of training and coaching, and performance measurement are important determinants of successful implementation. At the internal organisational level, resources and system supports are deemed essential to facilitate core implementation requirements to occur. Finally, at the level of external influence, social, political and economic factors at local and national levels play various and simultaneous roles in both enabling and impeding programme implementation efforts.

In-Home Family Preservation services implemented by Boys Town USA operate in a different geographic and service context to that of Mayo and Roscommon. While also implemented in community settings, in many Boys Town sites, Family Workers, or 'consultants', are available on a 24 hour basis to families, work in the main within a local context better described as a treatment town with all required services available, and are located on a continuum of services which is more extensive than that available to services here. This situation differs markedly from the implementation context for Mol an Óige in Mayo and Roscommon. Adopting Mol an Óige in these counties was a challenging process. It required workers to practice in a different way; it required supervisors to undertake very specific tasks; it required management to support the process through leadership, resourcing and participation. In short, it aimed to significantly alter the way services operated and delivered for *and with* children and families. Despite such challenges, however, Mol an Óige was adapted and implemented in a range of services, with increasing fidelity in most cases, indicating at one level that the transferring of this approach to an Irish context did not pose a problem for services. At another level, it also indicated the importance of particular influences operating at different levels.

8.4.1. Core Level

At the core level, training and support was provided by Boys Town USA throughout the period 2007-2010. This involved five different site visits to Ireland, as well as the provision of email and telephone support in certain cases. Staff perspectives on the training approach adopted in the initial phase were generally negative. It was reported to be too fast, too focussed on skills and not enough on the process of applying the model. Further training in 2010 was reported to have lacked clarity about its purpose, particularly in relation to changes to the family plan and assessment forms. However, as staff data reveals, this situation was compensated for by staff working through the model in their own way, adapting, learning on the job, and through support accessed via more experienced colleagues and particular individuals within delivery organisations skilled up to training level, which was deemed to be extremely valuable. Additional case support accessed from Boys Town was also deemed to have played an

important role for some staff. Performance and fidelity feedback provided from observations and in supervision to staff was also deemed to have been a core support.

At the internal organisation level, the referral process is a core system process for the operation of the model. Referrals to Mol an Óige-operating services come through a number of conduits. Some services' referrals come through social work only, while others come via both professional and self-referral. Some services report working mainly at levels two and three on the Hardiker scale; for others, they clearly work at levels three and four. While some have specific referral criteria, others have more general referral forms. Some services coordinate the referral process between them, while others manage referrals individually but meet to monitor numbers going through the model overall.

8.4.2. Organisational Level

At the organisational level, it is clear that a conscious effort was made to provide as many resources as possible to staff. Many staff recounted the willingness of the organisation to purchase specific programme resources to support implementation, as well as access to financial resources through their services to meet the additional needs of families. Staff also accessed non programme resources and other supports through their own previous experience, their organisation and drew on the experience again of colleagues in working through particular situations, cases and contexts. Notably, there appeared to be involvement of senior management within the organisation at various levels of implementation. While many staff highlighted the central leadership role played by senior managers in the organisation in bringing Mol an Óige to their service, some also highlighted the willingness of these managers to undertake observations and provide feedback to staff. That they were familiar with the model and indeed with many families progressing through it was viewed by staff as strength of the implementation process.

8.4.2.1. Fidelity

When examining fidelity, a variety of issues are relevant, such as adherence to content, coverage, frequency and duration of the programme, and the role of mediating factors such as the complexity of the intervention, support strategies put in place (resources, feedback loops), the quality of delivery, and family responsiveness. The interaction between these mediating factors is also important (Carroll et al, 2007). However, assessing fidelity to Mol an Óige is not as straightforward as this list might suggest. The very nature of some cases - much like the assessment forms discussion above – precluded some elements of the Mol an Óige skill set being used. It is not a prescriptive, manualised, dose-based intervention like other programmes. Rather, it is a behavioural-based approach to working with families. While the skill set may be the same, the use of such skills is highly differentiated between families.

As staff indicated in their interviews, working with some families required the use of many skills, while with others only a few were needed. In some cases the level of need was greater than others, with some families being open to many visits a week, while others were not. Some staff reported working directly with families several times a week, while for others it was a once-a-week occurrence. As highlighted in the file data chapter, some families began the intervention, then disengaged, while others disengaged almost immediately or simply refused to engage. Some staff indicated that in the early days, Mol an Óige was attempted with very difficult cases, families who were not receptive at all to any service at that point, and the failure of this dented optimism about the approach. Family responsiveness is clearly a mediating factor, but so is the limit to the amount of resources available. As highlighted previously, this is a programme being delivered in a different service context.

Fidelity reports in themselves are organisational system supports to ensure implementation. Notwithstanding the challenges outlined above to monitoring total fidelity, the reports analysed by Boys Town and forwarded to the services over 2007-2009 tell us much about fidelity to skills and particular aspects of the approach. Aspects core to the model, such as teaching components and relationship building, displayed steady progress towards effective implementation by 2009 and progressed steadily upwards throughout 2010, in so far as these can be tracked through the new fidelity measures. Similarly with Relationship Building/Relationship and Engagement, scores progressed through 2009 to effective implementation, and to consistent and effective implementation in 2010. These, along with scores for safety and the provision of concrete support, indicate that fidelity - where measured – was broadly adhered to. If the new, post 2010 skills-based fidelity reports are taken on their own, overall scores are maintained at the consistent and effective implementation level (i.e. average rating of four out of five).

In an overall sense then, fidelity to the core aspects of the approach was achieved. It is notable though, that the numbers of fidelity reports submitted across both counties fell by 79% in 2010, to 16 reports in total. This figure rose slightly to 20 in 2011. While there was some uncertainty about the continuing requirement to submit fidelity reports to Boys Town, services should consider maintaining fidelity monitoring as a practice support, particularly if some staff are to be re-skilled. Furthermore, developing an opportunity for staff of different experiences to come together intermittently in a community of practice and share experiences of programme implementation would serve to reinforce fidelity and foster collaboration.

The fidelity reports also raise another implementation issue: organisational capacity. Capacity to deliver all aspects of the model is central to its implementation. While a willingness to reduce caseloads is an appreciation of the more intensive work involved, some workers were required to maintain other aspects of their work, and some were willing to maintain those

other aspects. This did not prevent Mol an Óige from being operated in both counties. However, the implementation of Mol an Óige placed a greater emphasis on supervisors regularly going into homes with workers to observe, monitor fidelity and provide feedback to the worker in a timely fashion. There is clearly a resource implication for such a role. While some supervisors did have the capacity to do this on a consistent basis, others did not. Organisational upheaval, additional and different workloads and increasing pressures on supervisors and some staff placed a strain on the operation of the model, and the capacity of staff to implement it and observe it. There is little doubt that the implementation of the model suffered as a result.

8.4.3. External Level

At the external level, the extent of implementation was affected by a series of political, economic and socio-cultural factors which all impacted on the previous two levels, and still have the potential to do so. There is a strong emphasis on religion in the original Boys Town programme. However, such an emphasis was removed from the Irish version, and therefore not implemented. Furthermore, while staff commented on the American style phrases and interaction style, they reported adapting programme elements to an Irish audience. Also, the sense that this was a model associated with particular individuals at particular times was commented on by some staff operating the model as being key to its introduction and early implementation. While there were some reservations expressed about its potential to be the only approach to be used, the majority who did comment on this aspect of the model's initial phase cited it as a passing concern. However, the loss of leadership in both counties through the implementation phase, with one child care manager retiring and another going on long-term sick leave, as well as the proposed organisational move to a new agency, has created doubt amongst staff about the future of the model. While they perceive it strongly to add value to their practice, the organisational uncertainty has the potential to create a vacuum regarding its future use. At a delivery level, staff are also fearful of proposed reductions or capping of mileages allowances which may prevent them from doing the amount and extent of work required. The potential for external level factors to impact on the future of the model still exists and require clarification.

8.5. Working Ecologically: Linking with Other Organisations

Mol an Óige aims to work across the five domains of individual, family, school, peer and community, through linking with other organisations and professionals involved with families or those best placed to meet their additional needs. While working collaboratively was not new to Child and Family Services, the operation of the model required it to be central to meeting families' needs.

Staff were in the main positive about their perceptions of connecting with the various domains outlined above. Survey data highlights that their perceived ability to connect with family members, schools and other organisations have increased or greatly increased. However, they are less certain in both interview and survey data about their ability to work for change in the peer domain. This picture is also borne out in family data, as highlighted above.

More generally, staff were very positive about their experience of working with other organisations and reported that this was on a needs basis. However, there is a strong sense in the data that the operation of the model has caused greater cohesion between professionals. When baseline and follow up survey data amongst staff is analysed, a stronger picture of interagency working emerges post use of the model. While there were small declines in some interagency-related questions between baseline and follow up, in an overall sense there was a statistically significant increase in staff perceptions about interagency working. Positive changes in attitudes towards being part of a multidisciplinary team, perception of respect from other professionals and a reduction in the amount of unpleasant experiences with other agencies were all statistically significant. While not possible to interpret this as being exclusively down to the operation of the model, it is clear from this and interview data that the model is having a positive effect on fostering connections with other agencies.

When data from other professionals is considered, it is clear that while many are explicitly aware of the model or its tendencies – such as working from a strengths-based perspective – others are not. There was some evidence to suggest that these professionals worked with Mol an Óige staff closely to reinforce common messages to particular families, but in the main there is little evidence of them taking this on as an approach. The main reasons given across the data for this is that these professionals already work from a similar perspective, or that they are busy in their own work spheres. However, for those professionals who have worked with Mol an Óige staff, they are very positive about the impact it has had on their service users. Creating a greater awareness about Mol an Óige amongst other professionals in the locality should be considered as part of a wider dissemination strategy.

8.6. Overall Evaluative Judgement and Recommendations

From the discussion set out in this Chapter, a number of points can be made about Mol an Óige

1. It is clear from the range of data presented in the preceding chapters that as an approach Mol an Óige shows significant promise for families in overcoming their difficulties in a strengths-based, capacity building manner. However, given the limitations of the data, further research is required, incorporating rigorous pre and post assessment measures and complete file analysis for all cases as central parts of a quasi-experimental research approach.

2. Mol an Óige offers strong potential as a framework to structure work with children and families with various levels of need in a focused, goal-orientated manner which can be time-limited. It provides a mechanism to contribute to an accountable, transparent, structured service which works for staff and families while creating the space for creative practice to flourish.

3. Mol an Óige plays a prominent role in increasing interagency working between professionals and creates a positive perception amongst other professionals of those operating it. While other professionals may not be taking on all the skills of Mol an Óige, they are certain about its impact on service users and the way in which Mol an Óige staff work. That these other professionals are working with children and families in a variety of different settings – schools, social work services, psychology, and nursing – underscores it potential to bring professionals together in working for children and families.

The following are recommendations for services in Mayo and Roscommon to consider in operating Mol an Óige in the future:

1. In light of the information presented here, Mol an Óige shows significant promise for achieving outcomes in families. It is recommended that the intervention continue to be offered by services to those families who wish to engage, and in light of further recommendations below. However, the development nad implementation of a full quasi-experimental research plan to assess outcomes for Mol an Óige families is recommended.

2. While some families' resilience increases after the intervention, others may require additional support. While programmes like Common Sense Parenting may be a suitable route for some, groups do not suit all, and may not be necessary. Services should examine the requirements of cases for providing less intense, semi-formal support after Mol an Óige has concluded.

3. Services should re-examine the referral criteria for Mol an Óige and assess whether it is being pitched at too high a level of need in certain cases. Further to this, where it does not exist, services should move to a joint referral process. Structures already exist for this to readily occur. It would foster further sharing, collaboration and dissemination of knowledge about model experience. It would also serve to formally identify the small number of families which re-enter Mol an Óige via different services. While current data sharing restrictions may complicate this process, these should be addressed.

4. Services should engage in assessing for outcomes. Assessments are undertaken for case development, but it is also important that post-intervention assessments are undertaken for outcome impact. There is plenty of experience of using a variety of assessment tools in services. Such experience should be utilised. Some services have begun undertaking six month follow up assessments. All services should replicate this approach. Management and services should examine the appropriate *outcome* measures to be used in each case – SDQ, PCRI or AWB, or a combination of these.

5. Information is critical to the workings of any service. Each service should examine its own past caseload to identify further factors not available to the research team in explaining why families refuse to engage or disengage.

6. It has been clear to the evaluation team that while some services have access to their service data quite readily, others do not. Services should develop a process of gathering case data for their own use in a timely and systematic manner, particularly as cases close. This could be modelled on templates developed for the evaluation, with some expansion. This data should be kept by each supervisor or service manager and analysed regularly.

7. It is clear from staff data that Mol an Óige works for practice. It is recommended that such an approach to practice continue. However, services should explore the need for refresher training or other skills development options. Where they do not exist and where possible, services should explore the possibility of having dedicated Mol an Óige workers. Where this is not possible, dedicated Mol an Óige case work time should be set aside.

8. Critical to the full operation of the model for practice is the capacity to provide observation and supervision. These are core aspects of the model, and require resourcing.

9. Services should examine the possibility of creating a Community of Practice for those operating Mol an Óige. Such a community could serve to underscore fidelity, create a joint problem solving arena, and provide an opportunity for staff to meet. Establishing such a structure within each county initially should be considered.

10. Where it does not exist, management should explore the potential for dedicated psychological support to be made available to Mol an Óige staff on a clinic basis. Where this has existed, it has been a clear support.

11. Services should maintain fidelity reports. They serve as a useful tool to structure observation, are part of the infrastructure of staff support and contribute to the delivery of the model.

12. Services should engage Boys Town to discuss the possibility of having fidelity report analysis continue into the future, or about sharing their method of analysis with services in Mayo and Roscommon for in-house analysis into the future.

13. In the interests of refreshing fidelity to the model, services should explore the possibility of sharing a small amount of staff observations, if capacity and management lines permit.

14. Services should seek to disseminate knowledge about their activities in the community about what they do, and in the policy and practice world about how they do it and what it achieves.

15. While not a focus of the evaluation, it is clear Common Sense Parenting plays a role in supporting parents in both counties. Services should consider evaluating this programme.

APPENDIX A: PROGRAMME DESCRIPTION OF THE BOYS TOWN MODEL[6]

Introduction

This section of the report provides an overview of the Boys Town approach to family support. It highlights the range of services which the organisation provides along its continuum of care before proceeding to outline the specific characteristics of family preservation model as laid out in a variety of Boys Town literature. In particular, it emphasises the various aspects of the model as applied in Ireland and discusses the role of supervision in the process. It concludes with an update of the family service plan process as outlined by Boys Town staff in February 2010.

Background to the Boys Town Models

The Boys Town Family-based Services Programme is a teaching model of family support, developed by the USA-based child-care organisation Boys Town. The organisation has its origins in the Boys Home started by Fr. Flanagan. Since then much work and research has been invested in developing scientifically sound, yet practical and workable models, which involve family consultants (teachers) working with youth at risk and their families to teach skills, help build relationships and empowering young people to gain self discipline and control.

Family-style, community-based programmes are often utilised. In these settings married couples called Family-Teachers are the primary treatment agents, along with a full-time Assistant Family-Teacher. Family-Teachers are responsible for structured supervision of youth in daily living and treatment activities. The couple and their assistant work on both treatment and skill building in the home, and with community and family resources in the child's life. A major focus of this programme is teaching older youth functional skills that can help them achieve success in school, their families, and work settings.

Similarly, In-Home Family Services provides youth and families care through two programmes: 1) a short-term, six- to eight-week, intensive programme designed to prevent imminent out-of-home placement and keep families together and 2) a three- to six-month early intervention programme designed to teach new skills and reduce out-of-home placement. The main goals of these programmes are to build family strengths, help the family become self-sufficient, and reduce out-of-home placement of children and adolescents. These programmes are for families who need supportive services to address high-risk situations and to prevent early issues from becoming a crisis. Family assistance includes focusing on the child's behaviour and improving parenting and family problem-solving skills, as well as linking families to needed family services.

In the Treatment Foster Parents programme, parents care for youth of all ages who need more attention and treatment than is provided in a traditional foster care placement. Boys Town recruits, trains, and

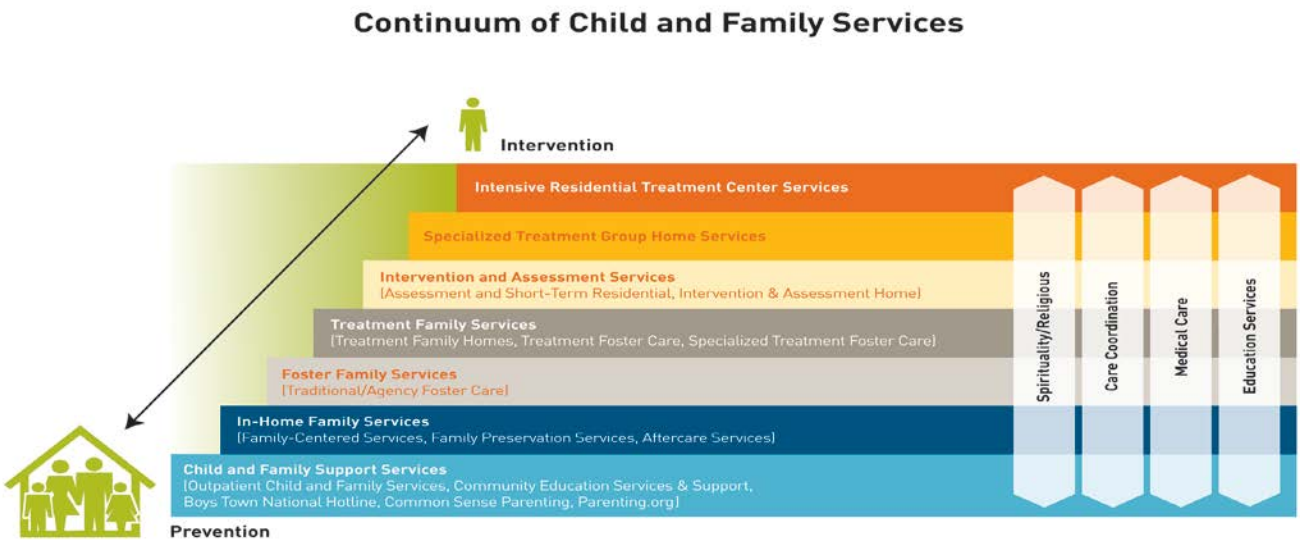
[6] The information contained in this report and references are largely drawn from Boys Town publications Davis and Daly, 2003; Father Flanagan's Boys Home (2007), Father Flanagan's Boys Home (2008) and Ingram and Vogel (2009). This section is reproduced from the Interim Evaluation Report (2010).

supervises Treatment Foster Parents, enabling them to care for youth with special needs in their private homes. A major focus of this programme is teaching older youth functional skills – often referred to as independent-living skills – that can help them achieve success in school, their families, and work settings. Treatment Foster Parents receive 24-hour, on-call support and treatment advice from Boys Town professionals.

The Boys Town programme also takes other forms and can include other elements depending on client needs and conditions. For example, the Intensive Residential Treatment Centre is a residential programme specifically designed to offer medically directed care for more seriously troubled youth who require supervision, safety, and therapy but do not require inpatient psychiatric care. Included are round-the-clock supervision, locked/secure facilities, and numerous other safety and programme features. Typically, youth admitted in this setting are unable to function in normal family or community settings. For many of these high-risk youth, placements in less restrictive treatment settings have repeatedly failed and reunification with the family holds little promise without a stabilising intervention.

Similarly, Boys Town Specialised Treatment Group Homes provide effective treatment within a family oriented environment for youth with psychiatric disorders. The programme offers support, care, and round-the-clock supervision to enable youth to progress in daily living skills and appropriate healthy socialisation. These youth are unable to function in normal family or community settings. The goal of the programme is to help children and adolescents successfully transition to a less-restrictive level of care. This programme offers assessment and short-term emergency care in a caring and nurturing environment for girls and boys who are typically ages 10 to 18. Many youth who are served through this programme are abused, neglected, runaway youth, or have been in trouble due to criminal or delinquent activities (adjudicated). Referrals come from a variety of sources, including state agencies, juvenile courts, and private sources. This programme provides mediation and counselling to strengthen families and emphasises family reunification, if it is in the best interest of the youth. During their stay, youth participate in individual treatment planning to help them deal with their problems. Facilities where the programme is offered may be described as staff-secure detention centres, emergency shelters, or short-term residential centres.

An overview of the Boys Town practice setting can be seen in the graph below:



The Ecological Family Based Services Programme provides in-home support for multi-risk and multi-crisis families, using an approach with an emphasis on teaching and often involving intensive in-home support. Its approach is derived from several different theories, including the Multi-systemic Treatment Model, cognitive behavioural approach and the Environmental Ecological Model. The Multi-systemic Treatment Model incorporates the work of Bronfenbrenner (1979) and was developed by Henggeler (1998) and his colleagues in addressing the needs of serious juvenile offenders. It views individuals as nested within a complex network of inter-connected systems involving family, peer, school and community. The model also draws on behavioural approaches and the assumption is that behaviours are learned. Behaviours that are problematic or no longer functional can therefore by unlearned and new, more functional behaviours can be learned in their place. Finally ecology plays an important role in a young person's development and family is only one part of its ecology, with environmental influences also coming from a variety of people, places and activities. These other domains also contribute to the family's means of handing problems, rearing children and interacting with resources.

Family consultants play a key role as teachers, coaches, and partners and can act as catalysts in the process of change. The consultant often helps to "teach" new behaviours and to build functional life skills. This involves constantly assessing the family's identified needs, strengths and agendas. The teaching element involves teaching parents or other adults new behaviours and skills, teaching children skills and behaviours and teaching adults how to teach the children in their care. Whilst there is an emphasis on teaching, the families and consultants are partners in the process and the consultant also needs to build up a trusting and caring relationship with family members. The role is often intense and the model recommends being on call at all times and providing very intensive support when required.

The Ecological Family Based Services Programme and its Ecological Approach

The ecological approach used in the Family Based Services Programme emphasise the "head" (teaching to change for the better) and the "heart" (building positive relationships). The roots of the model stem from behavioural models related to learning and prescriptive teaching. The emphasis however is on building skills that can then be "generalised" in a range of settings. Some of the key elements of the model include:

1. *Teaching skills*: This helps people learn new ways of thinking, feeling and interaction. Much emphasis is placed on motivation and helping people to motivate themselves internally.
2. *Building healthy relationships*: The staff members in the programme interact with warmth and compassion and families are encouraged to build positive healthy relationships.
3. *Supporting moral and spiritual development*: The model has spiritual underpinnings and families are encouraged to develop their spiritual lives. Emphasis is also placed on character building and good citizenship.
4. *Creating a positive family style environment:* The family unit is viewed as the best context for the positive and healthy development of children. When children experience difficulties, the programme teaches the family the skills needed to correct them.

5. *Promoting self-government and self-determination*: The programme emphasises individual and group self-determination, leadership and responsibility.

The ecological approach of the model views children and their families in a wider environmental context, with family, friends, neighbours, acquaintances and society making up a complex web of relationships that are the person's ecology. Munger (1988) coined the term "environmental ecology" to define a treatment process that tries to understand the relationships between environmental factors as they influence the child and his/her family. Children can therefore only be fully understood in the context of their ecosystem. The family consultant also tries to understand and bring about changes in problem behaviours through understanding its function within the larger ecology. Unlike traditional mental health treatment, the ecological approach contends that most child problems do not reflect internal medical, neurological or educational causes. Rather it assumes a disturbance in the ecosystem of the child. A key assumption of the model is also "you can act your way into a new way of thinking much easier than you can think your way into a new way of acting". Using the teaching approach, new behaviour is modelled and practised rather than first seeking to change the way of thinking.

Family consultants are also expected to have a good understanding of the process of normal child development. Difficulties are often viewed as a result of interaction with elements of their ecosystem that have influenced the trajectory of development to a point that it occurs outside of the normal pathway. Linked to this is the assumption that human beings are surrounded by a natural therapy system. Family consultants look for and help to build strengths as part of this system, such as the ability to bounce back or to learn new skills. Returning a youth to a more functional developmental pathway often requires making changes in the way they interact with their environment.

The programme is designed for use with families in situations such as:

- When a child or family member is experiencing serious difficulties that puts the child at risk of being placed outside the family.
- When difficulties with the child/family have already resulted in outside placement.
- When an intervention can prevent serious problems from occurring with a child.

In each of these cases a family consultant is assigned to the family who provides support in-home and in the community. This support is often intense and may be for up to 20 hours per week for a limited time. In conjunction with the families, treatment priorities are assessed and a *Service Plan* is drawn up. Consultants examine the various domains in the child or family's life to determine the best treatment approach. The structure of the intervention is divided into stages, with interventions in the various domains sometimes at different stages. The consultant ideally helps the family to move from being open to learning new skills and changing behaviours, to using new skills and behaviours to finally choosing to use new skills and appropriate behaviours on their own.

Assessing Families and Identifying Risk and Protective Factors

One of the first processes a family consultant undertakes is assessing multiple areas of the family and its ecology, before implementing treatment. Consultants are expected to develop a hypothesis statement on what is most likely maintaining a problem or a problem behaviour. The ecological assessment approach then has three main characteristics, which are:

1) Determining the referral problems and the functions they serve
2) Exploring the ecology to identify liabilities and assets and
3) Ensuring that assessment is ongoing and has a reciprocal effect on the entire intervention.

In order to understand the factors within the ecosystem influencing the problem, these can be classified under the five domains of the individual, family, peer, school and neighbourhood/community. The manual provides an assessment template called the Initial Family Assessment Guide, with guidelines questions for each of the domains. Some basic principles guide the assessment process, such as:

- Problems are multifaceted, with multiples causes and solutions
- Interventions must be developmentally and culturally relevant to the family
- Assessment is an on-going process and is reciprocal with intervention
- Assessment is an interactive process with all five domains, with the family providing much expertise and information
- The focus of the assessment is on helping the family members to stay together and meet their needs within their ecology.

The ***Initial Assessment Guide*** continues to be used throughout the intervention, with each potential liability being explored to determine whether it needs to be assessed during treatment.

Much research has focused on determining what causes youth to develop or not develop anti-social behaviour. ***Risk factors*** have been defined as influences that increase the probability of onset, digression or maintenance of a problem condition (Coie et al., 1993). They can be expressed as probabilities, meaning that children exposed to risk factors are more likely to experience negative outcomes. On the other hand ***protective factors*** are the positive forces that help people adapt positively and resist risk. Risk and protective factors can occur at the same time across different domains and systems of the child. The training manual identifies 20 specific research-based risk factors for adolescent problem behaviours across the five domains. It is noted however that children and their families can be resilient, even in the face of insurmountable negative forces. This resiliency often offers families hope and motivation to change for the better.

In assessing and designing an intervention with a family, it is important for the consultant to assess a child's risk and protective factors and determine the impact interventions and treatment strategies have on each domain. The ecological perspective implies that the consultant should assess the environment of the family and find a probable cause or correlate for the behaviours that have led to referral on the programme.

Supporting Physical, Emotional and Spiritual Development and Learning

Much of the work done within the programme involves working with families and identifying problem behaviours and their causes and replacing them with more appropriate skills and behaviours. In order to do so, it is essential that consultants are familiar with the processes of child development and to understand when behaviour may be inappropriate. The manual provides a brief guide to the various areas of child development, including physical, motor, cognitive and social/emotional development. Whilst the family consultants are not expected to be experts in child development, it can be useful to understand whether children are meeting their expected milestones and to know when to refer to other services when appropriate. Having an understanding of child development also assists consultants in developing effective service plans for the family they are working with.

Spirituality is also viewed as an important element of treatment in the Boys Town programme. Whilst the origins of the programme come from a Christian background, people of all faiths are encouraged to develop their faith and to examine the spiritual dimension of their lives.

As the model is essentially a teaching model, understanding how families learn and acquire new skills is very important. There is an overarching assumption built into any treatment that children and adults have the capacity to learn and generalise new behaviours and skills. The programme uses a ***behaviourally based treatment approach*** as opposed to a traditional behaviour modification programme. This means that families are full partners in the process and they help consultants to develop treatment goals and behavioural objectives. A number of assumptions are built into this approach, namely:

- Behaviour is learned and new behaviours can be taught.
- Insight is helpful but not necessary to change behaviour. It is believed that families can learn new behaviours if there is support from their environment and with the application of reasonable, often natural consequences.
- Incentives to change behaviour must be individualised. Each person has unique “reinforcers” or “punishers” that will help him or her to change behaviours.
-

The programme also sees behaviour as occurring within a context of internal and external events. Behaviour often occurs in order to have an effect on one’s surroundings. Behaviour is seen as bi-directional i.e. it has an effect on the social environment and the environment is simultaneously affecting the individual. This process is divided into components of Antecedents, Behaviours and Consequences or the ABC contingency.

An ***antecedent*** is the condition or situation that exists before behaviour occurs. It can be the cue that a particular behaviour is appropriate. Consultants are expected to assess what are the antecedents to certain behaviours occurring, such as who was present, what time of day, what activities were occurring and where it took place. Understanding the history of the family can also help to determine what learning has occurred in the past. Patterns of behaviour occurring after or during certain events may be determined.

Behaviour is anything a person does or says that can be directly or indirectly observed. The programme is often based on observing behaviour or asking others (e.g. parents, teachers etc.) to observe and describe behaviour accurately. Consultants are expected to do so, avoiding judgements and interpretations that are vague.

Consequences are the events that occur following an individual's behaviour and they can be either positive or negative. Reinforcing events usually increase the chances that the same behaviour will occur again in the future and non-reinforcing or punishing events decrease the likelihood that it will occur again. Consequences can be natural, logical or artificial. Natural ones occur without planned intervention e.g. getting a bruise from falling off a bicycle. Logical ones result from intentional intervention, but often use naturally occurring stimuli e.g. extra play time for doing the dishes. Behavioural treatment programmes often also use artificial consequences, which may start as neutral items but acquire the power of reinforcement because they can be exchanged for already established enforcers. They often use a system of points, tokens, stickers etc. The advantages of using them include their ready availability at any time, that they provide immediate feedback and that they can be used in proportion to the skill being learnt.

Methods for encouraging Positive Changes in Families

One of the first elements in working with and helping families to bring about positive change in their lives is to develop a relationship with them. Each family is unique and has its own attitudes, values, beliefs, traditions and behaviours. These differences may be influenced by factors such as culture, ethnicity, geography, race, upbringing, nationality and religion. Such differences need to be understood, acknowledged and respected by consultants. Consultants are expected to be culturally competent, the first step of which may be to examine one's own traditions, values and beliefs and realise that it is only one way, Consultants should try to work within a family's preferences and tailor interventions to fit the family's values. Respecting the family differences can help them to be more at ease with the consultant. Where possible the family's agenda should be followed and focus should first be put on what the family wants to change, except in situations where child safety may be an issue. A successful consultant should also be able to combine the families goals, his/her own and those of the referral agency.

Some principles used in building effective relationships with families include showing support and being empathetic, building on strengths and using praise, providing concrete services such as helping with practical tasks, using the family's particular way of talking or "lingo", knowing when to use self-disclosure and seeing the positive side and reframing negative situations. Consultants should also have a good level of self-awareness and an understanding of the effect of their own verbal and non-verbal behaviour on the family.

Since interventions are not just limited to the family domain, the consultant may also be expected to forge relationships with and co-operate with other actors in the family's ecology. These include:

- ***Children's peer networks***: For children and especially adolescents peers often become the central focus of their social development. A consultant may need to gain a better understanding on the

effect of a peer network on a young person and where appropriate the consultant may meet with the peer group or become involved with the child's peer activities by playing games etc.

- ***Building relationships with schools***: Families can find it difficult to build a relationship with the school system and sometimes schools complain that it is difficult to build a relationship with the family. Consultants may be expected to work with the school and particularly to help families and schools to build effective relationships with each other, which ultimately can lead to much improved outcomes for the child.
- ***Assessing resources and networking in the community***: Outside resources are crucial for the family and no family can operate in complete isolation. It is important for the consultant and the family to gain a good understanding of all the resources available in the wider community and mapping is often used as a tool to map the neighbourhood resources available. Community resources are both formal and informal and both need to be understood. Consultants help families to network within their communities through a process of Assessment, Assistance and Advocacy (the *Triple A Process*).

Teaching Tools and how to use them

Teaching is the primary therapeutic tool used in the treatment of families in Boys Town programmes. Its success can become evident when family members can consistently use appropriate behaviours as they assume more control over their own lives. Teaching comes both from the "head" and the "heart" i.e. with an emphasis on developing competence and the compassion and caring connection between the consultant and the family. Therefore both teaching and relationship building skills are required. Teaching can occur with various family members and in a range of situations. It should be individualised to fit each person's needs (e.g. adult/child/adolescent). A number of specific teaching techniques have been developed as part of the programme and they are briefly outlined below:

1) ***Active listening***: In order to listen effectively a consultant should accept the family members and their perceptions and create an atmosphere of openness and allowing family members to express themselves.

2) ***Exploration***: Exploration goes further than active listening and is used to gather and assess information about a family and its ecology. Issues that might be explored include the family's own agenda, the referral issues, family strengths etc.

3) ***Effective Praise***: Sincere and effective praise of family members can increase their positive behaviour and build up the relationship between the consultant and the family. Praise can be used for things they already do well, but also any improvements or positive attempts at new skills.

4) ***Metaphors***: These are used in the form of anecdotes, short stories, analogies etc. that compare the concept or skill being taught. They should be used in language and with references that the family understands and can relate to. Parents can also be taught to use metaphors with their children.

5) ***Circular Refocusing***: Sometimes family members can use the time with the consultant to talk excessively about issues that are not relevant. Circular refocusing can then be used as a tool to get the conversation back on track by finding something in the off-topic conversation that relates to the issue at hand. It is generally used after a relationship has been established with the family and after the development of a service plan.

6) ***Reframing***: This is a technique that can be used to turn the negative perception of a situation into a positive one by casting negative thoughts and feelings in a new light. It can be particularly useful when someone is showing hostility or resistance.

7) ***Teaching by suggestion****:* This technique is similar to coaching and can be used when someone is attempting a skill and the consultant offers positive reinforcement and suggests a better way of doing it. It incorporates praise and is not the same as giving criticism. In some cases role play can be used to practise the new skill.

8) ***Practice***: A key element of the Boys and Girls Town approach is allowing people the opportunity to learn from doing and not from merely listening. Practice can be similar to role play where e.g. a parent might practice using consequences with his/her son who consistently comes home late.

9) ***Confrontation****:* This is used when a consultant wishes to express concern that a behaviour needs to change. It can also be taught to parents to use with their children. It may be used in situations where a family member fails to follow through with a suggestion made repeatedly or where someone engages in a behaviour that could have serious implications.

Using such teaching techniques effectively in a limited time period can be challenging and one that consultants may struggle with. Consultants are therefore expected to maximise their teaching opportunities and to be ready with the required skills. In some situations teaching opportunities may be more subtle and sometimes teaching is done in a less deliberate way through techniques such as modelling behaviour (demonstrating various skills), prompting when appropriate or in some cases ignoring inappropriate behaviours so as not to reinforce them. It should be noted however that if a consultant ignores behaviour or shows parents how to do so, the behaviour should not be causing any harm and alternative strategies should be put in place to increase positive behaviour.

Whilst the model provides many teaching tools and various domains to work in, it is important for the consultant to keep the interventions focused and not to try to solve all the problem areas in a family's ecology at once. The service plan should act as a good guide and there should be a focus on teaching one or two skills at a time.

Crisis Intervention

Whilst many of the tools are associated with helping families to develop skills during normal life, a consultant may also find him/herself dealing with a family in acute crisis. Such a crisis can be either situational where families were unprepared for a situation that arose or they can developmental and are expected in the normal development of an individual e.g. adolescence, birth of a baby. When a family is

in crisis, their normal coping and defence mechanisms may be weakened but they may also be open to new ideas. Crisis intervention is used as a specific approach that focuses on the family's ability to solve the crisis. Consultants are expected to use a range of problem-solving techniques that work best for the family. Principles of crisis-intervention include staying focused and being solution-oriented, respecting the family's procedures, staying on equal terms with all parties, remaining calm, and having concern for safety issues, including one's own safety. In some cases consultants can also act as mediators and may even draw up a mediation contract between the parties in conflict.

Emphasis on Effective Parenting, Self-motivation and Character Building

Parents are a child's primary educators and much of the focus of the work can be on showing parents how to use ***proactive teaching*** with their children i.e. preparing their children for situations before they arise (e.g. learning how to cross the road safely). Proactive teaching can be used when a child is learning something new or has had a difficulty in the past and may face a similar situation again. It is usually used at a calm time during the absence of problem behaviours. It involves describing a skill or behaviour, giving a reason and then practising.

Corrective teaching can also be used when a consultant needs to address inappropriate or dangerous behaviour. It can be taught to parents or other caregivers and is used when children are misbehaving or not following instructions. It involves stopping the problem behaviour (e.g. siblings fighting), giving an appropriate negative consequence, describing what you want, giving reasons and may also involve practising the new skill.

Another key skill that is shown to parents or other care givers is ***teaching self-control*** to children when they are angry, frustrated or upset. If a child frequently uses tantrums or whines until they get what they want, they will continue to use this behaviour to meet their needs. Teaching self-control helps children to respond to frustrating situations in healthier ways and in the long term helps them get along with people. It helps children to learn how to control their behaviour as well as giving adults a skill and teaching process that will help them remain calm and deal with difficult behaviours.

A key part of the behavioural model is that ***consequences*** are at work all the time and that consequences change behaviour. Consultants should teach parents to use consequences (positive and negative) that have the power to change behaviour. Children need to understand the relationship between their behaviour and the consequence in order to change their behaviour. The consequence should be relevant and important to the child. If a child likes to watch TV or ride their bike outside with his friends for example, these can be used as consequences (allowing extra time or removing). Consequences also need to be immediate or else they lose their significance. They should also be used enough times to effectively change behaviour, but not so many times that they lose their effectiveness. The size of the consequence should be as small as possible to change the behaviour.

When working with troubled young people, motivating them to work on their treatment issues can be difficult and they may not believe that their negative behaviours need to change. A ***motivation system***,

used alongside a teaching approach can be an effective tool in helping young people develop the desire to change their behaviour. Once the young person becomes comfortable and skilled at using the new behaviour, the extra incentives can be faded away. Motivation systems differ from bribery, which is paying in advance for positive behaviour. Motivation systems are structured and spell out clearly specific expectations and positive and negative consequences for behaviour. They may use artificial consequences such as stickers or tokens that can be lost for negative behaviour and gained for positive behaviour and exchanged for a range of privileges.

The Girls and Boys Town model also works from the approach of developing good character and values and teaching them to families and children. In the United States Boys Town have also teamed with the CHARACTER COUNTS Coalition of 500 youth and community organisations and have jointly developed a book called *Parenting to Build Character in Your Teen* (Girls and Boys Town Press, 2001). It demonstrates teaching methods to teach the six pillars of character: trustworthiness, respect, responsibility, fairness, caring and citizenship.

The Role of Supervision

The tasks expected of consultants can be daunting, emotionally draining and very intense. Research at Fr. Flanagan's Boys Home has shown that only a portion of what is learnt in a workshop setting is actually implemented. The model therefore has a strong system of supervision and support built in, where supervisors work very closely with staff to ensure that the programme is implemented properly. The philosophy of the programme is based on the behavioural approach, which is taken into account in designing a very specific supervision system, with defined roles for supervisors and their staff. Some key hallmarks or features of this model include:

- ***Staff autonomy***: In order for staff to work effectively, they need to have the autonomy to act and to implement the programme. Supervisors need to respect and maximise this autonomy, within the limits of authority.

- ***Skill-based training***: Supervisors are also offered skills training that helps them in advising staff.

- ***Data-based Approach***: Just as staff are expected to use data to monitor, assess, plan and report on their work, supervisors use a similar approach to staff in the supervision process.

- ***Systematic Procedures:*** There are a number of principles or characteristics that underpin the social change model, which are also replicated in the supervision process. These include characteristics that can be described as reliable, efficient, socially valid, complete, specific, simple flexible and sustainable.

- ***Consumer Orientation:*** Just as staff members need to stay focused on meeting the needs of their clients, supervisors must develop strong and co-operative relationships with staff if they in turn are to be effective in meeting the needs of their families.
- ***Emphasis on Outcome Evaluation:*** The measurement of staff performance is a crucial element of the programme and outcome evaluation feedback is given to staff.
- ***Behavioural Approach to Problem-solving:*** Just as applied behavioural analysis is the conceptual base of the programme, supervisors need to apply a behavioural approach in dealing with staff. They need to analyse problems from a behavioural point of view, design effective interventions and monitor their outcomes.
- ***Ethical Procedures:*** These are important throughout the entire programme, which is committed to providing a safe environment for every child served. Supervisors need to ensure that an ethical approach is used in all procedures.

The programme uses a triadic model of supervision, involving the supervisor, the staff and the youth and families. The staff do not directly provide treatment to the youth and families but may instruct, advise and consult with the staff members who do.

A detailed manual on ***Developing Staff Skills*** (2007) has been developed, which provides a comprehensive overview of the philosophy behind the triadic model of supervision, a comprehensive guide to roles, the supervision process itself, building and maintaining supervision relationships, the conceptual feedback process and performance problems and their solutions. A few key points to note from this manual include:

- Supervisors need to understand the family's and staff's social environment to help them to administer effective contingencies to bring about changes in youth/family behaviour. Contingency management is an important principle, which refers to when a behaviour increases in frequency over time, the positive influences outweigh the negative ones. The sources and process of reinforcement need to be understood by supervisors who can support and advise their staff on influencing reinforcers.
- The role of a supervisor is multi-fold and it includes that of teacher, communicator, data manager, supporter of staff, developer of new policies, guardian of the programme, crisis intervener, protector of youth and family's rights, problem solver and time manager. The needs of youth families should be put first, followed by staff and then others.
- In order to understand and assess how staff work, staff observation is necessary. It does not occur at every visit and supervisors maintain a low profile, not providing any direct intervention. Supervisors also assist in service planning and ensuring effective implementation of the programme.
- Time should be set aside for interactive meetings with staff, which need to incorporate elements of relationship building, teaching, services planning, documentation, discussing progress and giving and receiving feedback.
- Building and maintaining effective relationships with staff is an important element of the supervision model and many suggestions are made on how a mutually rewarding relationship can be nourished. Effective communication on both sides is essential and staff should feel they can trust their

supervisor, express their feelings and provide input into the programme. Similarly supervisors need to be responsive to the needs of staff, provide them with the appropriate resources and compliment them on their performance. Feedback also needs to be given to staff that is constructive and focus on their behaviour in an objective manner.

- The model also uses a ***conceptual feedback*** process, in which supervisors provide feedback that promotes the generalisation of skills to many different situations. Supervisors may sometimes provide feedback on a group of similar behaviours to show that a common theme has emerged, for example a staff member who frequently uses inappropriate language, dresses inappropriately and shows other behaviour that is not appropriate for an adult role model. The supervisor can then talk to the staff member on "what we are going to work on" and allow them to monitor some of their own behaviours. Conceptual feedback allows supervisors to generalise the feedback and help staff to learn the necessary skills to do their job effectively.
- Evaluation of the supervision process is also a key element and staff should be asked to respond to questionnaires etc. that can be used to refine and improve supervision procedures.
- Performance problems can arise with staff and supervisors are provided with a range of tools to analyse and act on performance problems. This often focuses on assessing whether it is an absence of skill or motivation. Absence of a skill may require more training or teaching and in the case of an absence of motivation, positive and negative consequences may be used.

Tools for Building Skills

Whilst some of the material presented above summarises the model, its theoretical underpinnings and its main principles, there are also numerous resources both in the Training Manual and the Staff Supervision Manual which provide practical examples, details specific tools and how to use them and templates for data collection, assessment and the development of a Service Plan. Other material includes Participant Workbook on Building Skills in High Risk Families. This workbook focuses on a number of the principles and tools demonstrated in the Training Manual, with a range of practical exercises, worksheets and detailed lists and explanations of specific skills across a range of levels and domains. This workbook is complementary to the main manual and provides staff with a practical resource with detailed guidelines on each of the tasks they may be expected to cover during their work. Under each of the areas, the principles of the area are outlined (e.g. developing skills, developing relationships, cultural and family differences), followed by a practical step-by step guide to implementing the approach, using case studies and worksheets for the participants to complete.

Service Planning Update

A key component of the model is the development of Service Plans adapted to the needs of each family. A new and up to date guide called the Family Problem Areas Manual has been recently developed (Ingram & Vogel, 2009) to assist family workers in assessing the needs of families. Information is given regarding 25 family problem areas, their corresponding goal areas, resources and supports to be used as objectives and suggested activities to meet the family's goals. Service planning is conducted through a process, involving several stages. Firstly the worker should address the ***Strengths and Stressors*** of the

family, using 34 questions which are directly linked to 25 family problem areas. Appropriate family problem areas need to be selected. Usually the areas that have the most success are the most serious stressors that are also in keeping with the family's own agenda.

The development of a ***Social Network Map*** is also crucial to the service planning process. It is an assessment tool designed by Tracy and Whitaker (1990) to explore the extent to which informal and formal resources are being used and relied upon in an individual's social network. The Service Plan can then build on social support resources already being used by the family.

The next step is the identification of goals from the family problem areas. More detailed information and assistance is provided on the Boys Town National Database on goal areas and resources/skills/supports. The goals are then broken down into the resources, skills and supports that can assist in meeting the family's needs and then finally the family worker and the family can draw up suitable activities.

Below is an example of the process:

Family Problem Area = Housing

Goal Area = Budgeting for rent/utilities

Family's Goal =The Murphy family will better manage their budget and ensure that their household bills are paid on time

<u>Resource/Skill/Supports</u>

Resource Example

- Helping the family fill in a form for Family Income Supplement payment

Skill Example

- Teaching the family how to draw up a household budget and plan for utility bills

Support Example

- Connecting the family with Money Advice and Budgeting Service (MABS) to learn how to budget better

The Family Problem Areas Manual identifies resources, skills and supports under each of the family goal areas of the 25 family problem areas and supplies a practical list of suggested activities under each one. The list of activities is not exhaustive and family workers are encouraged to come up with their own ones to meet the individualised needs of families. It serves, however, as a very useful and practical guide to the process and demonstrates the wide extent and variety of supports and skills a family worker can work on with families.

Conclusion

This section has outlined the model as it has been developed by Boys Town in the USA. It gives an overview of its theoretical underpinnings and background, its key principles, the tools available to family consultants and how they can be used, and an overview of some of the practical resources available to those wishing to implement the model. The Boys Town ecological family-based services model is a tried and tested model that has been successful in many places in helping youth and families to take control over their lives and change them for the better. Behavioural treatment occurs within a family setting and there is a strong emphasis on the role of the family consultant as a teacher. The ecological approach does not view individuals or families in isolation, but views them as part of their wider ecology, which have a mutual effect on each other. Family consultants assist families in identifying problem areas in their behaviour and their environment and developing new skills and solutions to bring about positive change.

APPENDIX B: BASELINE AND FOLLOW UP MEAN RANK SCORES

SURVEY ITEM	Baseline or follow up group	N	Mean Rank
My agency has a keen understanding of community needs	baseline	22	20.02
	follow up	22	24.98
	Total	44	
There are good planning processes in my agency	baseline	22	19.48
	follow up	22	25.52
	Total	44	
My agency has a clear focus on its goal	baseline	22	18.91
	follow up	22	26.09
	Total	44	
People here actively contribute to shaping agency objectives	baseline	22	22.52
	follow up	22	22.48
	Total	44	
My agency is committed to evaluation	baseline	22	23.73
	follow up	22	21.27
	Total	44	
My agency engages in high quality needs assessments	baseline	20	19.20
	follow up	22	23.59
	Total	42	
Making progress isn't simply a matter of resources	baseline	21	21.33
	follow up	22	22.64
	Total	43	
My agency routinely re-evaluates its goals/missions	baseline	21	17.60
	follow up	22	26.20
	Total	43	
Most of my work involves joint work with other agencies	baseline	21	22.43
	follow up	22	21.59
	Total	43	
Other agencies are happy to share service-user information	baseline	22	21.50
	follow up	22	23.50
	Total	44	
I've found other agencies to be very helpful in my success	baseline	22	21.57
	follow up	22	23.43
	Total	44	
I could not do my job without the assistance of other agencies	baseline	22	24.48
	follow up	22	20.52
	Total	44	
I value the skills that other disciplines bring to my casework	baseline	22	20.30
	follow up	21	23.79
	Total	43	
In most of my work I see myself as part of a multidisciplinary team	baseline	22	14.00
	follow up	22	31.00
	Total	44	
I believe I make a difference	baseline	22	24.11
	follow up	22	20.89
	Total	44	
I see clear evidence of the impact of my work	baseline	22	21.61
	follow up	22	23.39

	Total	44	
My work has lasting impact	baseline	22	20.23
	follow up	22	24.77
	Total	44	
We need new frameworks/models for youth services	baseline	22	25.48
	follow up	22	19.52
	Total	44	
My supervisors provide regular feedback on my performance	baseline	22	18.09
	follow up	22	26.91
	Total	44	
I receive recognition for my work	baseline	22	19.95
	follow up	22	25.05
	Total	44	
My supervisors provide backing for my decisions	baseline	22	20.09
	follow up	22	24.91
	Total	44	
There are adequate agency resources to achieve my goals	baseline	21	20.02
	follow up	22	23.89
	Total	43	
My agency tries to make sure I don't have too many cases	baseline	22	18.80
	follow up	21	25.36
	Total	43	
My supervisors take steps to decrease case worker burnout	baseline	22	19.70
	follow up	21	24.40
	Total	43	
The supervision processes supports my work	baseline	22	19.91
	follow up	22	25.09
	Total	44	

There is sufficient casework recording in my agency	baseline	22	17.93
	follow up	22	27.07
	Total	44	
My agency provides adequate opportunities for reflection	baseline	22	18.20
	follow up	22	26.80
	Total	44	
We don't have enough caseworkers to get things done (REVERSED)	baseline	21	21.88
	follow up	22	22.11
	Total	43	
We don't have sufficient funding to achieve our goals (REVERSED)	baseline	21	25.76
	follow up	22	18.41
	Total	43	
My experience with other agencies has been unpleasant (REVERSED)	baseline	22	17.23
	follow up	22	27.77
	Total	44	
Other agencies want to take credit for my work (REVERSED)	baseline	22	21.91
	follow up	22	23.09
	Total	44	
I would prefer not to work with other agencies (REVERSED)	baseline	22	21.36
	follow up	22	23.64
	Total	44	
Other agencies are hostile towards my work (REVERSED)	baseline	22	20.93
	follow up	22	24.07
	Total	44	
Interagency work only makes it harder to meet client needs (REVERSED)	baseline	22	23.50
	follow up	22	21.50
	Total	44	

Other disciplines are not respectful of my role (REVERSED)	baseline	22	12.70
	follow up	22	32.30
	Total	44	
The system is too complicated for me to make a difference (REVERSE)	baseline	22	19.45
	follow up	22	25.55
	Total	44	
The children I work with have too many problems to deal with in a community setting (REVERSED)	baseline	21	21.19
	follow up	22	22.77
	Total	43	

APPENDIX C: RESPONSE VALUES FOR EACH SURVEY ITEM BASELINE AND FOLLOW UP

	Time spent per week planning work					
	Mean hrs	Median hrs	Mode hrs	St. Deviation hrs	Min to Max	Missing (no response)
Baseline	5.29	4	4	3.17	1 to 12	4
Follow up	6.14	6	8	2.575	2 to 11	1
	Time spent per week doing direct face to face work					
	Mean hrs	Median hrs	Mode hrs	St. Deviation hrs	Min to Max	Missing (no response)
Baseline	15.09	12	5	8.98	5 to 35	4
Follow up	12.24	11	6	6.434	2 to 24	1
	Time spent per week recording work					
	Mean hrs	Median hrs	Mode hrs	St. Deviation hrs	Min to Max	Missing (no response)
Baseline	4.69	4	5	3.4	1 to 12	4
Follow up	6.81	8	8	3.43	1 to 15	1
	On average, how many cases are you responsible for in a week					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing (no response)
Baseline	13.4	9	Multiple	11.18	3 to 40	3
Follow up	15.36	10	20	24.297	1 to 120	0
	Total number of cases closed prematurely in the last 12 mths.					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing (no response)
Baseline	1.61	1.5	0	1.72	0 to 6	5
Follow up	1.9	2	2	2.29	0 to 10	2
	Total number of cases closed in the last 12 mths.					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing (no response)
Baseline	6.94	6	Multiple	5.33	1 to 25	5
Follow up	10.65	5	Multiple	24.92	0 to 115	2
	My agency has a keen understanding of community needs					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	5	6	7	4	1

Follow up	0	0	2	13	7	0
	There are good planning processes in my agency					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	5	6	7	4	1
Follow up	0	1	4	12	5	0
	My agency has a clear focus on its goal					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	6	5	8	2	1
Follow up	0	4	2	10	6	0
	We don't have enough caseworkers to get things done					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	5	3	8	4	2
Follow up	0	4	9	4	5	0
	People here actively contribute to shaping agency objectives					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	2	5	9	6	1
Follow up	0	2	4	11	5	0
	My agency is committed to evaluation					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	5	2	9	5	1
Follow up	1	8	2	6	5	0
	My agency engages in high quality needs assessments					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	4	6	7	3	3
Follow up	1	2	3	11	5	0
	Making progress isn't simply a matter of resources					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	4	2	11	4	2

Follow up	1	2	0	16	3	0
	My agency routinely re-evaluates its goals/missions					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	9	8	4	0	2
Follow up	1	3	6	10	2	0
	We don't have sufficient funding to achieve our goals					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	11	4	6	0	2
Follow up	0	4	9	6	3	0
	Most of my work involves joint work with other agencies					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	1	0	15	5	2
Follow up	0	0	2	15	5	0
	Other agencies are happy to share service-user information					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	3	3	13	3	1
Follow up	0	1	3	15	3	0
	My experience with other agencies has been unpleasant					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	2	14	4	2	0	1
Follow up	9	13	0	0	0	0
	Other agencies want to take credit for my work					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	3	11	5	2	1	1
Follow up	3	12	5	2	0	0
	I've found other agencies to be very helpful in my sucess					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	2	6	13	1	1

Follow up	0	1	6	13	2	0
	I would prefer not to work with other agencies					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	14	7	1	0	0	1
Follow up	16	6	0	0	0	0
	Other agencies are hostile towards my work					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	7	12	3	0	0	1
Follow up	10	10	1	1	0	0
	I could not do my job without the assistance of other agencies					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	2	3	9	8	1
Follow up	0	1	6	11	4	0
	Interagency work only makes it harder to meet client needs					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	7	13	1	1	0	1
Follow up	4	17	1	0	0	0
	I value the skills that other disciplines bring to my casework					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	2	1	13	6	1
Follow up	0	0	1	12	8	1
	Other disciplines are not respectful of my role					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	0	0	11	10	1
Follow up	2	14	5	1	0	0
	In most of my work I see myself as part of a multidisciplinary team					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	2	12	4	4	0	1

Follow up	1	0	1	14	6	0
	I believe I make a difference					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	0	1	12	9	1
Follow up	0	0	0	17	5	0
	I see clear evidence of the impact of my work					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	1	4	13	4	1
Follow up	0	0	3	15	4	0
	My work has lasting impact					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	0	9	11	2	1
Follow up	0	0	4	16	2	0
	The system is too complicated for me to make a difference					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	2	15	3	2	0	1
Follow up	4	18	0	0	0	0
	The children I work with have too many problems to deal with in a community setting					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	4	11	6	0	0	2
Follow up	5	12	5	0	0	0
	We need new frameworks/models for youth services					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	3	5	9	4	1
Follow up	1	4	10	6	1	0
	My supervisors provide regular feedback on my performance					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	2	5	2	10	3	1
Follow up	0	1	3	9	9	0

	I receive recognition for my work					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	3	5	12	2	1
Follow up	0	2	4	9	7	0
	My supervisors provide backing for my decisions					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	0	4	13	5	1
Follow up	0	0	2	11	9	0
	There are adequate agency resources to achieve my goals					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	4	6	11	0	2
Follow up	0	4	3	13	2	0
	My agency tries to make sure I don't have too many cases					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	4	6	11	0	1
Follow up	1	0	6	10	4	1
	My supervisors take steps to decrease case worker burnout					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	6	4	11	0	1
Follow up	0	2	9	5	5	1
	The supervision processes supports my work					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	2	1	2	15	2	1
Follow up	0	1	2	13	6	0
	There is sufficient casework recording in my agency					
	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	1	4	1	14	2	1
Follow up	0	0	1	13	8	0
	My agency provides adequate opportunities for reflection					

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Missing (no response)
Baseline	0	7	6	9	0	1
Follow up	0	1	7	10	4	0
	Weekly	Monthly	Fortnightly			
Baseline	2	18	2			
Follow up	1	16	5			
	How old were you on your last birthday?					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing
Baseline	33.9	360	30	6.9	25 to 50	2
Follow up	36.55	36	34	5.24	23 to 48	0
	How many years experience in this field have you?					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing
Baseline	9.77	8.5	8	4.535	3 to 19	1
Follow up	12.73	12	12	5.138	2 to 22	0
	Average hours worked per week					
	Mean	Median	Mode	St. Deviation	Min to Max	Missing
Baseline	32.8	35	35	7.63	18 to 39	3
Follow up	30.82	35	35	8.209	8 to 39	0
	Work is carried out on					
	Entirely individual	Individual	Both group and individual	Group	Entirely group	Missing
Baseline	3	8	11	0	0	1
Follow up	2	7	13	0	0	0
	Level at which you work					
	Level 1	Level 2	Level 3	Level 4		Missing
Baseline	2	7	11	1		2
Follow up	2	1	15	3		1

APPENDIX D: FULL STATISTICS REPORT ON CONSENTED FILE ANALYSIS

PART I: Demographic Information

Cases

Pre-February 2010, a total of 23 cases (15 children cases, five parent cases and three parent and child cases) were handled by Mol an Óige. Two of the parent & child cases consisted of one child, while the third case consisted of a lone parent and 3 children.

Post-February 2010, 35 cases (19 children cases, 11 parent cases & 5 Parent and child cases) were reported. Four of the parent & child cases consisted of a parent and one child, while the fifth case consisted of a parent and three children. In total, pre- and post-February 2010, 58 cases with a total of 77 children and 33 parents have been directly and indirectly (including extended immediate family) involved in cases presented in the current database.

So, in total, the following analysis is based on 58 files/cases where information was given to the evaluation team. A number of these cases contained incomplete assessment information. For example, a number of pre-intervention assessments may have been undertaken, but for whatever particular reason no post-assessment intervention was undertaken. This significantly limits the ability of the evaluation team to objectively assess the effectiveness of the intervention based on pre and post assessments scores. In total, the following was the case for the different assessments forms used:

	PRE (cases/forms)	*POST*
SDQ • *Parent* • *Child* • *Teacher*	 • *27* • *22* • *4*	 • *17* • *14* • *2*
AWB	*26*	*19*
PCRI/PAF	*32*	*14*
FBEA	*15**	*13**
Strengths and Stressors	*29*	*16*

*These figures represent the absolute maximum case values and do not reflect that in many cases not all of the post intervention assessment was completed.

These figures should also be considered in light of the total number of Mol an Óige cases which were implemented both prior to 2010, and post assessment change in 2010. Hence, they cannot be treated as representative of the entire Mol an Óige caseload across both counties over 5 years. Instead, this is an analysis of files based on consent received by service users and data extracted and provided anonymously to the evaluation team as outlined in the methodology in Chapter One.

Analysis

The average age of children in all the cases (a total of 64 Children) was 12.30 years (*SD =* 3.79 years), with an age range of 3 – 17 years.

The average length of time from referral to start date was 1.65 months, with a range of 0 – 11 months.

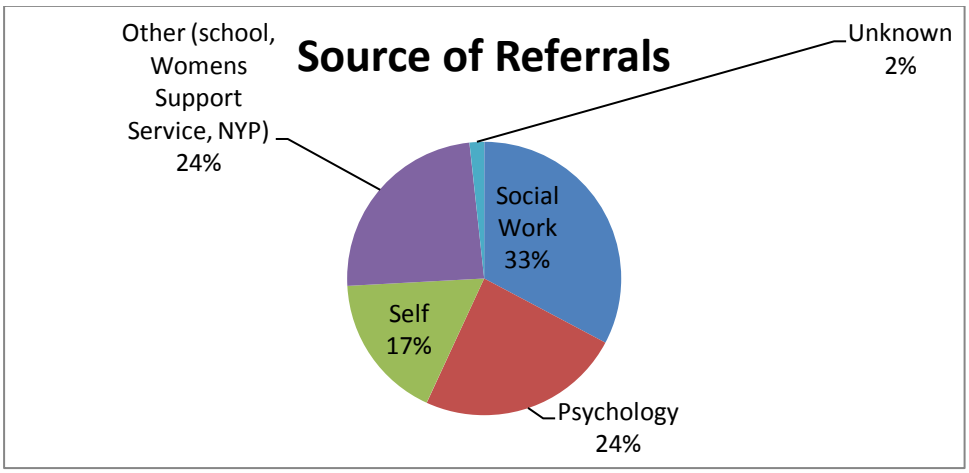


Figure 1: Percentages of Source of Referral

The majority of cases were referred from the Social Work Department (19 cases, 33%). This was followed by cases from "Psychology", for example CAMHS, Addiction Services, and Psychologists, and "Other" sources (e.g., ISPCC, Garda Diversion Programme, Family Support Worker, School, Child Guidance, Childcare Team leader, and NYP) which both accounted for 24% of referrals. A further 17% were self-referrals, while 2% did not record a referee (See Figure 1).

Reason for Referral

There were three primary reasons for referral (19 cases): violent/aggressive behaviour by child (e.g., threatening behaviour towards family); School difficulties (e.g., suspended from school, not attending school); and Parenting difficulties (e.g., poor parenting, Mum is worried about her daughter; see figure 2). Thirteen cases had a reason for referral that was categorised under "Substance Abuse/Misuse", for example "alcohol and drug abuse" and "underage drinking". "Mental Health Issues" (e.g., child has ADHD), "Relationship breakdown" (e.g., Young person bullying younger sibling), and "Behaviour Management" (e.g., engaging in promiscuous behaviour with strangers) were also prevalent, with 6 cases categorised under each of these headings. A further four cases had "Issus with Gardaí" (e.g., known to Gardaí), while 10 cases were categorised as "Other" (e.g., support foster placement, return child home).

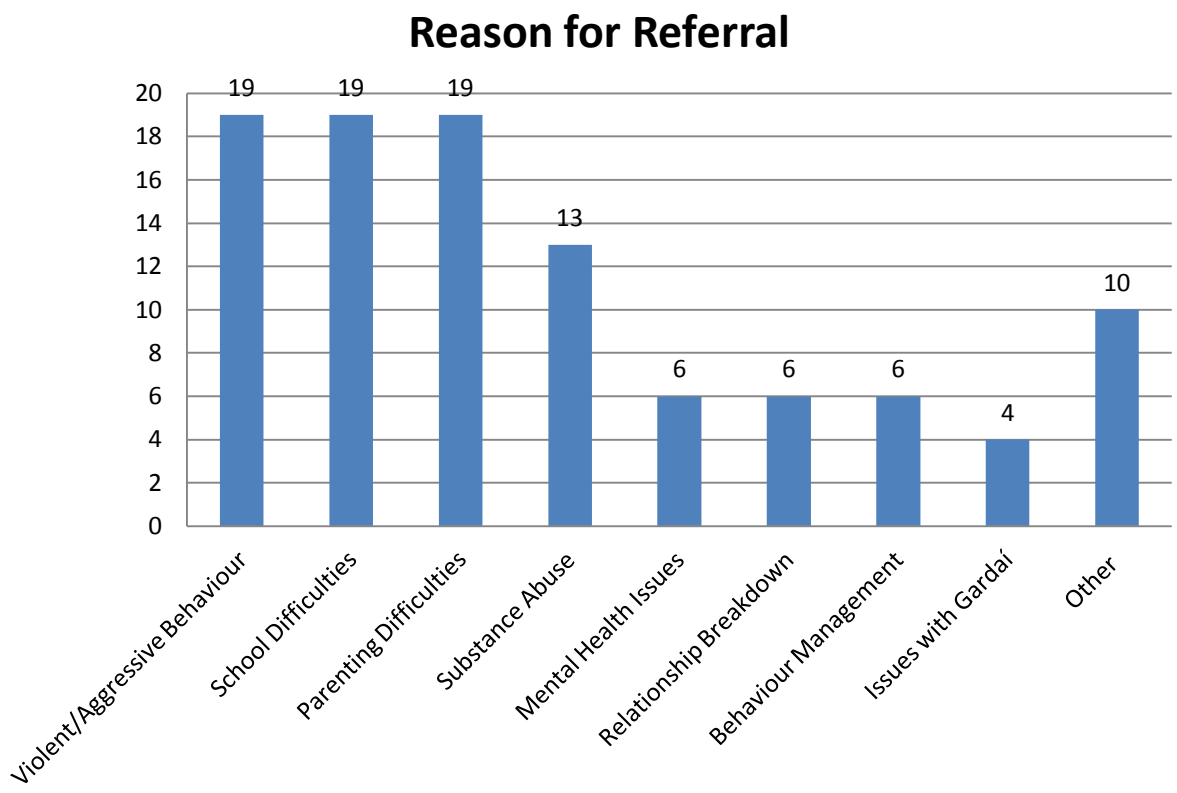


Figure 2: Reasons for Referral

Other Professionals

A total of 51 out of 58 cases involved other professionals, with an average of 2.32 other services involved (range form 0-6). Other professionals involved included 31 Psychology-based professionals (e,g, CAMHS, Educational Psychologist, NEPS), 17 health-based professionals (e.g., Public health Nurse, G.P., Speech & Language Therapist), 15 Social Work professionals (e.g., Social Worker), 14 School-based professionals (e.g., Principal, Resource Teacher, Education Welfare Officer), 13 youth-offending professionals (e.g., Juvenile Liaison Officer, Garda Diversion Programme, Justice Project), and 20 other professionals, including financial support services, Youth homeless officer, ISPCC, Western Care, MABS, and NYP.

31 out of 58 cases (53.44%) had previously been engaged with the HSE services, including Social Work (16), mental health services (7), Social Work and Child Care Leaders (1), Social Work and mental health services (3), and not defined (4).

Length of Phases

42 out of 58 cases indicated the length of phase 1. On average, phase one was 2.12 months in duration (*SD* = 1.55 months, range = 0.5 – 7 months). Phase two (*N* = 43) lasted on average 4.58 months (*SD* = 3.00 months, range = 0 – 13 months). 32 out of 58 cases indicated using a fading-out period (Phase 3), with an average duration of 2.41 months (*SD* =

2.27 months, range = 1 – 12 months). In total, the average length of cases was 9.31 months (*SD* = 4.20, range = 5 – 19 months).

Reopened Cases

A total of 3 cases out of 58 were reopened after initially being closed. A reason was given for one case, where the child went to live with ex-partner and so a new file was opened with the ex-partner. No reason was given for the other two reopened cases, but one was closed again after two months, while the other remained open at the time of data collection. In total, 43 cases did not reopen, two cases were closed but used drop-in services, seven cases were still open at time of data collection, while a further three had no information recorded.

PART II: Statistics

Strengths & Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire for children. There are multiple versions, including a parent, child (self-report), and teacher version. All versions ask about 25 attributes of a child. This includes; emotional symptoms, conduct problems, hyperactivity, peer relationship problems, and prosocial behaviour. Four scales may be combined to create a "Total Difficulties" outcome, with prosocial behaviour remaining separate. In the current report, due to the low numbers (*N* = 27 pre-assessment, *N* = 17 post-assessment), results are first presented for the "total difficulties" scale and the "prosocial behaviour" scale, and then SDQ subscales, for each of the completed parent, child, and teacher versions. For ease of interpretation, "Total Difficulties" scores are categorised into one of three groups; "Normal" (0-13 parent, 0-15 child, 0-11 teacher), "Borderline" (14-16 parent, 16-19 child, 12-15 teacher), and "Abnormal" (17-40 parent, 20-40 child, 16-40 teacher). "Prosocial behaviours" are also categorised into one of three groups; "Normal" (6-10 parent, child & teacher), "Borderline" (5 parent, child & teacher), and "Abnormal" (0-4 parent, child & teacher).

SDQ-Parent

A total of 27 cases reported using the SDQ-Parent at initial assessment (13 cases pre-February 2010, 14 cases post-February 2010). Out of 27 cases, 17 cases included pre- and post-assessment scores. The average "total difficulties" score at pre-assessment was marginally above the "Borderline" range of scores (*M* = 16.88, *SD* = 5.36, range = 7-27). The average "total difficulties" score at post-assessment was 14.88 (*SD* = 6.25, range = 4-26). This is within the "Borderline" range of scores. In total, out of the 17 cases at follow-up, 12 cases did not change category. Four cases improved (3 moved category from "Abnormal" range of scores to "Normal" range of scores, 1 case moved from "Abnormal" to "Borderline" range of scores), while one case deteriorated, moving from "Normal" range of scores to "Abnormal" range of scores. A paired sample t-test was used to ascertain whether there

was a significant difference between SDQ-Parent "Total Difficulties" scores at pre- and post-assessment. No significant difference was found, $t(16) = 1.518$, $p = .148$.

SDQ-Parent Prosocial scores were also assessed. Out of 17 cases with a follow-up score, 12 did not change their category. A further two cases improved (moving from "Borderline" to "Normal" and "Abnormal" to "Borderline" range of scores respectively), while three cases deteriorated (2 cases moved from "Normal" to "Borderline" and 1 case "Normal" to "Abnormal" range of scores). No significant difference was found between pre-assessment prosocial scores ($M = 6.00$, $SD = 2.74$, range = 0-9) and post-assessment prosocial scores ($M = 6.35$, $SD = 2.69$, range = 1-10), $t(16) = .566$, $p = .579$.

SDQ-Child

A total of 22 cases reported using the SDQ-Child measure at initial assessment (12 cases pre-February, 10 cases post-February). Out of these 22 cases, 14 cases reported follow-up assessment scores. The average "Total Difficulties" scores at pre-assessment was 15.64 ($SD = 6.62$, range 3-31). The 14 follow-up assessments recorded an average of 11.86 ($SD = 5.79$, range = 3-23). Out of these 14 follow-up cases, nine recorded no change in category of "Total Difficulties"(Normal, Borderline, or Abnormal), while five cases improved, with three moving from "Borderline" to "Normal", and a further two cases moving from "Abnormal" to "Normal" range of scores. A paired sample t-test was carried out to examine whether there was a statistically significant improvement in "Total Difficulties" scores. No significant difference was found, $t(13) = 2.044$, $p = .062$.

SDQ-Child Prosocial scores were also examined. Out of the 14 cases with follow-up scores, eight did not change category, while six improved (3 moved from "Abnormal" to "Normal" range, and 3 moved from "Borderline" to "Normal" range of scores). A significant difference was found between initial prosocial scores ($M = 6.07$, $SD = 2.50$, range = 1-9) and follow-up prosocial scores ($M = 7.57$, $SD = 1.28$, range = 6-10), $t(13) = 2.329$, $p < .05$, with prosocial behaviour scores improving between initial assessment and follow-up.

SDQ-Teacher

A total of 4 cases reported using the SDQ-Teacher assessment (3 cases pre-February 2010, 1 case post-February 2010). A further two cases collected follow up information. One case improved ("Abnormal" to "Borderline" range of scores), while the other case did not change category. The average "Total Difficulties" pre-assessment score ($N = 2$) was 22.50 ($SD = 4.95$, range = 19-27), while the average at follow-up was 16.00 ($SD = 2.83$, range = 14-18). No significant difference was found between initial and follow-up scores, $t(1) = 4.33$, $p = .144$. Prosocial scores were also recorded. The average pre-assessment prosocial scores were 4.00 ($SD = 0.00$), while post-assessment scores were 6.00 ($SD = 2.83$). There was no significant difference found between initial prosocial scores and follow-up prosocial scores, $t(1) = 1.0$, $p = .50$.

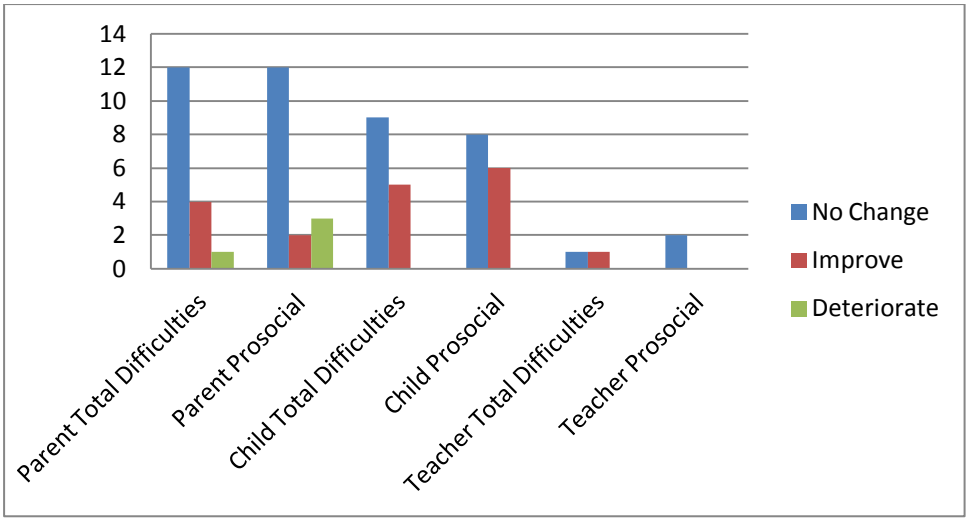


Figure 3: Changes between Pre- and Post-Assessment in SDQ scores

In total, the majority of cases across parent, child and teacher assessments showed no change. The most improvement in range of scores (e.g., from "Abnormal" range of scores to "Normal" range of scores") was seen in the child assessments, with the highest number of improvements (and only significant pre- and post-assessment difference) in SDQ-Child Prosocial scores (N = 6). Looking at the SDQ subscales (Table 1), similar trends were found, with the majority of subscales showing no significant change over time. The one exception to this was "SDQ-Child Hyperactivity" subscale, t (13) = 2.342, p < .05, which showed a significant decrease in average scores from 6.29 (SD = 2.49), to 5.00 (SD = 2.45). Also of note, is that while a high number of cases reported school difficulties (19 cases, see Figure 2), a low number of assessments included the SDQ-Teacher measure (N = 4 pre, N = 2 post-assessment).

Table 1: SDQ Information

	Pre-Assessment Scores (only including cases with post-scores)				**Post-Assessment Scores**			
SDQ-Parent	*N*	*M*	*SD*		*M*	*SD*	Range	Difference
Total Difficulties	17	16.88	5.36		14.88	6.25	7-27	ns
Conduct Problems	17	4.53	2.55		3.53	2.24	0-10	ns
Emotional Problems	17	2.82	1.98		3.00	2.83	0-9	ns
Hyperactivity	17	6.65	2.29		6.12	2.57	1-10	ns
Peer Problems	17	2.71	2.20		2.18	1.81	0.6	ns
Prosocial Scores	17	6.00	2.74		6.35	2.69	0-9	ns
SDQ-Child								
Total Difficulties	14	15.64	6.62		11.86	5.79	3-31	ns
Conduct Problems	14	4.71	2.43		3.14	1.75	0-6	ns
Emotional Problems	14	2.86	2.56		2.29	2.73	0-9	ns

Hyperactivity	14	6.29	2.49		5.00	2.45	0-10	***p* < .05**
Peer Problems	14	1.79	1.42		1.43	1.28	0-5	ns
Prosocial scores	14	6.07	2.50		7.57	1.28	1-9	***p* < .05**
SDQ-Teacher								
Total Difficulties	2	22.50	4.95		16.00	2.83	19-27	ns
Conduct Problems	2	5.50	.71		3.00	0	3	ns
Emotional Problems	2	3.50	3.53		2.00	2.83	0-4	ns
Hyperactivity	2	8.50	.71		6.50	.71	7-6	ns
Peer Problems	2	5.00	0		4.50	.71	4-5	ns
Prosocial scores	2	4.00	0		6.00	2.83	4-5	ns

Adolescent Well-Being Scale

The Adolescent Well-Being Scale (AWB) is a 17-item screening tool for depression among 7- to 16-year-olds scored on a three-point scale: *most of the time*, *sometimes*, and *never*. Birleson and colleagues (1981) suggest that scores above 13 are indicative of a problem.

A total of 26 cases recorded an AWB score at initial assessment (11 cases pre-February 2010, 15 cases post-February). A further 18 cases were followed-up. The average score at initial assessment was 11.83 (*SD* = 5.71, range 3-35). The average score at follow-up was 5.99 (*SD* = 3.23, range 1-13). Using a paired sample t-test, a significant difference was found in AWB scores, $t(17) = 4.815$, $p < .001$. Adolescent Well-Being scores were found to significantly improve between initial assessment and follow-up, as lower scores indicate lower levels of depression.

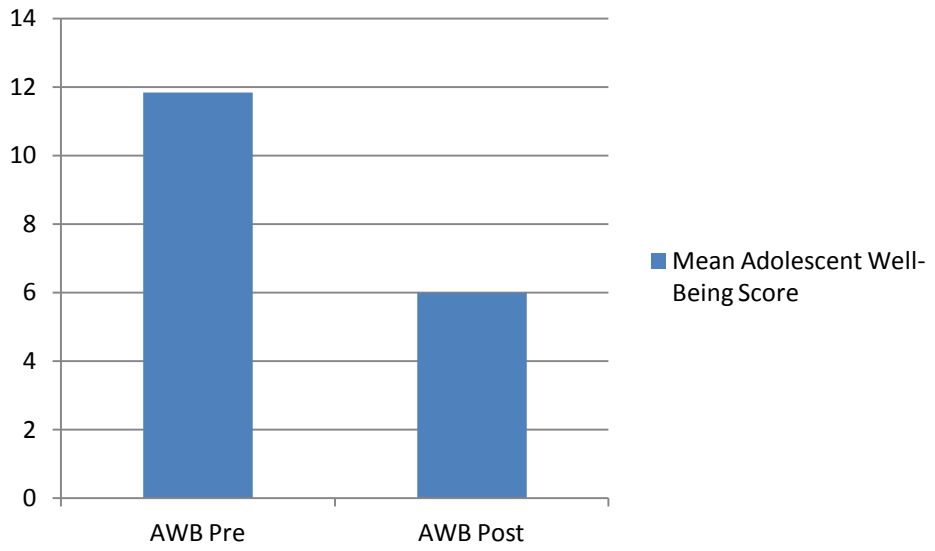


Figure 4: Mean Adolescent Well-Being scores at Pre- and Post-Assessment

Parental Well-Being

The Parent and Child Relationship Inventory (PCRI; Gerard, 1994) is a self-report measure of parental well-being. The measure is divided into four subscales; Support, Satisfaction, Involvement, and Communication. In order to facilitate ease of interpretation, scores are categorised into one of three levels of need; "Low", "Some", and "High". See Table 2 for breakdown of categories by subscale.

Table 2: Parent and Child Relationship Inventory (PCRI) Pre and Post Categorisation and mean, standard deviation, range, and significance scores.

PCRI Pre (N = 32) Post (N = 14)		**Low Need (*N* cases)**	**Some Need (*N* cases)**	**High Need (*N* cases)**	***M*** (*N* = 14)	***SD***	**Range**	***P***
Support	Pre	10	9	13	22.86	9.01	9-36	
	Post	6	5	3	24.14	6.85	10-33	ns
Satisfaction	Pre	13	12	7	34.43	5..58	22-40	
	Post	7	3	4	33.64	6.51	18-40	ns
Communication	Pre	4	19	9	26.21	3.54	20-33	
	Post	5	6	3	26.71	4.39	19-32	ns
Involvement	Pre	5	16	11	42.64	6.06	31-53	
	Post	2	8	4	43.36	4.65	35-52	ns

No significant difference was found between pre and post assessment scores (see Table 2, Figure 5) for support, $t(13) = .911$, $p = .379$, satisfaction, $t(13) = .665$, $p = .518$, communication, $t(13) = .451$, $p = .659$, and involvement, $t(13) = .583$, $p = .570$. Looking at pre-assessment scores, it is noteworthy the high proportion of cases that have "Some Need" and "High Need" in the involvement and communication aspects of parenting, compared to the aspects of support and satisfaction. Also of note, is the loss of follow-up data (over 50% of cases).

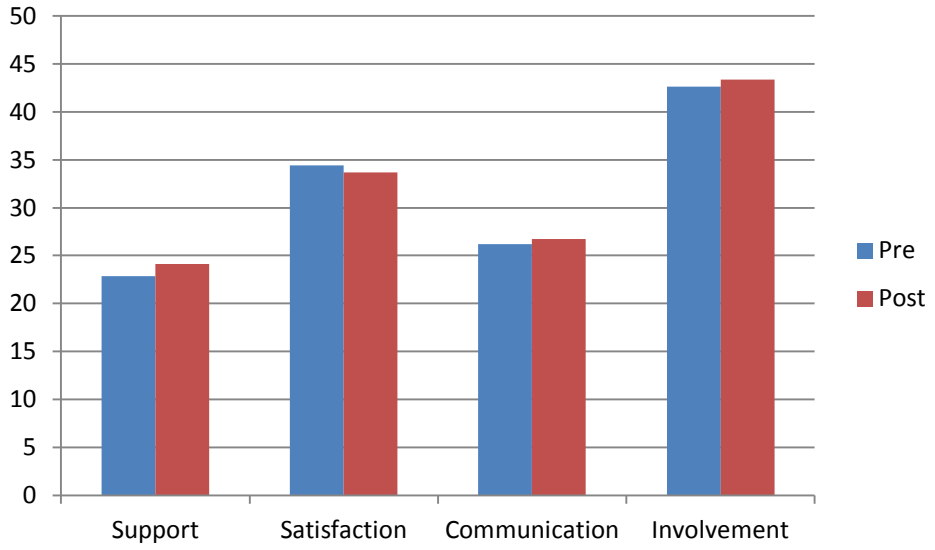


Figure 5: Mean Parent and Child Relationship Inventory (PCRI) Pre and Post Subscale Scores

Family Based Ecological Assessment (Pre-February 2010)

The Family-Based Ecological Assessment (FBEA) is a measure of 5 ecological domains (Individual, Family, School, Peer and Community). Each domain consists of a number of domain components that refer to a particular assessment element (e.g., Family domain → "general parenting" is a domain component). Each domain component is determined to be not applicable (N/A), an Asset (rated as +1), a Liability (rated as -1 to -4), or Neither (rated as 0). In this report, focus will also be given to the change from pre- to post-assessment. The change is documented by a sign ("+" for increase in scores, "-" for decreases in scores) and a whole number to indicate degree of change (e.g., if a rating moves from "-2" to "0", that is an increase of "+2"). No changes are indicated by a "0".

In total, information from a Family-Based Ecological Assessment (FBEA) was obtained from 15 cases at pre-assessment and 13 cases at post-assessment. Therefore, change was assessed using the 13 cases with pre- and post-assessment scores. After change was assessed, the percentage of cases that improved their score at post-assessment was examined to identify which components improved during intervention.

Change is assessed in the following manner. First, the breakdown of changes in each case is recorded for each of the components of the domain (e.g., for each of the 18 components of the "Family Functioning" domain (see Appendix A). Following this, the total number of negative, positive, and "no changes" is calculated by summing the number of cases in each component that could be categorised under each heading. This is presented in a table indicating the percentage of cases over the domain that had a positive, negative, or no change (e.g., see Table 3). Secondly, the percentage of cases for each component that has a positive change is calculated (see % improvement in Appendix A, also see description of each component).

Family Functioning

There are 18 components in the "Family Functioning" domain. The number of cases per component ranged from 7 to 13 cases. In total, 200 scores from 13 cases were recorded over the 18 domain components.

Looking at improvements post-assessment in the "Family Functioning" domain, the most successful changes were seen in the "Family Communication" component (improvement in 69.23% of cases), the "Mental Health" component (improvement in 62.50% of cases), and the "Family Relationships" component (improvement in 61.54% of cases). In contrast, the lowest success was evident in the "Criminal Justice Involvement" component (0% improvement), the "Substance Use" component (improvement in 14.29% of cases), and the "Addictive behaviour" component (improvement in 14.29% of cases).

Overall, improvement in the "Family Functioning" domain across all 18 components was seen in 33.50% of cases (see Table 3). There was no change between pre- and post-assessment family functioning scores in 60.50% of cases, while scores deteriorated in 6.00% of cases (see Figure 6). See Appendix A for breakdown of the Family-Functioning Family-Based Ecological Assessment.

Table 3: Percentage of Family Functioning Scores over 18 components by Degree of Change

No Change	0 = 60.50% of cases (*N* = 121)			
Improvement	+1 = 15.00%	+2 = 12.50%	+3 = 4.50%	+4 = 1.50%

	(*N* = 30)	(*N* = 25)	(*N* = 9)	(*N* = 3)
Deteriorate	-1 = 4.50% (*N* = 9)	-2 = 0.5% (*N* = 1)	-3 = 0.5% (*N* = 1)	-4 = 0.5% (*N* = 1)

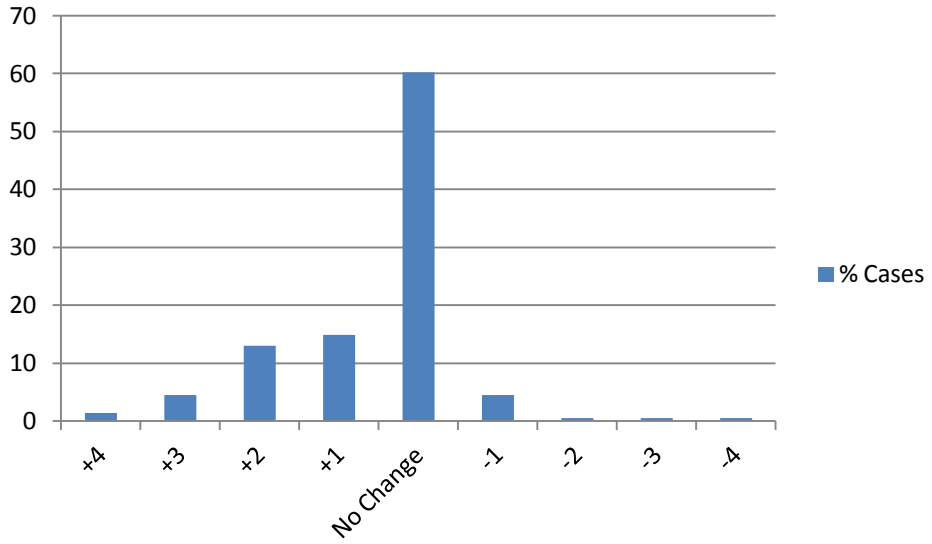


Figure 6: Percentage of Scores by each degree of change in Family Functioning

Parenting Domain

There are 3 components in the "Parenting" domain. The number of cases per component was 13 cases. In total, 39 scores from 13 cases were recorded over the 3 domain components.

Taking "Parenting" as an individual domain, improvements were seen in 61.54% - 84.62% of cases (see Figure 7). The majority of cases assessed for parenting showed an improvement of +2 (33.33% cases, *N* = 13). A further 20.51% (*N* = 8) and 17.95% (*N* = 7) of cases improved by +1 and +3 respectively. 25.64% 0f cases (*N* = 10) did not show any change, while 2.56% (*N* = 1) decreased in score by -1. See Appendix A for a breakdown of the Family-Functioning Family-Based Ecological Assessment.

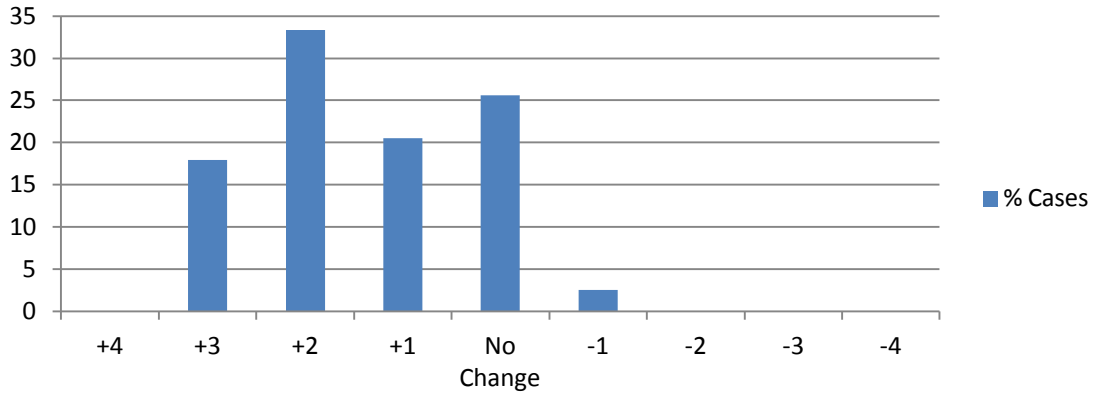


Figure 7: Percentage of Scores by each degree of change in Parenting Domain

Child Functioning

There are 14 components in the "Child Functioning" domain. The number of cases per component ranged from 9 to 13 cases. In total, 151 post-assessment scores from 13 cases were recorded over the 14 domain components.

Looking at improvement in domain components, the most successful changes were seen in the "Relationships with Others" component (improvement in 76.92% of cases), the "Criminal Justice Involvement" component (improvement in 66.67% of cases), and the "Daily Life Management" component (improvement in 46.15% of cases).. In contrast, the lowest success was evident in the "Spirituality" component (improvement in 11.11% of cases), and the "Employment" (improvement in 22.22% of cases) and "Developmental Status" component (improvement in 27.27% of cases). Overall, improvement in the "Child Functioning" domain across all 14 components was seen in 40.82% of cases (see Table 4). Looking at the degree of change (Figure 8), there was no change between pre- and post-assessment "Child functioning" scores in 51.66% of cases, while scores deteriorated in 7.95% of cases. See Appendix A for breakdown of the Family-Based Ecological Assessment.

Table 4: Percentage of Child Functioning Scores by Degree of Change

No Change	0 = 51.66% of scores (*N* = 78)			
Improvement	+1 = 19.20% (*N* = 29)	+2 = 15.23% (*N* = 23)	+3 = 3.31% (*N* = 5)	+4 = 1.99% (*N* = 3)
Deteriorate	-1 = 5.30% (*N* = 8)	-2 = 1.99% (*N* = 3)	-3 = 0.66% (*N* = 1)	-4 = 0% (*N* = 0)

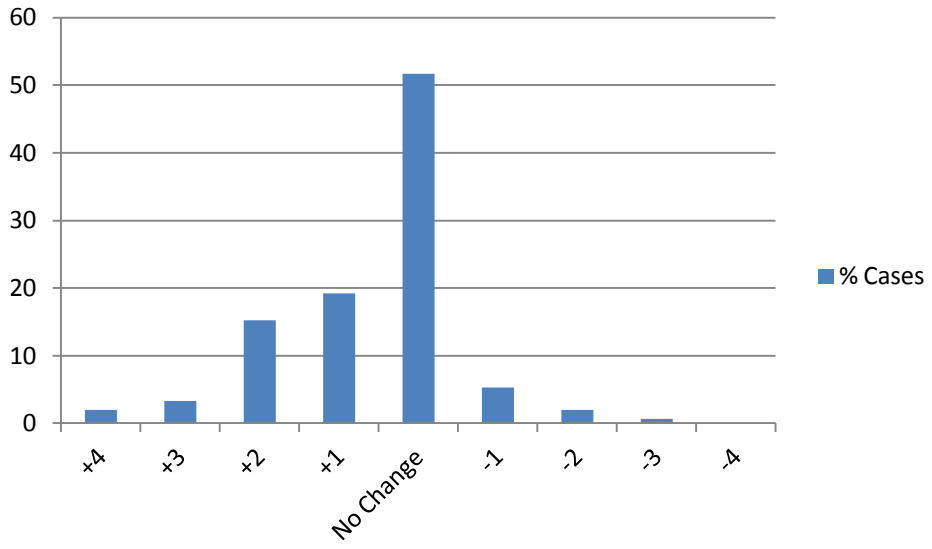


Figure 8: Percentage of Scores by each degree of change in Child Functioning Domain

Peer Domain

There are 9 components in the "Peer" domain. The number of cases per component ranged from 9 to 13 cases. In total, 105 post-assessment scores from 13 cases were recorded over the 9 domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Substance Use of Peers" component (improvement in 54.54% of cases), followed by the "Level of Involvement with Peers" component (improvement in 53.85% of cases), and the "Patterns of Peer Interaction" component (improvement in 46.15% of cases). The lowest success was evident in the "Other Friendships" component

(improvement in 27.27% of cases). Overall, improvement in the "Peer domain" across all 9 components was seen in 40.95% of cases (see Table 5). Looking at the degree of change (Figure 9), there was no change between pre- and post-assessment "Peer Domain" scores in 50.48% of cases, while scores deteriorated in 7.62% of cases. See Appendix A for breakdown of the Family-Based Ecological Assessment.

Table 5: Percentage of Peer Functioning Scores by Degree of Change

No Change	0 = 50.48% of scores (*N* = 53)			
Improvement	+1 = 15.24% (*N* = 16)	+2 = 20.95% (*N* = 22)	+3 = 2.86% (*N* = 3)	+4 = 2.86% (*N* = 3)
Deteriorate	-1 = 5.71% (*N* = 6)	-2 = 1.90% (*N* = 2)	-3 = 0% (*N* = 0)	-4 = 0% (*N* = 0)

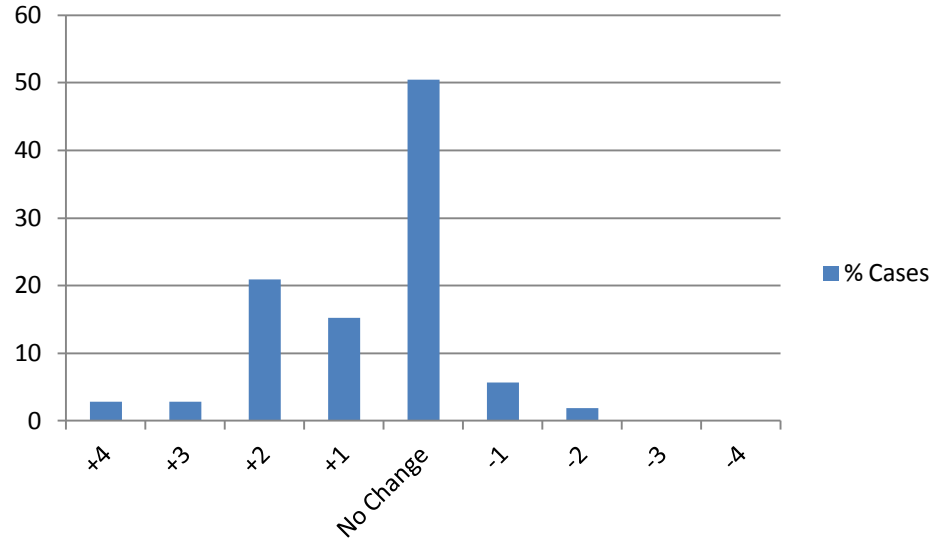


Figure 9: Percentage of Scores by each degree of change in the Peer Domain

School Domain

There are 8 components in the "School" domain. The number of cases per component ranged from 10 to 13 cases. In total, 95 post-assessment scores from 13 cases were recorded over the 8 school domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "School Attendance" component (improvement in 41.17% of cases), and the "School Achievement" component (improvement in 38.46% of cases). The lowest success was evident in the "School Support Systems" and the "Drug Activity in School" component (improvements in 10.00% of cases). Overall, improvement in the "School domain" across all 8 components was seen in 24.21% of cases (see table 6). Looking at the degree of change (Figure 10), there was no change between pre- and post-assessment "School Domain" scores in 68.42% of cases, while scores deteriorated in 7.37% of cases. See Appendix A for breakdown of the "School Domain" Family-Based Ecological Assessment.

Table 6: Percentage of School Domain Scores by Degree of Change

No Change	0 = 68.42% of scores (*N* = 65)		

Improvement	+1 = 11.58% (*N* = 11)	+2 = 6.32% (*N* = 6)	+3 = 2.11% (*N* = 2)	+4 = 4.21% (*N* = 4)
Deteriorate	-1 = 4.21% (*N* = 4)	-2 = 3.16% (*N* = 3)	-3 = 0% (*N* = 0)	-4 = 0% (*N* = 0)

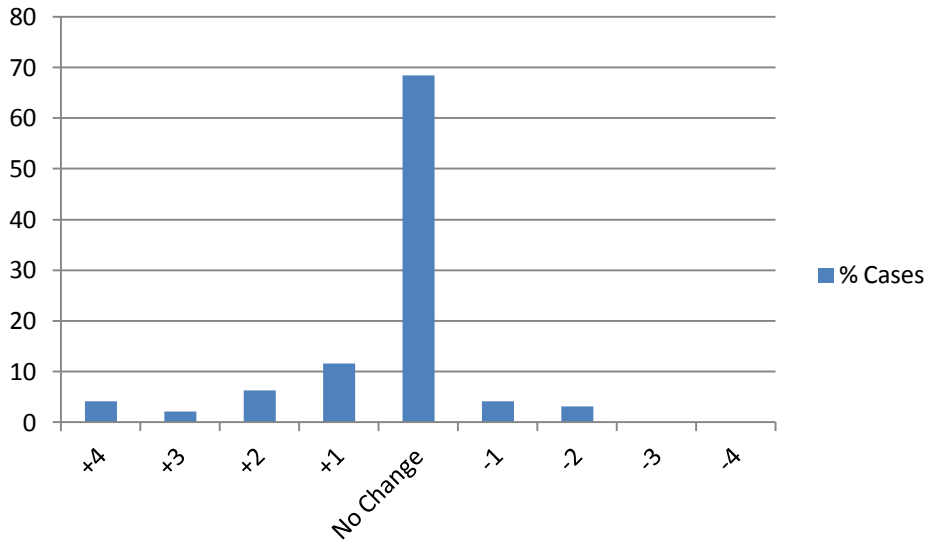


Figure 10: Percentage of Scores by each degree of change in the School Domain

Community Domain

There are 10 components in the "Community" domain. The number of cases per component ranged from 9 to 13 cases. In total, 121 post-assessment scores from 13 cases were recorded over the 10 community domain components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Community Involvement" component (improvement in 45.45% of cases), the "Neighbourhood Involvement" component (improvements in 41.67% of cases) and the "Accessibility to Community Resources" component (improvements in 38.46% of cases). The lowest success was evident in the "Availability of Religious Institutions" component with successful improvement in 0% of cases. Overall, improvement in the "Community Domain" across all 10 components was seen in 18.98% of cases (see Table 7). Looking at the degree of change (Figure 11), there was no change between pre- and post-assessment "Community Domain" scores in 79.34% of cases, while scores deteriorated in 1.65% of cases. See Appendix A for breakdown of the "Community Domain" Family-Based Ecological Assessment.

Table 7: Percentage of Community Domain Scores by Degree of Change

No Change	0 = 79.34% of scores (*N* = 96)			
Improvement	+1 = 14.88% (*N* = 18)	+2 = 3.30% (*N* = 4)	+3 = 0% (*N* = 0)	+4 = 0.8% (*N* = 1)
Deteriorate	-1 = 0% (*N* = 0)	-2 = 1.65% (*N* = 2)	-3 = 0% (*N* = 0)	-4 = 0% (*N* = 0)

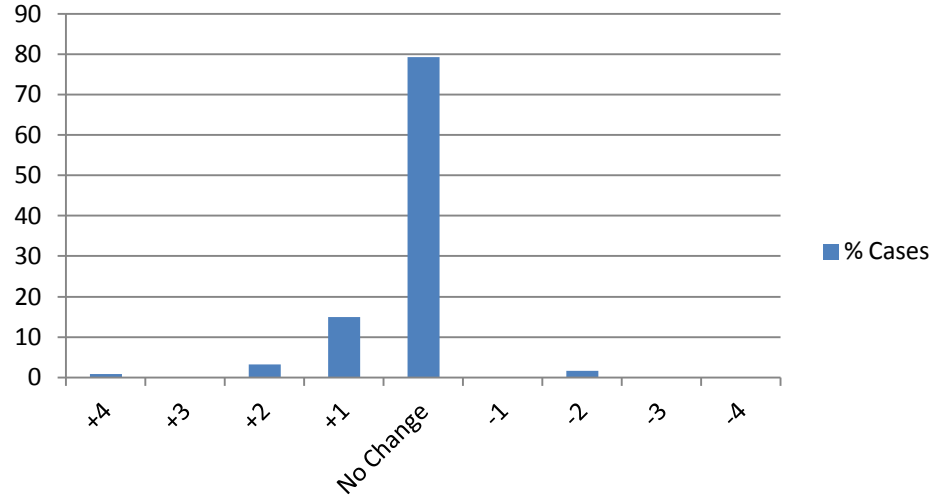


Figure 11: Percentage of Cases by each degree of change in the Community Domain

Summary of Family-Based Ecological Assessment

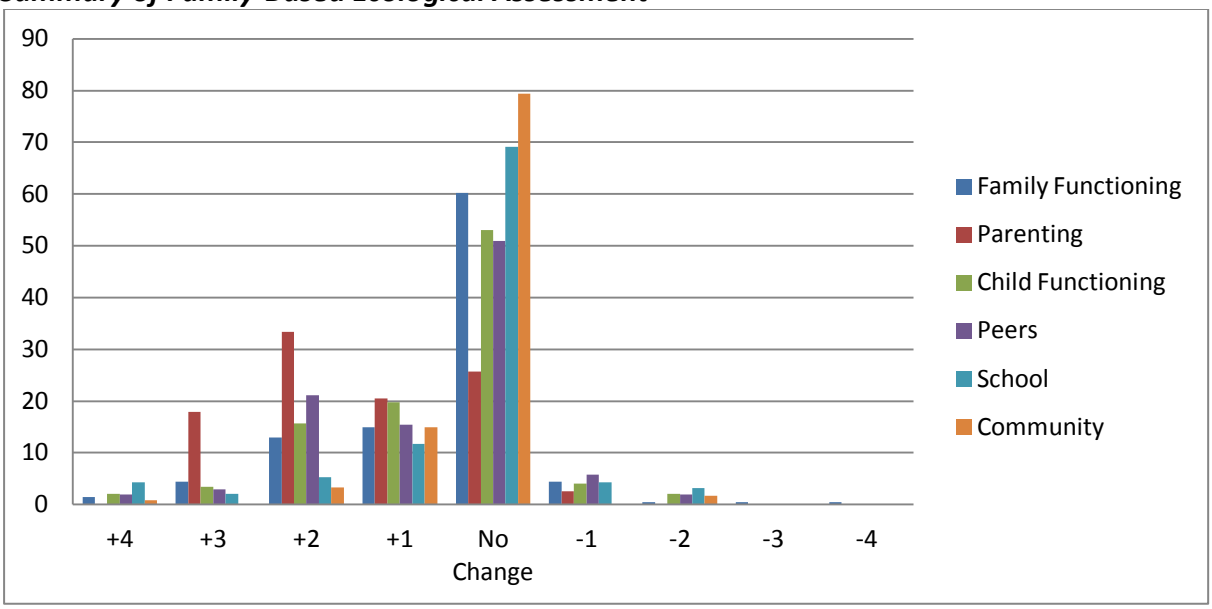


Figure 12: Degree of Change in Each Domain of the Family-Based Ecological Assessment

From figure 12, it is clear that the majority of cases that record pre- and post-assessment scores do not report a change. However, it is important to note that not all of the components in a domain may have been relevant for the case at hand, and therefore components may have been scored "0". Thus, the high percentages for "no change" must be interpreted with caution. In addition, given the low number of cases in some components (e.g., N = 9), improvements in a small number of cases may lead to large

percentage improvements overall. Thus, caution is advised when interpreting components with low numbers.

The percentage of cases that recorded no change ranged from 25.64-79.34%. The most change between pre- and post-assessment scores was seen in the "Parenting Domain", with 71.79% of cases recording an improvement in scores. The domain that registered the largest proportion of "no change" was the "Community Domain", with 79.34% of cases recording no change. This is unsurprising given the relative difficulty of changing a component such as "Availability of religious institutions". Overall, while the majority of cases showed no change, a higher proportion of cases recorded improvement across the six domains compared to decreases in scores (see figure 13).

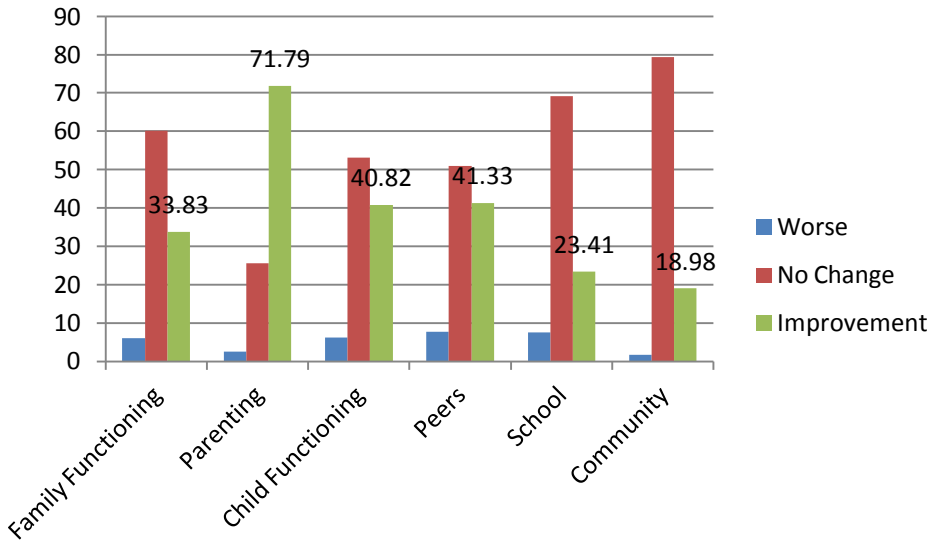


Figure 13: Percentage of Scores by change in each domain of the Family-Based Ecological Assessment

Strengths & Stressors *(Post-February 2010)*

The Strengths and Stressors Tracking Device (SSTD) is a rapid assessment measure of family well-being that assesses the particular strengths and needs of families. The measure assesses families in the domains of environmental conditions, social support, caregiver skills, and child well-being.

In the current dataset, there are two sources of scores with pre- and post- assessment data available from 16 cases;the family scores (*N* = 10) and worker scores (*N* = 16) for each component. In order to present clear information, this data will be combined (N = 26), and total changes (-6 to +6) of each component will be reported.

Environmental Conditions

There are 9 components in the "Environmental Conditions" domain. The number of case scores per component ranged from 24 to 26. In total, 225 post-assessment scores from 16 cases were recorded over the 9 environmental conditions components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Financial Management" component (improvement in 52% of case scores), the "Income" component (improvement in 44.00% of case scores), and the "Food & Nutrition" component (improvement in 40.00% of case scores). In contrast, the lowest success was evident in the "Personal Hygiene" component (improvement in 12.00% of case scores) and the "Safety in Community" component (improvement in 20.00% of case scores). Overall, improvement in the "Environmental Conditions" domain across all nine components was seen in 32.44% of cases (see Table 8). Looking at the degree of change (Figure 14), there was no change between pre- and post-assessment "Environmental Conditions" scores in 48.89% of cases, while scores deteriorated in 18.67% of cases. See Appendix B for breakdown of the Strengths and Stressors Assessment.

Table 8: Percentage of "Environmental Conditions" Scores by Degree of Change

No Change	0 = 48.89% of cases (*N* = 110)			
Improvement	+1 = 13.33% (*N* = 30)	+2 = 15.56% (*N* = 35)	+3 = 1.33% (*N* = 3)	+4 = 2.22% (*N* = 5)
Deteriorate	-1 = 8.89% (*N* = 20)	-2 = 8.0% (*N* = 18)	-3 = 0.89% (*N* = 2)	-4 = 0.89% (*N* = 2)

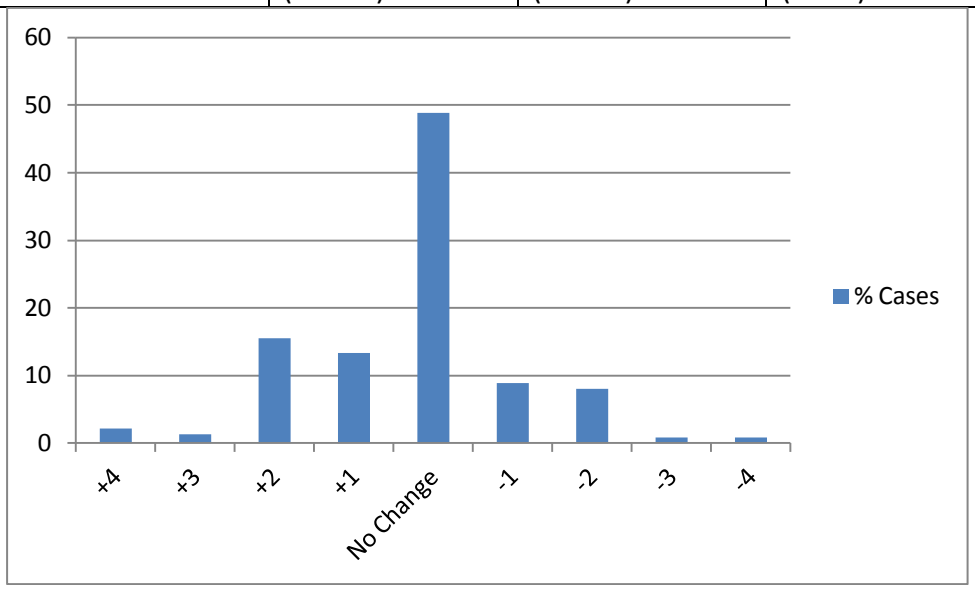


Figure 14: Percentage of Case Scores by each degree of change in the Environmental Conditions Domain

Social Support

There are four components in the "Social Support" domain. The number of case scores per component ranged from 25 to 26. In total, 101 post-assessment scores from 16 cases were recorded over the 4 social support components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Regular Services" component (improvement in 60.00% of case scores). The "Emergency Services" component and the "Motivation for Support" component both improved in 32.00% of case scores, while the "Social Relationships" component improved in 30.77% of case scores.. Overall, improvement in the "Social Support" domain across all four

components was seen in 38.61% of cases (see Table 9). Looking at the degree of change (Figure 15), there was no change between pre- and post-assessment "Social Support" scores in 50.50% of cases, while scores deteriorated in 10.89% of cases. See Appendix B for breakdown of the Strengths and Stressors Assessment.

Table 10: Percentage of "Social Support" Case Scores by Degree of Change

No Change	0 = 50.50% of case scores (*N* = 51)			
Improvement	+1 = 7.92% (*N* = 8)	+2 = 11.88% (*N* = 12)	+3 = 6.93% (*N* = 7)	+4 = 11.88% (*N* = 12)
Deteriorate	-1 = 2.97% (*N* = 3)	-2 = 7.92% (*N* = 8)	-3 = 0% (*N* = 0)	-4 = 0% (*N* = 0)

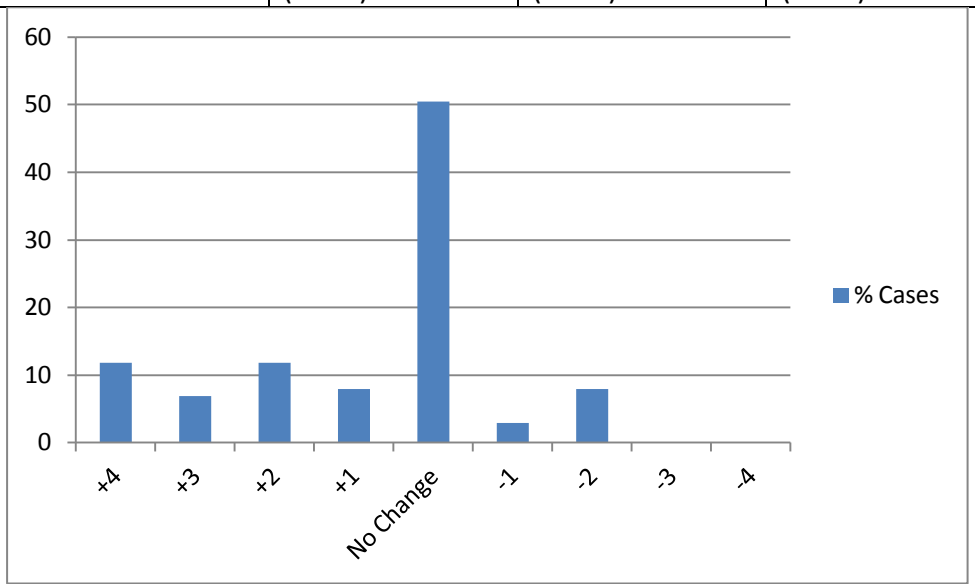


Figure 15: Percentage of Case Scores by each degree of change in the Social Support Domain

Family/Caregiving

There are 11 components in the "Family/Caregiving" domain. The number of case scores per component ranged from 24 to 26. In total, 279 post-assessment scores from 16 cases were recorded over the 11 family/caregiving components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Mutual Support" component (improvement in 83.33% of case scores), the "Parenting Skills" component (improvement in 76.92% of case scores), and the "Adult Supervision" component (improvement in 73.08% of case scores). In contrast, the lowest success was evident in the "Physical Health that affects Parenting" component (improvement in 7.69% of case scores) and the "Alcohol/Drug Abuse that affects Parenting" component and the "Bonding with Children" component (both showed improvement in 23.08% of case scores). Overall, improvement in the "Family/Caregiving" domain across all 11 components was seen in 41.63% of case scores (see Table 10). Looking at the degree of change (Figure 16), there was no change between pre- and post-assessment "Family/Caregiving" scores in 51.97% of cases, while scores deteriorated in 6.45% of cases. See Appendix B for breakdown of the Strengths and Stressors Assessment.

Table 10: Percentage of "Family/Caregiving" Case Scores by Degree of Change

No Change	0 = 51.97% of cases		

	(*N* = 145)			
Improvement	+1 = 12.19% (*N* = 34)	+2 = 10.09% (*N* = 34)	+3 = 6.45% (*N* = 18)	+4 = 12.90% (*N* = 36)
Deteriorate	-1 = 1.79% (*N* = 5)	-2 = 4.66% (*N* = 13)	-3 = 0% (*N* = 0)	-4 = 0% (*N* = 0)

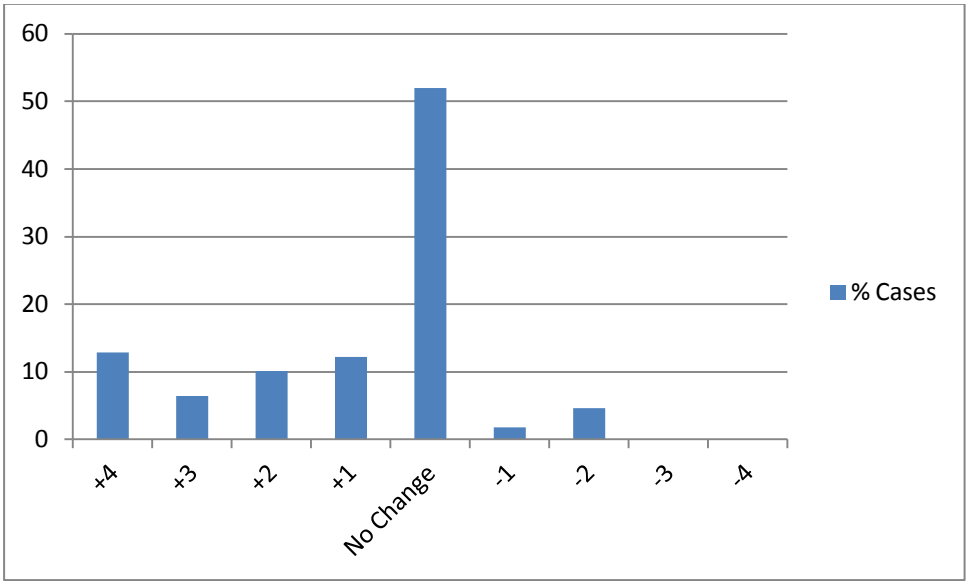


Figure 16: Percentage of Case Scores by each degree of change in the Family/Caregiving Domain

Child Well-Being

There are 12 components in the "Child Well-Being" domain. The number of case scores per component ranged from 5 to 26. In total, 289 post-assessment scores from 16 cases were recorded over the 12 child well-being components.

Looking at improvement in scores in each component, the most successful changes were seen in the "Child's Behaviour" component (improvement in 100% of case scores, *note only 5 cases were applicable*), the "Child's Mental Health" component (improvement in 88.46% of case scores), and the "Relationship with Caregiver" component (improvement in 84.62% of case scores). In contrast, lower success was evident in the "Relation with Sibling" component (improvement in 37.50% of case scores). Low scores were also seen in the risk assessment scores (e.g., Child Sexual abuse = 0% improvement, to "Child Physical Abuse" = 34.62%), however these low improvement scores are exaggerated by the recording of scores when not applicable. Overall, improvement in the "Child Well-Being" domain across all 12 components was seen in 43.95% of cases (see Table 11). Looking at the degree of change (Figure 17), there was no change between pre- and post-assessment "Child Well-Being" scores in 52.25% of cases, while scores deteriorated in 3.11% of cases. See Appendix B for breakdown of the Child Well-Being Strengths and Stressors Assessment.

Table 11: Percentage of "Child Well-Being" Case Scores by Degree of Change

No Change	0 = 52.25% of cases (*N* = 151)			
Improvement	+1 = 15.92%	+2 = 13.15%	+3 = 6.92%	+4 = 7.96%

	(*N* = 46)	(*N* = 38)	(*N* = 20)	(*N* = 23)
Deteriorate	-1 = 0.69% (*N* = 2)	-2 = 2.42% (*N* = 7)	-3 = 0% (*N* = 0)	-4 = 0.69% (*N* = 2)

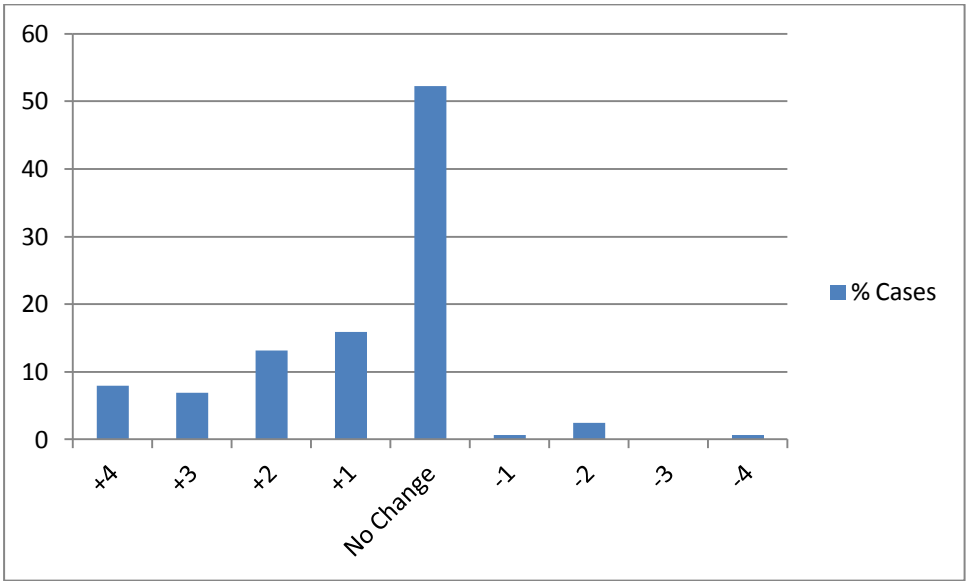


Figure 17: Percentage of Case Scores by each degree of change in the Child Well-Being Domain

Summary of Strengths & Stressors Assessment

From figure 18 (below), it is clear that the majority of cases that record pre- and post-assessment scores do not report a change. However, this finding must be interpreted with caution as the scoring of components as zero when not relevant is likely to significantly inflate this figure. The percentage of cases that recorded no change ranged from 48.89%-52.25%. The most change between pre- and post-assessment scores was seen in the "Child Well-Being" domain, with 43.95% of cases recording an improvement in scores. The domain that registered the largest proportion of "no change" was also the "Child Well-Being", with 52.06% of cases recording no change. Again, this is likely to be inflated due to the irrelevance of components such as "Sexual Abuse", which recorded "no change" in all cases as there was no sexual abuse recorded in any of the 16 cases. The largest proportion of cases that showed a deterioration in scores (i.e., negative change) were found in the "Social Support" domain (with 18.67% of cases showing a decrease in post-assessment scores), and the "Environmental Conditions" domain (15.86% of cases showing a decrease). This is relatively high compared to the other domains (Family/Caregiving = 6.45%, and Child Well-Being = 3.11% of cases). Overall, while the majority of cases showed no change, a higher proportion of cases recorded improvement across the four domains compared to decreases in scores (see Figure 19).

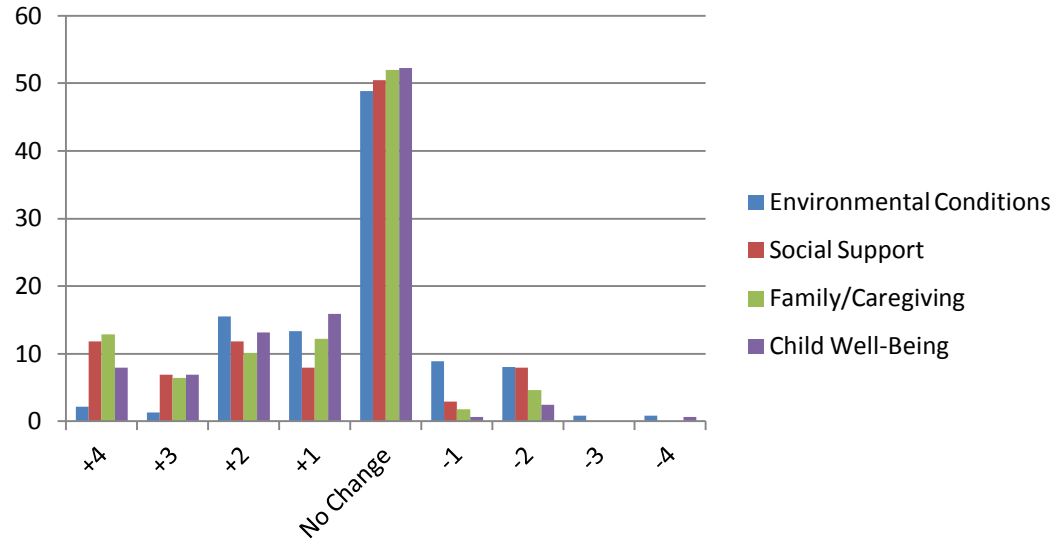


Figure 18: Degree of Change in Each Domain of the Strengths and Stressors Assessment

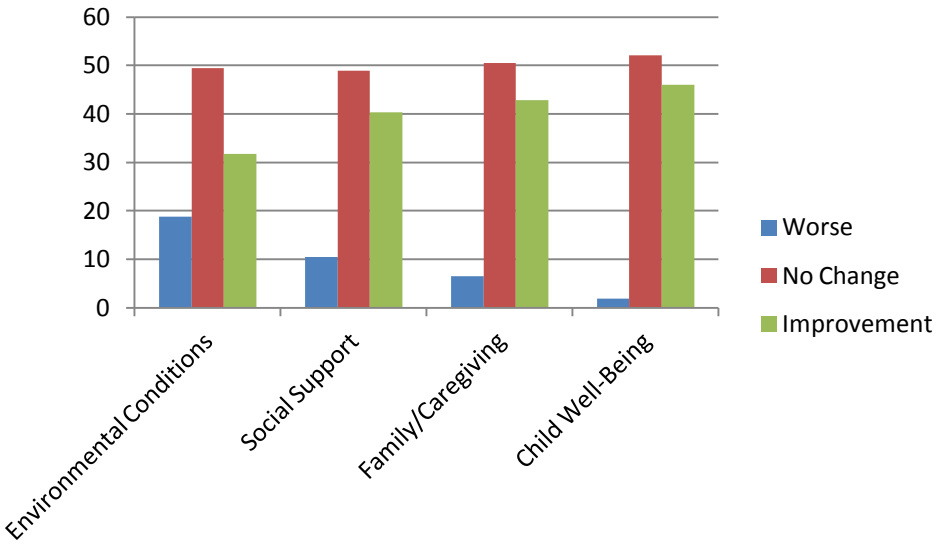


Figure 19: Percentage of Cases by change in each domain of the Strengths and Stressors Assessment

SUB-APPENDIX A Family-Based Ecological Assessment Scores

Family Functioning Domain
18 Components

Scale – Family Functioning (a – r) **18 components** **N = 13 (unless otherwise stated)**										**%** **Improvement**
(a) Ability to Access Resources	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	4				3	7				
Post	0				3	10				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					9		4			30.77%
(b) Daily Life Management	**Liability**				**Neither**	**Asset**				
Pre	7				2	6				
Post	2					11				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	5	2	4	1		53.85%
(c) Family Basic Needs	**Liability**				**Neither**	**Asset**				
Pre	1				4	10				
Post	1				2	10				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	10	2				15.38%
(d) Family Concrete Needs	**Liability**				**Neither**	**Asset**				
Pre	2				4	9				
Post	1				2	10				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	9	2	1			23.08%
Scale										**%** **Improvement**
(e) Financial	**Liability (No. of cases)**				**Neither (No. of**	**Asset (No. of cases)**				

					cases)					
Pre	4				4	6				
Post	1				5	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	2	3			38.46%
(f) Employment	**Liability**				**Neither**	**Asset**				
Pre	3				4	7				
Post	1				6	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					10	2		1		23.08%
(g) Medical Issues (N = 8)	**Liability**				**Neither**	**Asset**				
Pre	4				5	1				
Post	1				5	2				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					6	1	1			25.00%
(h) Mental Health (N = 8)	**Liability**				**Neither**	**Asset**				
Pre	5				3	2				
Post	1				2	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases		1			2	2	2	1		62.50%
(i) Substance Use (N = 7)	**Liability**				**Neither**	**Asset**				
Pre	1				7	0				
Post	2				5	0				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				2	4	1				14.29%
(j) Addictive Behaviours (N = 7)	**Liability**				**Neither**	**Asset**				
Pre	1				6	1				
Post	1				5	1				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	

No. of cases				1	5	1				14.29%
Scale										**% Improvement**
(k) Criminal Justice (N = 8)	**Liability**				**Neither**	**Asset**				
Pre	0				7	2				
Post	1				4	3				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases	1				7					0%
(l) Family Assessment (N = 8)	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	3				3	4				
Post	1				3	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					6	2				20.00%
(m) Family Motivation	**Liability**				**Neither**	**Asset**				
Pre	3				2	10				
Post	2				1	10				
Change	Worse				No Change	Improve				
	-4	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	9	2	1			23.08%
(n) Family Values	**Liability**				**Neither**	**Asset**				
Pre	3				7	4				
Post	1				6	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					9	4				30.78%
(o) Spirituality (N = 11)	**Liability**				**Neither**	**Asset**				
Pre	1				9	2				
Post	1				5	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	3				27.27%
(p) Family Relationship	**Liability**				**Neither**	**Asset**				

Pre	12				0	3				
Post	2				3	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	4		5	1	2	61.54%
Scale										**% Improvement**
(q) Family Communication	**Liability**				**Neither**	**Asset**				
Pre	11				2	2				
Post	2				2	9				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	3	2	3	3	1	69.23%
(r) Family Support	**Liability**				**Neither**	**Asset**				
Pre	8				5	2				
Post	3				4	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		7	2	1	2		38.46%

FBEA - Parenting domain components
3 Components

(a) Parenting	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				**% Improvement**
Pre	8				2	5				
Post	2				1	10				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	4	3	4	1		61.54%
(b) Monitoring	**Liability**				**Neither**	**Asset**				
Pre	10				2	3				
Post	3				2	8				
	Worse				No	Improve				

					Change					
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					4	3	4	2		69.23%
(c) Discipline	**Liability**				**Neither**	**Asset**				
Pre	14				0	1				
Post	3				2	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					2	2	5	4		84.62%

FBEA - Child Functioning
14 Domain Components (a – n)

Scale (N = 13 unless otherwise stated)										% Improvement
(a) Daily Life management	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	9				0	5				
Post	4				1	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1	1	5	2	3		1	46.15%
(b) Employment (N = 9)	**Liability**				**Neither**	**Asset**				
Pre	2				5	3				
Post	2				4	3				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					7	2				22.22%
(c) Medical Issues (N = 10)	**Liability**				**Neither**	**Asset**				
Pre	5				5	1				
Post	2				6	2				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	6	1	1		1	30.00%
(d) Mental Health (N = 10)	**Liability**				**Neither**	**Asset**				

Pre	3				7	1				
Post	1				5	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		5	1	2		1	40.00%
(e) Substance Use (N = 10)	**Liability**				**Neither**	**Asset**				
Pre	8				3	0				
Post	3				3	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases		1		2	4	2	1			30.00%
(f) Addictive Behaviours (N = 9)	**Liability**				**Neither**	**Asset**				
Pre	4				6	0				
Post	4				4	1				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					6	2	1			33.33%
Scale										**% Improvement**
(g) Criminal Justice Involvement (N = 9)	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	7				3	0				
Post	1				4	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	2	2	4			66.67%
(h) Childs Assessment (N = 9)	**Liability**				**Neither**	**Asset**				
Pre	4				5	1				
Post	0				6	3				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					5	2	1	1		44.44%
(i) Child's motivation	**Liability**				**Neither**	**Asset**				
Pre	8				2	4				
Post	4				1	8				

	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					7	3	1	2		46.15%
(j) Developmental Status (N = 11)	**Liability**				**Neither**	**Asset**				
Pre	2				6	4				
Post	1				5	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		7	2	1			27.27%
(k) Family Values	**Liability**				**Neither**	**Asset**				
Pre	3				8	3				
Post	2				5	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	7	3	2			38.46%
(l) Spirituality (N = 9)	**Liability**				**Neither**	**Asset**				
Pre	4				7	1				
Post	3				4	2				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	1				11.11%
Scale										**% Improvement**
(m) Interests & Hobbies	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	7				2	5				
Post	4				1	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	7	3	2			38.46%
(n) Relationships with Others	**Liability**				**Neither**	**Asset**				
Pre	13				2	0				
Post	3				2	8				
	Worse				No Change	Improve				

Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	2	3	4	2	1	76.92%

FBEA - Peer Domain
9 Domain Components

Scale **(N = 13 unless otherwise stated)**										% Improvement
(a) Substance Use of Peers **(N = 11)**	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	8				3	1				
Post	4				2	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	4	2	3		1	54.54%
(b) Addictive Behaviour of Peers **(N = 9)**	**Liability**				**Neither**	**Asset**				
Pre	4				5	1				
Post	2				3	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	4	1	2		1	44.44%
(c) Criminal Justice Involvement of Peers **(N = 10)**	**Liability**				**Neither**	**Asset**				
Pre	5				4	2				
Post	2				3	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		5	2	2			40.00%
(d) Peer Group	**Liability**				**Neither**	**Asset**				
Pre	7				3	3				
Post	4				3	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	8	1	2	1		30.77%

(e) Level of involvement with Peers	**Liability**				**Neither**	**Asset**				
Pre	11				1	2				
Post	5				1	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	5	3	3	1		53.85%

(f) Relationships with Peers	**Liability**				**Neither**	**Asset**				
Pre	6				5	3				
Post	3				3	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	8	2	2			30.77%

(g) History of Peer Involvement (N = 12)	**Liability**				**Neither**	**Asset**				
Pre	8				2	3				
Post	4				4	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		5	3	1	1	1	50.00%

(h) Patterns of Peer Interaction	**Liability**				**Neither**	**Asset**				
Pre	9				3	2				
Post	4				3	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	6	1	5			46.15%

(i) Other Friendships (N = 11)	**Liability**				**Neither**	**Asset**				
Pre	5				5	2				
Post	3				4	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	1	2			27.27%

FBEA - School Domain
8 Domain Components

Scale (N = 13 unless otherwise stated)									% Improvement
(a) Family Involvement with School	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**			
Pre	4				1	9			
Post	2				2	9			
	Worse				No Change	Improve			
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**
No. of cases					10	2	1			23.08%
(b) School Support Systems (N = 10)	**Liability**				**Neither**	**Asset**			
Pre	1				3	7			
Post	1				1	8			
	Worse				No Change	Improve			
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**
No. of cases					9	1				10.00%
(c) Drug Activity in School (N = 10)	**Liability**				**Neither**	**Asset**			
Pre	0				9	2			
Post	0				7	3			
	Worse				No Change	Improve			
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**
No. of cases					9	1				10.00%
(d) School Safety (N = 12)	**Liability**				**Neither**	**Asset**			
Pre	1				4	8			
Post	0				2	10			
	Worse				No Change	Improve			
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**
No. of cases					10	1	1			16.67%
(e) School Attendance (N = 12)	**Liability**				**Neither**	**Asset**			
Pre	7				1	5			
Post	3				1	8			

	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2	1	4	2	2		1	41.17%
(f) School Achievement	**Liability**				**Neither**	**Asset**				
Pre	8				3	3				
Post	5				3	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1	1	6	3		1	1	38.46%
(g) School behaviour	**Liability**				**Neither**	**Asset**				
Pre	7				2	5				
Post	3				3	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				2	7		1	1	2	30.77%
(h) Involvement in Extra-Curricular Activities (N = 12)	**Liability**				**Neither**	**Asset**				
Pre	6				5	3				
Post	4				3	5				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					10	1	2			16.67%

FBEA - Community Domain
10 Domain Components

Scale (N = 13 unless otherwise stated)										% Improvement
(a) Accessibility to Community Resources	**Liability (No. of cases)**				**Neither (No. of cases)**	**Asset (No. of cases)**				
Pre	5				2	8				
Post	1				1	11				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	2	2		1	38.46%
(b) Availability of	**Liability**				**Neither**	**Asset**				

Religious Institutions										
Pre	0				7	8				
Post	0				6	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					13					0%
(c) Community Stability	**Liability**				**Neither**	**Asset**				
Pre	1				4	10				
Post	1				5	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		11	1				7.70%
(d) Neighbourhood Stability (N = 12)	**Liability**				**Neither**	**Asset**				
Pre	1				3	10				
Post	1				3	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		9	2				16.67%
(e) Community Involvement (N = 11)	**Liability**				**Neither**	**Asset**				
Pre	6				5	2				
Post	2				5	4				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					6	4	1			45.45%
(f) Neighbourhood Involvement (N = 12)	**Liability**				**Neither**	**Asset**				
Pre	4				6	4				
Post	1				4	7				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					7	4	1			41.67%
(g) Drug Activity in Neighbourhood (N = 12)	**Liability**				**Neither**	**Asset**				
Pre	6				5	3				
Post	4				5	3				

	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					10	2				16.67%
(h) Employer Support (N = 9)	**Liability**				**Neither**	**Asset**				
Pre	0				4	6				
Post	0				3	6				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					8	1				11.11%
(i) Safety in Community	**Liability**				**Neither**	**Asset**				
Pre	3				3	9				
Post	2				2	9				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					12	1				7.70%
(j) Safety of Neighbourhood	**Liability**				**Neither**	**Asset**				
Pre	2				4	9				
Post	2				3	8				
	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					12	1				7.70%

SUB-APPENDIX B Strengths & Stressors Assessment Scores

S&S - Environmental Conditions Domain
9 Components

Component of Environmental Conditions (N = 25 unless otherwise stated)	**Degree of Change**					**Degree of Change**				**% Improvement**
(a) Housing Stability	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		13	2	6	1	1	40.00%
(b) Safety in Community	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases	1	1	5	1	12	1	4			20.00%

(c) Habitability of Housing	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2	4	12	1	5	1		28.00%
(d) Income	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				3	11	6	5			44.00%
(e) Financial Management	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				3	9	8	1		4	52.00%
(f) Food & Nutrition	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases		1	2	1	11	2	8			40.00%
(g) Personal Hygiene	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				4	18	2		1		12.00%
(h) Transportation	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases	1		4	1	13	3	3			24.00%
(i) Learning Environment	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			3	3	11	5	3			32.00%

S&S - Social Support Domain
4 Components

Component of Social Support (N = 25 unless otherwise stated)	**Degree of Change**					**Degree of Change**				**% Improvement**
(a) Social Relationships (N = 26)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		17	1	2	4		30.77%
(b) Regular Services	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	

No. of cases			4		6	3	6	2	4	60.00%
(c) Emergency Services	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				3	14	2	4		2	32.00%
(d) Motivation for Support	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			3		14	2		1	5	32.00%

S&S - Caregiver Skills Domain

11 Components

Component of Caregiver Skills (N = 26 unless otherwise stated)	**Degree of Change**					**Degree of Change**				**% Improvement**
(a) Family/Caregiver (N = 23)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	8	2	8	3	1	60.87%
(b) Adult Supervision	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					7	5	2	4	8	73.08%
(c) Parenting Skills	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				3	3	4	4	8	4	76.92%
(d) Support for Child Development (N = 24)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		17	1		1	4	25.00%
(e) Parental Mental Health	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			3		16	4	2		1	26.92%
(f) Physical Health	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		23				2	7.69%
(g) Alcohol/Drug Abuse	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		18	4	2			23.08%

(h) Bonding with Children	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		18	1	1		4	23.08%
(i) Expectations of Children	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		15	6	1		2	34.62%
(j) Mutual Support (N = 24)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					4	3	5	2	10	83.33%
(k) Marital Relationship	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2	1	16	4	3			26.92%

S&S - Child Well-Being Domain

12 Components

Component of Child Well-Being Domain (N = 26 unless otherwise stated)	**Degree of Change**					**Degree of Change**				**% Improvement**
(a) Child Physical Abuse	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					17	5	2	2		34.62%
(b) Child Sexual Abuse	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					26					0%
(c) Child Emotional Abuse	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		18	4		2		23.08%
(d) Child Neglect	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					22	2	1	1		15.38%
(e) Child Domestic Violence	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					21	4	1			19.23%

(f) Childs Mental Health	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					3	5	6	2	9	88.46%
(g) Child's Behaviour (N = 5)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases					0	0	4	1		100%
(h) Child's School Behaviour	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases				1	11	2	4	2	6	53.85%
(i) Relationship with Caregiver	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			1		3	5	9	5	3	84.62%
(j) Relationship with Siblings (N = 24)	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases	2				13	6	2	0	1	37.50%
(k) Relationship with Peers	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2	1	7	6	7	2	1	61.54%
(l) Motivation/Co-operation	Worse				No Change	Improve				
Change	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**	
No. of cases			2		10	7	2	2	3	53.85%

APPENDIX E: TRACKED FIDELITY SCORES 2007-2011

REALTIONSHIP BUILDING AND ENGAGEMENT					
ITEM	Family traditions and beliefs				
YEAR	2007	2008	2009	2010	2011
SCORE	2.75	2.67	2.89	3.67	4.06
N	24	83	67	9	17
ITEM	Relevant family included in intervention				
YEAR	2007	2008	2009	2010	2011
SCORE	2.73	2.77	3.15	4.29	4.42
N	22	21	46	7	12
ITEM	Youth/families express views and opinions				
YEAR	2007	2008	2009	2010	2011
SCORE	2.88	2.8	3.42	4.43	3.94
N	24	75	55	7	17
ITEM	Maintain quality components				
YEAR	2007	2008	2009	2010	2011
SCORE	3.54	3.31	3.53	5	4.4
N	24	24	70	7	17
ITEM	Family as experts/family empowerment				
YEAR	2007	2008	2009	2010	2011
SCORE	2.5	2	3.24	3	4.18
N	24	71	50	8	17
ITEM	Join in family communication style				
YEAR	2007	2008	2009	2010	2011
SCORE	2.73	2.93*	3.17	3.22	4.12
N	22	23	63	9	17
ITEM	Appropriate professional behaviour/roles and boundaries				
YEAR	2007	2008	2009	2010	2011
SCORE	3.05	3.02	3.22	3.44	4.5
N	22	82	64	9	10
TEACHING COMPONENTS/ASSESSMENT AND EXPLORATION					
ITEM	Issues based on family plan				
YEAR	2007	2008	2009	2010	2011
SCORE	2.17	2.13	2.58	4.25	4.27
N	23	15	59	7	17
ITEM	Preventive prompts				
YEAR	2007	2008	2009	2010	2011
SCORE	2.33	2.16	2.68	3	4.09
N	18	19	58	6	11
ITEM	Use Praise				
YEAR	2007	2008	2009	2010	2011
SCORE	2.46	2.38	2.72	3.33	4.33
N	24	24	61	9	12
ITEM	Teaches parents to apply consequences				
YEAR	2007	2008	2009	2010	2011
SCORE	2.18	2.75	2.97	4	4
N	17	24	64	5	8

ITEM	Uses rationales				
YEAR	2007	2008	2009	2010	2011
SCORE	2.41	2.75	2.97	4	4.42
N	22	24	64	7	12
ITEM	Ensures adequate practice of skills				
YEAR	2007	2008	2009	2010	2011
SCORE	1.5	2.92	2.94	2.4	4.1
N	12	24	29	5	10
ITEM	Uses assignments				
YEAR	2007	2008	2009	2010	2011
SCORE	2.41	2.75	3.17	3	4.42
N	22	65	54	9	12
ITEM	Uses variety of teaching techniques				
YEAR	2007	2008	2009	2010	2011
SCORE	2.38	2.72	3.09	3.22	4.42
N	24	67	66	9	12
ITEM	Active listening				
YEAR	2007	2008	2009	2010	2011
SCORE	3	2.88	2.88	3.56	4.24
N	24	24	69	9	17
ITEM	Addresses issues family want to change				
YEAR	2007	2008	2009	2010	2011
SCORE	2.92	2.57	3.37	3.22	4.06
N	24	81	62	9	17
ITEM	Uses exploration				
YEAR	2007	2008	2009	2010	2011
SCORE	2.78	2.71	3.02	3.56	4.41
N	23	14	67	9	17
SAFETY					
ITEM	Ensure safety of self				
YEAR	2007	2008	2009	2010	2011
SCORE	3	3.03	3.32	3.17	4.71
N	16	37	31	6	7
ITEM	Safety of family members				
YEAR	2007	2008	2009	2010	2011
SCORE	2.88	2.96	3.17	4.5	4.33
N	16	51	52	6	9
ITEM	De-escalates crises				
YEAR	2007	2008	2009	2010	2011
SCORE	1.44	3.54	3.34	4	4.33
	9	24	3	4	3
RESOURCES AND SUPPORTS					
ITEM	Concrete supports and services				
YEAR	2007	2008	2009	2010	2011
SCORE	2.71	2.67	3.38	4.8	4.4
N	14	49	34	5	10

*Four scores from year averaged due to incomplete data

APPENDIX F: COMMUNITY BASED PRACTICE QUESTIONNAIRE

Section 1 – Nature of Work

These questions are about the nature of your day to day work

	Entirely on an				Entirely on a Group Basis
1. My work is carried out:	❍	❍	❍	❍	❍

	Only Parents	Only Children	Both Parents and Children
2. In my current position, I work with:	❍	❍	❍

	Planning Work	Doing Direct Face to Face Work	Recording
3. Approximately how much time do you spend per week:	_____ hrs.	_____ hrs.	_____ hrs.

4. What three key theories do you draw on in your day to day practice?

i. _____

ii. _____

iii. _____

	Yes	No	Don't Know
5. Are your agency's policies grounded in a particular theoretical model?	❍	❍	❍

6. Now, we would like to ask you about your experience at work, your caseload, and your perceptions of the current state of the practice.	Number of Cases
On average, how many cases are you responsible for in a year?	_____

7. For a multitude of reasons, planned work can't always be completed and cases are closed prematurely. Please indicate:

Total number of cases closed prematurely in the last 12 months _____

Total number of cases closed in the last 12 months _____

8. Please tick the intervention level at which you do most of your work?

❍ Level 1 - Work with all children and young people

❍ Level 2 - Work with children with additional needs requiring preventive supports

❍ Level 3 - Work with children with chronic or serious problems requiring intensive support in the community

❍ Level 4 - Work with children and family has broken down temporarily / permanently and who are likely to be living away

Section 2 – Context of Work

9. It is also important for us to understand the wider context in which your work takes place. Please tell us about the context of your work in relation to the following statements.	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1. My agency[7] has a keen understanding of community needs.	❍	❍	❍	❍	❍
2. There are good planning processes in my agency.	❍	❍	❍	❍	❍
3. My agency has a clear focus on its goal.	❍	❍	❍	❍	❍
4. We don't have enough caseworkers to get things done.	❍	❍	❍	❍	❍
5. People here actively contribute to shaping agency objectives.	❍	❍	❍	❍	❍
6. My agency is committed to evaluation.	❍	❍	❍	❍	❍
7. My agency engages in high quality needs assessments.	❍	❍	❍	❍	❍
8. Making progress isn't simply a matter of resources	❍	❍	❍	❍	❍
9. My agency routinely re-evaluates its goals/missions.	❍	❍	❍	❍	❍
10. We don't have sufficient funding to achieve our goals.	❍	❍	❍	❍	❍

10. Agencies sometimes work together, are sometimes at odds with each other, or operate independently. Please tell us about your interagency experiences.	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1. Most of my work involves joint work with other agencies.	❍	❍	❍	❍	❍
2. Other agencies are happy to share service-user information	❍	❍	❍	❍	❍
3. My experience with other agencies has been unpleasant.	❍	❍	❍	❍	❍
4. Other agencies want to take credit for my work.	❍	❍	❍	❍	❍
5. I've found other agencies to be very helpful in my success.	❍	❍	❍	❍	❍
6. I would prefer to not work with other agencies.	❍	❍	❍	❍	❍
7. Other agencies are hostile toward my work.	❍	❍	❍	❍	❍
8. I could not do my job without the assistance of other	❍	❍	❍	❍	❍
9. Interagency work only makes it harder to meet client needs.	❍	❍	❍	❍	❍
10. My manager expects us to be part of interagency work.	❍	❍	❍	❍	❍
11. I value the skills that other disciplines bring to my casework	❍	❍	❍	❍	❍
12. Other disciplines are not respectful of my role	❍	❍	❍	❍	❍
13. In most of my work I see myself as part of a multidisciplinary team	❍	❍	❍	❍	❍

[7] **Agency** refers to the local level project / service that you work for.

11. What three key agencies do you collaborate with in your day to day work?

1. _____
2. _____
3. _____

Section 3 – Impact of and supports for Work
These questions are about your perceptions of the impact of your work and the support you receive in doing your job.

12. In the five most recent cases that have come to a conclusion, please indicate the extent to which you have achieved the child /family goals and the key evidence of this.

	Goals Achieved				
Case	**None**	**Some**	**Most**	**All**	**Key Evidence**
1	❍	❍	❍	❍	
2	❍	❍	❍	❍	
3	❍	❍	❍	❍	
4	❍	❍	❍	❍	
5	❍	❍	❍	❍	

13. People have different impressions of the impact that their work has. How strongly do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1. I believe I make a difference.	❍	❍	❍	❍	❍
2. I see clear evidence of the impact of my work.	❍	❍	❍	❍	❍
3. My work has a lasting impact.	❍	❍	❍	❍	❍
4. The system is too complicated for me to make a difference.	❍	❍	❍	❍	❍
5. The children I work with have too many problems to deal with in a community setting.	❍	❍	❍	❍	❍
6. We need new frameworks/models for youth services.	❍	❍	❍	❍	❍

14. Many forms of support allow us to better meet our goals. There are also many obstacles that can get in the way of successfully achieving outcomes. Please tell us how strongly you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1. My supervisors provide regular feedback on my performance.	❍	❍	❍	❍	❍
2. I receive recognition for my work.	❍	❍	❍	❍	❍
3. My supervisors provide backing for my decisions.	❍	❍	❍	❍	❍
4. There are adequate agency resources to achieve my goals.	❍	❍	❍	❍	❍
5. My agency tries to make sure I don't have too many cases.	❍	❍	❍	❍	❍
6. My supervisors take steps to decrease caseworker burnout.	❍	❍	❍	❍	❍
7. The supervision processes supports my work.	❍	❍	❍	❍	❍
8. There is sufficient casework recording in my agency.	❍	❍	❍	❍	❍
9. My agency provides adequate opportunities for reflection.	❍	❍	❍	❍	❍

	Fortnightly	Monthly	Other
15. How frequently do you receive supervision:	❍	❍	❍

Please

16. Do you think there is a scope for improving your day to day practice in working with children and parents?

Yes	No
❍	❍

If yes, please identify three key things that would help improve your practice?

1._____

_____

_____

_____

2.

_____

_____

_____

3._____

_____

_____

_____

Section 4 – Impact of Mol an Oige/Boys Town Approach

These questions are about whether Mol an Oige/Boys Town approach has had an impact on your work. Based on your experience with the Boys Town programme, please tell us to what extent your knowledge/skills in the following areas have increased or decreased

Statements	GreatlyDecreased	Decreased	Neither Increased or Decreased	Increased	Greatly Increased
1. Imparting knowledge to parents through my teaching skills	❍	❍	❍	❍	❍
2. Building healthy relationships	❍	❍	❍	❍	❍
3. Creating a positive family environment	❍	❍	❍	❍	❍
4. Promoting self determination /self government	❍	❍	❍	❍	❍
5. Ability to connect with the various programme domains	❍	❍	❍	❍	❍
6. Ability to connect with client family members	❍	❍	❍	❍	❍
7. Ability to connect with peer networks of children	❍	❍	❍	❍	❍
8. Ability to connect with schools	❍	❍	❍	❍	❍
9. Ability to connect with other organisations in the family's life	❍	❍	❍	❍	❍
10. Understanding of social networking/mapping	❍	❍	❍	❍	❍
11. Teaching as intervention	❍	❍	❍	❍	❍
12. Active listening	❍	❍	❍	❍	❍
13. Corrective teaching	❍	❍	❍	❍	❍
14. Proactive teaching	❍	❍	❍	❍	❍
15. Assessing resources in the community	❍	❍	❍	❍	❍
16. Teaching self-control	❍	❍	❍	❍	❍
17. Using consequences as part of a motivation system	❍	❍	❍	❍	❍
18. Staff supervision as part of the programme's implementation	❍	❍	❍	❍	❍
19. Staff autonomy	❍	❍	❍	❍	❍
20. Skills-based training	❍	❍	❍	❍	❍
21. Data-based approach	❍	❍	❍	❍	❍
22. Systematic procedures	❍	❍	❍	❍	❍
23. Consumer orientation of supervisor towards staff	❍	❍	❍	❍	❍
24. Emphasis on evaluation (outcomes)	❍	❍	❍	❍	❍
25. Behavioural approach to problem solving	❍	❍	❍	❍	❍
26. Ethical imperative to work	❍	❍	❍	❍	❍
27. Confrontation	❍	❍	❍	❍	❍

28. Reframing (turning negatives into positives)	❍	❍	❍	❍	❍
29. Suggestive teaching	❍	❍	❍	❍	❍
30. Circular refocusing (getting conversations back on track)	❍	❍	❍	❍	❍
31. Metaphors (using stories or analogies)	❍	❍	❍	❍	❍
32. Effective praise	❍	❍	❍	❍	❍
33. Exploration	❍	❍	❍	❍	❍

Section 5 – About You

Finally, we want to ask you a few questions about yourself. You may be assured of complete confidentiality. Data will only be used as part of an overall aggregate analysis.

Gender		How old were you on your last birthday?	Do you live in the same County as you work?		How many years of experience in this field have you?
❍	Male	_____	❍	Yes	_____ years
❍	Female		❍	No	

What county do you work in?			What agency/service do you work for (remember, this is confidential)?
❍	Mayo	❍	HSE Child Care
❍	Roscommon	❍	The Edge
		❍	Sli Nua
		❍	Community-Based family Support Service
		❍	NYP
		❍	HSE family Support

Job Title	Is your training mainly in:		Training background/qualifications
❍ Project Leader	❍ Early years	❍ Youth work	❍ Institute of Technology Certificate
❍ Project Worker	❍ Childcare	❍ Teaching	❍ Institute of Technology Diploma
❍ Child Care Leader	❍ Social Work	❍ Other:	❍ Institute of Technology Degree
❍ Other _____	❍ Community work	_____	❍ University degree programme
			❍ University post-graduate degree programme
			❍ Other _____

Please tick all relevant qualifications

Average Hours Worked Per Week:	_____

In the space provided below, please feel free to offer any information that you feel would help us better understand the practice environment in which you work.

_____
_____
_____
_____
_____
_____
_____

APPENDIX G: THEORETICAL OVERVIEW OF THE PHILOSOPHICAL UNDERPINNINGS OF THE PROJECT[8]

Introduction

The nature and degree of support encountered within the everyday social contexts of family, peers, school and community are generally considered crucial in appreciating how well adolescents are faring (Barnes, Katz, Korbin & O'Brien, 2006; Bowes & Hayes, 2004; Brennan, Barnett, & Lesmeister, 2008; McGrath, 2004). These foundational supports are in turn shaped by wider societal conditions and changes. The Boys Town programme utilises a variety of models designed to tailor youth development outcomes to a variety of settings. All are characterised by a melding of youth, family, and community social supports.

This section outlines the literature relevant to the goals and intended outcomes of the Boys Town model as it operates across different countries. The review presents the theoretical basis for youth treatment, development and support by way of exploring the concept and practice of social support and how it relates to youth well being. The role played by social capital and community participation are also emphasised here, with particular emphasis placed on the natural sources of help within an adolescent's social network.

Theoretical Basis for Youth Treatment, Development, and Social Support

Resiliency, most simply, manifests itself as the ability to respond or perform positively in the face of adversity, to achieve despite the presence of disadvantages, or to significantly exceed expectations under given negative circumstances (Gilligan, 2007). Such conditions can be applied to the individual level (youth) or broader social context (communities). Reflective of individual level resiliency are characteristics such as cognitive capabilities, self-regulating behaviours, and social support levels. At the broader community level, resiliency is shaped by a variety of conditions ranging from social controls to the local adaptive capacities of organised residents (Brennan, 2006). Central to the latter are dense social networks and channels of interaction spanning the diversity of our localities.

Well-being and social support from informal social networks

It is generally accepted that 'social support' is a multifaceted and complex phenomenon (Brugha, 1995; Cutrona, 1996; Eckenrode & Hamilton, 2000; Veiel & Baumann, 1992; McGrath, 2004). Defining social support is difficult in itself (Veiel & Baumann, 1992), although Cutrona (1996) offers a succinct definition as those "acts that demonstrate responsivity to another's needs" (p.17). The significance of social support for adolescents is usually understood in the context of their psychological well-being and its role as a buffer against stress (Barbee, 1990; Cobb, 1976; Cohen & Wills, 1985; Gottlieb, 2000; Tardy, 1994; Teelan, Herzog & Kilbane, 1989; Weiss, 1974). The availability of social support is recognised as assisting adolescent well-being through the development of self-esteem and self-efficacy (Axelsson & Ejlertsson, 2002; Harter, 1993), while for children/adolescents in adverse social circumstances, positive and accessible social support networks have been identified as offering secondary protection (Belsky, 1997; Thompson, 1995).

[8] As presented in the interim report (2010).

Although social support can be accessed through both informal and formal sources (Cutrona & Cole, 2000; Ghate & Hazel, 2002), three particularly important categories of informal network members can be identified in adolescence: peers, family, and non-related adults (Bo, 1989; Cotterell, 1992; Jack, 2000). As noted by Jack (2000) these personal social networks of support have consistently played a positive role for families. The main functions of support have been identified as the provision of emotional support, instrumental help or concrete support, information/advisory support and esteem support (Cutrona, 2000; Jack, 2000).

Family and peers constitute the largest part of an adolescent's social network (Buysee, 1997; Frydenburg, 1997), with nuclear and extended family members representing the most likely source of natural helpers, as well as the most durable and dependable source of support (NicGabhainn, 2000; Tracy & Biegel, 1994; Tracy & Whittaker, 1990). Friends provide a further significant source of network membership, especially in adolescence (Cotterell, 1996; Feldman & Elliot, 1993). Adolescent friendship typically provides a source of concrete help and advice after parents (Dolan, 2006b). Studies show that peers provide an important sounding board for topics that might be off-limits with family while having strong friendship ties can buffer against bullying behaviour (e.g. Cowie, 1999; Naylor & Cowie, 1999). It appears that location also contextualises friendships, with rural adolescents tending to have smaller, more cohesive peer groups, which means issues of conflict and stress feature more prominently as concerns than among urban adolescents, who tend to be part of a much wider network of peers (Elgar, Arlett, & Groves, 2003). As with all types of network relationships, it is important to recognise that not all peer relations are positive (Barrera & Garrison-Jones, 1992).

Finally, outside of family and friends, 'other adults' can constitute an important role in young people's lives. A variety of studies show that young people's attachment to after-school programmes, groups and organisations is invariably linked to their relationship with a caring adult involved in the intervention (see Albanesi, Cicognani & Zani, 2007; Ferrari & Turner, 2006; Jarrett, Sullivan & Watkins, 2005; Paisley & Ferrari, 2005), while mentoring programmes across the world, such as Big Brothers and Big Sisters (Brady & Dolan, 2007; Grossman & Tierney, 1998), are becoming increasingly popular and effective forms of support. This research illustrates that the qualities of support from 'other adults' emerge from such relational features as authenticity, empathy, collaboration, and companionship (Spencer, 2006). Within school, Richman et al's (1998) research reveals that teachers, along with parents, can be seen by 'at-risk' students as an important primary source of support, in terms of emotional support, practical assistance and for general appreciation of effort (as will be elaborated below).

In sum, informal personal networks of support are central to providing the most immediate, accessible and common forms of support and have demonstrated consistent significance in promoting the well-being of adolescents. We now examine the empirical evidence concerning the connection between well-being and the community context in which young people live and interact.

Well-being, social capital and community participation

In this section we attempt to examine a number of dimensions associated with the general sociological features of 'social capital' and community participation. These areas have occupied particular interest among researchers and policy makers in terms of their contribution towards child and adolescent well-being (Bowes & Hayes, 2004; Barnett & Brennan, 2006; Brennan, *et al.,* 2007;

Brennan *et al*., 2008; Ferguson, 2006; Jack, 2000; Jack & Jordan, 2001;). In contrast to family social capital, community (exterior) social capital is defined through a person's or family's interactions and relationships with their surrounding community, including people and institutions such as school. Despite its elusive nature (Morrow, 2000), there are dimensions of social capital – through social support networks, civic engagement in local activities and institutions, trust and safety, degree of religiosity, quality of school and quality of neighbourhood – that are all recognised as promoting positive outcomes for children and adolescents (Ferguson, 2006). Social networks in a community can act as a form of collective agency and socialisation, especially where like-minded adults provide norms and sanctions concerning children and adolescents' well-being (Jack, 2000; Brennan, 2007b; Wilkinson, 1991).

As an associated feature of social capital, participation in community activities and formal groups is also associated with behavioural well-being among adolescents. Involvement in formal activities in groups and clubs, especially where meaningful relationships can be developed with adults outside the family and school, has potential for improving social well-being (Albanesi *et al.*, 2007). Participation in community activities has been shown to provide such outcomes as: increasing academic performance during high school, and further increasing the likelihood of college attendance (Eccles & Barber, 1999); greater school engagement (Brennan, *et al.*, 2007; Lamborn, Brown, Mounts & Steinberg, 1992); and reinforcing positive social values (setting an example) (Youniss & Yates, 1997). Other factors have been reported by youth as influencing their need for, and willingness, to be a part of a greater good through community involvement. These include: feelings of efficacy (Sherrod, Flanagan & Youniss, 2002), the need to be valued and taken seriously by others in the community (Barnett & Brennan, 2006; Flanagan & Van Horn, 2001), increasing their own self-esteem, and having a responsibility toward society by performing a public duty (Independent Sector, 2001). Recognition by the community at large is part of feeling valued (Scales & Leffert, 1999).

As a significant institution within the community, school has an important bearing on adolescents' sense of well-being. School can act as an important psychosocial resource in supporting young people, especially adolescents isolated from support networks (Rostosky, Owens, Zimmerman & Riggle, 2003). School connectedness has been defined to include common indicators such as: liking school, a sense of belonging, positive relations with teachers and friends, and an active engagement in school activities (Thompson, 1995). Further, school-based research literature finds that youth who feel they connect to school also report better health and emotional well-being as well as less substance abuse, suicidal ideation, depressive symptoms and risk of violent or deviant behaviour and pregnancy (Blum, McNeely & Rinehart, 2002; Bonny *et al*, 2000; Eccles, Early & Frasier, 1997; Jacobson & Rowe, 1999; Resnick, Bearman, & Blum, 1997).

Finally, the type of community in which a school is located can influence safety and discipline in multiple, and sometimes off-setting, ways. For example, American rural communities tend to have higher levels of community identification and participation (a positive influence on a school's environment) and lower levels of educational attainment and income (a negative factor) than suburban and urban locations (Stockard & Mayberry, 1992). The importance of school in a rural context also lies in the fact that it may be one of the few outlets where adolescents can socialise with their peers. Rostosky et al. (2003) in their research of rural communities in Kentucky, United States, found that a sense of school belonging and fitting in can be felt quite acutely among adolescents, since such places tend to be close-knit and typically conservative in nature.

Conclusion

The connections a family – and in particular adolescents – form with wider networks of support are useful indicators of the potential within their lives to obtain support from informal sources. Such connections can impact on well being in a positive way and produce good outcomes for children. The findings from the literature presented here are interesting for all those who work with young people and families, but particularly for those involved in implementing the Mol an Óige model in Ireland. The model places a strong emphasis on connecting individuals with a range of actors across different domains – family, school, peer and community – so as to increase their sense of well being and improve their family life overall. The context in which the model operates in Ireland is now where we turn.

APPENDIX H: BIBLIOGRAPHY

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