What interventions are effective in improving outcomes for children of families with multiple and complex problems?

Prepared by Ilan Katz, Catherine Spooner and Kylie Valentine
Social Policy Research Centre, University of New South Wales, Australia
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Australian Research Alliance for Children & Youth
PO Box 1360 WEST PERTH WA 6872
Level 13, Dumas House
2 Havelock Street WEST PERTH WA 6005
Telephone: 08 9476 7800

www.enquiries@aracy.org.au
www.aracy.org.au
INTRODUCTION

In Australia and internationally there is a great deal of activity around designing and delivering programs for families and young children. Communities for Children is an important part of this. Equally, an increasing focus on the efficacy of programs and the evidence base of ‘what works’ translates to a large and increasing body of research. The research literature is so large and complex that it is very difficult for practitioners, service managers and policy makers to use evidence-based practice. Furthermore, research and practice in relation to vulnerable families have tended to address problems in isolation. This is problematic because vulnerable families tend to have multiple problems. In this context, ARACY has identified a need for a practical guide for practitioners, service managers and policy makers on which interventions produce effective outcomes for children of families with complex and multiple problems. In this paper, we have distilled the evidence base into actionable messages for ready application by the Communities for Children projects.

This paper has three sections:

1. Translation of research into practice.
   This section describes practice lessons for working with families that have been distilled from research. They are designed to be useful in the design and delivery of all services and programs, rather than a template for setting up a particular program.

2. Interventions for families with multiple and complex problems.
   This section describes specific interventions and their key features, including information on where to find out more. These interventions were selected (1) on the basis of quality of evidence available about these programs and their effectiveness; and (2)
to represent the range of key features and different approaches that have been used.

3. Methods and annotated bibliography.
This section describes the primary research sources we used, the approaches we took to assessing these sources, and a list of other useful resources.

The paper can be used in a number of ways. The first section is designed to be of use for agencies who work with families with multiple and complex problems, for incorporation into core activities. This section also suggests some key lessons around implementation of new services. The second section is for agencies and services that are looking to implement new services, and provides information on some of the best known and empirically supported programs. In many cases these programs have extensive resources for organisations including training and manuals, and fairly strict requirements about the purchase of these. The third section provides information on how we put this paper together and resources for those interested in following it up further.
TRANSLATION OF RESEARCH INTO PRACTICE

In assessing the research, we grouped those findings that referred to general lessons for practice into: assessment of need; retention and engagement; implementation; program format; family members and types; and goals. This part of the paper concludes with lessons on what is known to be bad practice and gaps in the research, or what is not known.

Assessment of Need

Universal and targeted services

Services for families with young children who have multiple and complex programs can be categorised into three types:

- universal services that focus on parenting and/or on the needs of children;
- targeted services for families with complex needs or who are identified as being ‘at risk’, that focus on parenting and/or children; and
- services that address other needs of families than parenting or children – for example, housing or health services.

For the most part, the literature reviewed here is concerned with the first two, that is, with generalist or specialised services that have a content focus on parenting or on children.

Programs and services that address universal needs, such as early education and care, can benefit all families; and programs that educate parents in the needs of their children and in areas like behaviour management can also benefit families of all kinds. For these reasons, universal services such as quality child care and parent education and support programs are included in most lists of programs and services for families with multiple need.
However, families with multiple and complex problems may find it difficult to use generalist services. In addition, all families are different, and families with multiple and complex problems differ from each other as well as from families without such problems. It is therefore important that family needs are matched with services and that services are tailored to needs [1]. Prior to implementing any intervention it is important that the intervention be based upon the needs and wants of the target population or client group. These can be identified via a survey, key informant consultations (that is, talking with clients and other service providers) and/or a review of case notes. Meeting the specific requirements of parents, including referrals to other services and addressing immediate practical need, are also crucial [2, 3].

Once an intervention is planned, the question of which families should attend might arise (the issue of targeted vs. universal programs is discussed below). Ideally, families with multiple needs are being case-managed and participation in this intervention is part of a broader plan. Alternately, participation in the intervention might be the point of access for families who can then receive further assistance with other problems. Either way, these interventions alone will not be as successful as these interventions incorporated within a management plan that is based upon thorough assessment of all of the family's needs.

**Targeting, not labelling**

It is important that services and programs are tailored to meet the specific needs of families with multiple and complex problems, and that the failures of universal and generalist services in meeting their needs are recognised. It is equally important that services and programs do not focus on problems, and that the capacities and strengths of families are central. The importance of strengths-based approaches is discussed below. For this reason, it is
unhelpful to label families, as ‘high risk’ or as ‘multi-problem’, when recruiting and running services.

The balance between targeting appropriately (so that services are not utilised only by those families who don’t have multiple and complex problems) and avoiding labels (so that those families who do have multiple and complex problems aren’t further stigmatised) seems to be crucial to effective practice.

**Practice Lessons**

Strategies for practitioners and agencies in making sure those families receive services and support they need include:

- assessing the characteristics, needs and wants of families before they enrol in any program;
- gathering information about the family from both the family themselves and other sources where possible (for example, from other service providers or case notes); and
- identifying and meeting immediate needs for practical support and access to other services.

**Retention and Engagement**

**Summary of the challenges**

Although there are many reports of programs aimed at ‘high risk’ families, or families with particular difficulties, there are no programs in the literature which are specifically aimed at multi problem families. In addition, most programs for high risk families are not specifically targeted at children under five. Participation in programs by teenage parents, single parents in receipt of benefits, mothers reporting depression, alcoholism or drug abuse, and parents with previous involvement with child protection services has resulted
in improvements to their children’s behaviour. However, many of these parents are likely to drop out of programs [cited in 4]. Recruitment of families into preventive interventions is very challenging, particularly for at-risk populations. This is true even for the initial assessment stage of an intervention [cited in 5]. Vulnerability increases the likelihood of refusing the offer of services [6]. Engaging families through a trusted agency can be effective [3]. Families with complex needs, including families with children with more severe social and behavioural problems are among the significant proportion who tend to drop out of services early, or whose difficulties remain entrenched [7]. Research has shown that failure to persist through the initial intake is associated with parental feelings of helplessness and negativity; and that failure to persist is associated with therapist inexperience [8: 10]. However, it should also be noted that it is the characteristics of services rather than families that predict retention or attrition most strongly [6].

**Volunteers and referrals**

Parents who are identified as ‘in need’ on the basis of known risk factors often don’t volunteer for programs. This may contribute to the low participation and high drop-out rates in the programs [9]. Parents who volunteer to take part in parenting groups may not be representative of the wider group of parents. Perhaps this is because volunteers are often better motivated than parents who have been referred by professional agencies [8].
Family characteristics and dropping out

Cultural and racial marginalisation may be a contributing factor to poor participation rates, but Smith [9] reports that there is little evidence on whether drop-out rates from ethnic minorities is higher than others. Smith’s research centres on the UK and she reports that much evidence is from the US. There is uncertainty about the application of US (and UK) evidence to Australia. However, some research throws light on why families drop out of programs. For example, one study found that family socio-economic status was the only variable that predicted drop-out from the intervention under study [cited in 5]. Dropping out of parent education programs among families with children referred for antisocial behaviour was associated with: more severe conduct disorder symptoms and more delinquent behaviours; mother reporting greater stress from their relationship with their child; their own role functioning and life events; and families being at a greater socio-economic disadvantage [8].

Family characteristics have also been linked to expectations and perceptions of the program, and one study found that these predicted subsequent barriers to participation and engagement.

The most significant predictors of lower parent expectancies were socio-economic disadvantage and ethnic minority status, severity of the child’s problems, parental stress and depression. Among children at risk for relatively little therapeutic change, the perception of few barriers to treatment increased the degree of child improvement [10].

Recruitment and retention of families is also critical to finding the balance between program adherence and adaptation. Strict program adherence may offer unhelpful or counterproductive strategies for engaging with
parents, and changes to the format or delivery of programs may be necessary [5].

**Strategies to increase recruitment and retention**

Watson [6] sets out strategies to increase initial uptake and retention at caseworker and agency level for home visiting programs. The strongest evidence for caseworker-level strategies to increase initial uptake are quick follow up; frequent contact; and ensuring that mothers see the program as providing support for them as well as the child. Slightly weaker evidence points to prompt initial response; follow up in the absence of a response; assertive community outreach; and outreach worker supporting a known agency worker.

Strategies to increase initial uptake at agency level include allowing recruitment time and offer services during transition times such as the antenatal period. Recruiting families through an agency that does not represent authority; being non-stigmatising; and using other agencies as ‘ambassadors’ are also supported by some evidence. To assist engagement once families are participating in programs, agencies need to:

- be aware of services that are available
- have multiple portals or gateways into a service
- reduce eligibility criteria
- need few referral pathways
- dedicated clinics and
- focus on outcomes rather than throughput (so the number of people using a service is not a preoccupation – a lot of people may use a service for a short time, which may not be a good thing).

‘Universal services and strengths-based approaches’
The question of universal or targeted interventions is identified as relevant to take-up of services. Universal programs are described as reducing stigma around help-seeking behaviour and reaching those children at risk of poor outcomes. ‘Parenting programs should focus on positive gains such as parenting skills and children’s activities and avoid making parents feel singled out as “bad” parents’ [3].

One meta-analysis revealed that programs incorporating client involvement and a strengths-based approach were more effective than programs without these features. Programs that adopt a strengths-based approach focus on skills and proficiency, rather than focusing on shortfalls [cited in 11].

**Universal programs are described as reducing stigma around help-seeking behaviour and reaching those children at risk of poor outcomes.**

**Practice Lessons**

Based on the above and on other research, parents should:

- be encouraged initially and throughout the program or service to participate
- feel they are full participants in the process
- have the opportunity to use services or programs during key ‘transition’ times, for example just after having a baby
- be treated in non-stigmatising, supportive ways.

Strategies for practitioners and agencies to increase uptake and retention include the following:

- ‘tweaking’ program design to improve uptake and retention: for example, changing length or order of sessions
- adopt a strengths-based approach: focus on skills and proficiency rather than shortfalls
• ensure eligibility criteria for entry to programs or services are not excluding those who could benefit
• allow time for recruitment
• build workforce capacity, especially through experienced and trained staff
• ensure a quick response after initial referrals
• follow up in the absence of a response: at least three phone calls
• frequent contact, either through meetings or follow up phone calls
• ensure that goals and aims are communicated clearly
• focus on the needs of parents and children: ensure that support for the parent as well as the child is perceived
• have multiple gateways into a service, so there are plenty of opportunities for referral or finding out about the program or service
• community outreach, for example, home visits
• using a trusted organisation or worker as an ‘ambassador’ for the new program or service
• evaluate outcomes not throughput

Implementation

An important issue confronting the ‘what works’ debate is that it is becoming increasingly apparent that ‘what works’ may itself be the wrong question. In fact there is now overwhelming evidence that the ‘how’ — i.e. how well the program is implemented — is at least as important as the ‘what’.

...an important step is active engagement and responding to individual circumstances as required.

Although there is an increasing consensus that implementation and process issues are crucial determinants of program impact, there is debate around what is actually meant by a ‘well implemented’ program. Briefly there are two schools of thought in this area. On the one hand are proponents of program fidelity who gauge the quality of programs according to the
degree to which they have been implemented in accordance with the original program design. According to this view, deviations from the original program will inevitably lead to decreasing effectiveness. On the other hand are proponents of program adaptation - i.e. the belief that the key to successful programs is to adapt programs to the needs of the particular communities and service users it intends to engage.

In finding the balance between fidelity and adaptation, an important step is active engagement and responding to individual circumstances as required [2]. One part of this may be provision of practical, material support early on:

*The importance of meeting the immediate needs of families in the treatment process by providing concrete services cannot be overestimated ... Families with children must have sufficient funds to be able to provide for their basic needs before other strategies can be tried out [6].*

**Relationships**

The relationship between families and workers is an important factor. It has been suggested as a determining factor in the ongoing value of parenting programs [4]. Studies show that the effectiveness of a program is highly tied to the trainer’s personal efficacy and characteristics, and some estimates place the effect of trainer characteristics as high as 50-80% [cited in 3, cited in 6]. Effective styles of engagement with families with multiple problems seem to be those that use an ‘interactive model of learning that values parents’ own ideas and experience’ and builds a trusting relationship [6, 12]. Relationships between workers and services are also important, as connections to agencies and ease of referrals are identified as crucial to meeting the requirements of families in greatest need [2].

There is little specific evidence on the link between family-worker interactions and outcomes. However, the Incredible Years program has multiple modes of delivery and interaction with workers, which allows for comparison
between them. These are an individual, self-administered method; a group discussion with therapist input; and a group discussion with video-tape modelling and therapist input. The self-administered mode was successful in increasing self-efficacy by allowing families to solve problems and be responsible for their own treatment. This method of delivery also allowed for privacy, flexible scheduling, self-pacing, and self-control, all of which are difficult to achieve in a group setting. However, only the group discussion with video-tape modelling and skilled therapist input was successful in significantly reducing mothers' reports of parenting stress, and resulted in higher consumer satisfaction scores, lower drop-out rate, and higher attendance [cited in 8].

A recent review indicates the importance of communication style in engaging families, arguing that the strongest evidence in this regard is in respecting the family and empowerment. Use of verbal encouragement, ‘starting where the family is at’; supportive, non-punitive communication; and including the family in decisions are also supported [6].

**Take-up of New Programs**

In addition to determining the balance between fidelity and adaptation, the factors that will determine the adoption of a program are also important, because new programs need champions, buy-in and engagement at all levels. Four factors have been identified as most influential in determining adoption:

- information about characteristics
- information about efficacy
- identification of necessary resources
- responding to dynamics of change such as fears and resistances, and building participation and ‘ownership’ [5].

**Practice Lessons**
In finding the balance between program fidelity and program adaptation, relationships between families and workers/agencies are critical. Strategies for practitioners and agencies include the following:

- build trusting relationships that empower participants;
- active engagement and responding to individual circumstances as required;
- provision of support early on by providing concrete services, for example buying nappies;
- use interactive models of learning that value parents’ own ideas and experience;
- develop relationships with other agencies: ease of referrals and access to other services is critical;
- verbal encouragement and non-punitive communication.

**Format**

The majority of programs are either directed at parents with the aim of improving relationships or changing parenting behaviour, or provide early education and care of children, or consist of some combination of these. There are many differences within these broad categories, most obviously in terms of content. The format, aims and activities of some exemplary programs are outlined in Section 2.

Other critical differences between program types are usually agreed to centre on who delivers the program (trained therapists, other professionals, paraprofessionals, trained volunteers, peers); where it happens (during home visits, in group sessions, in trusted spaces in targeted neighbourhoods, in clinics, in child care centres); and how it happens (frequency and intensity). Some approaches to the question have been covered in the section on implementation. These approaches emphasise the importance of interpersonal connections. That said, ‘programs of proven efficacy tend to
use professionally trained workers and paraprofessionals rather than volunteers’ [13: 333] and it is sometimes argued that experienced therapists are more skilled than others in building relationships.

**Intensity**

Prolonged and intensive programs are seen to be more effective than short-term programs or those with infrequent contact. In addition, ‘booster’ or follow-up programs may be necessary to maintain or increase outcomes over the longer term [3, 11, 14].

**Multi-modal**

Parenting support services designed to have multiple components also tend to be more effective than single-issue designs. Many of the programs and initiatives that appear promising are complex efforts with multiple, interactive components [2]. Multi-component programs typically ‘address more than one area of need while still retaining a core set of objectives; provide components for children as well as parents; use a variety of materials to support learning; and use a range of methods of service delivery such as group work and home visitation sessions’ [13: 333]. This may involve elements such as parent skills training, information on child development and behaviour, and concrete services. There are a number of examples of intensive interventions that simultaneously tackle adversities across multiple domains of families’ lives (for example, Multi-systemic Treatment and the enhanced Triple P program), but these require substantial resources to set up and maintain, and can only treat a limited number of families at any one time. [7]

Parent programs have their foundation in Adlerian counselling and normally fall into one of two general categories. Behavioural approaches train parents to use praise and reinforcement effectively and focus on observable child behaviour. Relationship approaches aim to alter communication
patterns in families and promote acceptance of child feelings. Overall, behaviourally oriented programs seem to have more impact on children’s behaviour than those which emphasise relationships and communication. These behavioural programs are amenable to experimental research design and are therefore readily available to robust evaluation. There is a lack of evidence on relationship programs, with the exception of Parent Effectiveness Training, although these programs have been shown to have positive outcomes for parents [3, 4, 12].

**Group-based**

Group-based parent education programs are more successful in improving the behaviour of children than working with parents on an individual basis (including children from higher-risk backgrounds). They are also likely to be more cost effective as well as more acceptable to many parents. [3, 4, 12]. A number of studies discuss the parent-reported benefits of group programs. One study found that participants referred to the group benefits of meeting with other parents and sharing experiences and exchanging ideas. Another also referred to group process, and the validation of parental feelings through the experience of sharing them with other parents [cited in 8].

**Two-generational**

There is evidence that, as a general approach, programs with elements for both parents and children are more useful than those that target either parents alone or children alone. There is also some evidence that this approach has specific value in working with families with multiple and complex problems. This evidence indicates that working with parents alone is not enough to achieve long-term change in children, and parenting programs that include direct work with the child are likely to be more effective than those that do not [12]. Programs that combine support for parents with child-focused educational activities for activities seem to demonstrate the best outcomes for children’s development and academic
achievement, and the best long term benefits for parents [cited in 14, cited in 15]. Home visiting programs that attempt to improve the mothers’ life chances as well as reduce the risk of child maltreatment have shown improvements for both mothers and children [11]....

Empowerment

Empowerment is recognised as a factor that assists in recruiting and engaging with parents, but it appears that empowerment has an impact on outcomes as well as participation. Parent-reported changes in children’s adjustment have been associated with family empowerment. Increasing parental empowerment has also been found to predict change in children externalising problems [cited in 10].

Practice Lessons

In developing services and programs, the following characteristics appear promising:

- focus on behaviour: programs that train parents to use praise and reinforcement effectively seem to have more impact on children’s behaviour than those which emphasise relationships and communication
- focus on empowerment
- intensity: programs with infrequent contact are less effective, and intensive programs seem to reduce attrition
- prolonged rather than short-term
- build skills and address practical needs

...parenting programs that include direct work with the child are likely to be more effective.
• follow-up or ‘booster’ programs: to maintain effects over the long term
• comprehensive, with multiple components: address more than one area of need, for example parent skills training; cognitive retraining; child development information; and concrete services
• use a variety of materials to support learning
• use a range of methods of service delivery such as group work in family-friendly settings and home visitation sessions
• work with parents and children: parenting programs that include direct work with the child are likely to be more effective than those that do not
• groups: group-based programs can be effective in improving the behaviour of children from higher-risk backgrounds and offer opportunities for parents to share experiences and ideas.

Family Members and Types

Most participants in parent programs are mothers. The role of fathers in these groups has been subject to some analysis. For example, an evaluation of Mellow Parenting found that those mothers who had benefited from the groups were less likely than controls to have maintained their improvement if their partners had been hostile to their involvement. This suggests that the engagement of fathers is important [12]. It has also been argued that fathers participating in services parallel to mothers may enhance effects [13].

Little is known about ethnicity and indigienity in the context of participation or efficacy in groups. There is ‘considerable need to determine the nature and efficacy of culturally sensitive parenting programs’ [3]. However, it has been argued that while ethnicity is important, it is equally important that programs are not driven by preoccupations with culture and difference [7, 9].
The severity of problems experienced by families is almost certainly important to the impact of services, but there is little evidence on how and how much the level of severity affects outcomes. In many studies the level of severity is not included in the measurement of outcomes. Many studies show that parents from a range of backgrounds who are experiencing different kinds of problems can benefit from programs, but little is known about which particular program types are best suited to particular groups of families [8]. A little more is known about the impact of the severity of child problems on outcomes. Within ‘at-risk’ groups, the ‘highest functioning’ children, and those with environmental rather than biological risk factors, seem to fare better than those who with biological risk factors [14].

There is enough demographic data on parental and child problems in the parenting programs literature to suggest that families with a diverse range of problems may be able to benefit from these programs. However, caution should be exercised when generalising lessons or implementing new programs with different kinds of families:

The current recruitment of parents to programs reflects the assumption that all parents can benefit from whatever program is on offer. One danger of this is that parents who drop-out may be then blamed for their failure to complete the program, rather than the appropriateness of the program being called into question [8].

**Practice Lessons**

Strategies for practitioners and agencies include the following:

- engage with fathers where possible
- have parallel services for mothers and fathers
- cultural sensitivity: ethnicity is important, but it is also important that programs are not driven by preoccupations with culture and difference.
Goals

Programs and services that work across a range of domains and are sensitive to families’ individual needs are recognised as being more effective than those that are concerned with only one area. Notwithstanding this, services have been found to be more successful across a range of outcomes when they have a clearly articulated set of aims and goals and a mapped-out route for achieving them [13]. Generic ‘family support’ is less effective than matching family needs and resources and matching them with well-defined goals for parents and children.

Tied to this is the importance of aiming for appropriate kinds of goals. Current research lessons point to parenting ‘skills’ rather than ‘styles’. The best services are those that build practical skill and meet material needs. Counselling and therapeutic insight are regarded as more abstract or soft, and less valuable [6]. However these findings may reflect that skills are more measurable than styles, and insight and understanding are hard to measure. It is also possible that programs focusing on relationships and styles have longer term outcomes than those which focus on more immediate goals such as parents’ or children’s behaviour. Most studies follow up families for relatively short periods of time (weeks or months rather than years).

Goals may also be important in setting limits on what it is reasonable for practitioners and families to expect. Interventions that target very young children, and are theory-driven, well-resourced and well-implemented show encouraging results, but changing the lives of very disadvantaged families is extremely difficult and overall outcomes are best described as modest. In addition, these changes may take a while to appear, or they may not be sustained over time. For these reasons it is important to define reasonable expectations from programs in recognition that complex social problems do not have instant solutions [14].
**Practice Lessons**

Services have been found to be more successful across a range of outcomes when they have:

- a clearly articulated set of aims and goals
- a mapped-out route for achieving goals
- goals that are matched to family needs and resources
- reasonable and realistic expectations, as multiple and complex problems are not easily resolved.

**Counter-productive Practice**

In addition to the lessons from the areas above on what constitutes effective and less effective practice, some specific lessons on counter-productive practice emerge from the literature. Programs that are poorly resourced or poorly or informally run may not only fail to produce the expected outcomes but can do more harm than good. Finding the balance between strict program fidelity and adaptation is an important part of implementation, but significant modifications to programs can have unintended and unexpected consequences.

In the process of implementing new programs, four elements have been identified as constraining good practice:

- lack of time to train implementers
- lack of personnel to serve in implementing roles
- lack of funds for training materials or for release time to permit training to occur
- lack of administrative support to promote a program’s smooth operation [5].

**Practice Lessons**
Messages from the research about what is counter-practice include:

- informally or poorly run programs can do more than good
- loss of program fidelity can sometimes lead to ‘chaos’
- blaming families for dropping out: a program that is useful for one type of family may not be useful for others. In this situation it may be the suitability of the program for that type of family that should be questioned
- insufficient time and resources for training in the implementation of new programs and services
- lack of personnel
- lack of administrative support.

Gaps

There is a large body of research (on practice supported and theory-driven information) that focuses on what programs are effective for families with multiple problems, and how to work to work with these families. However, there are still very large gaps in knowledge in this area. Three of these areas are especially deficient:

- What’s effective practice in delivering services that address other needs of families than parenting or children – for example, housing or health services. Most of the research on families with young children who have multiple and complex problems are focused on family services; that is, services to improve family relationships, parenting skills or meet the needs of children.
- What are the outcomes of community development approaches to building services and supports for families with multiple and complex problems; What lessons for practice and policy built on these approaches.
- What’s effective practice in case managing and coordinating care for families with multiple and complex problems. Case management
is adopted in several areas other than family support, for example, drug treatment services. Given that many of these families will need a range of services and support in getting access to them, this model may offer lessons for supporting families, but little is known in this area.

There are other areas where very little is known, or where not enough is known to guide practice. Increasingly, calls are being made for more, and more rigorous, evaluation of services and programs to build the evidence base of ‘what works’. In addition to these calls, arguments are also made that some kinds of interventions and services cannot be easily recognised as effective. This means that the absence of evidence may be a product of the way effects are measured. This should be considered as a separate question from effects themselves:

Only very slim pickings emerge when the methodological funnel is constructed as narrowly as it is today. Thus society is robbed of rich interventions whose causal connections have not been proven but from which we desperately need to learn to make wiser decisions about resource allocation and program design [2: 7].

In the specific area of parent and child programs for families with multiple and complex problems, there are unknowns that relate to program types and family types. In terms of program format, there is a lack of rigorous studies of relationship programs, with the exception of Parent Effectiveness Training [4, 12].

More research is needed about the relationship between effects and program or target-group characteristics. Much more needs to be known on the relationship between content elements and ingredients — for example,
changing negative perceptions of the parent, enhancing parenting skills, improving material or social conditions — and effects. Many studies focus on key formal or organisational elements, such as home visits or group sessions, duration of intervention, use of volunteers or professionals and so on. [9, 16].

More needs to be known on the extent to which factors such as ethnicity predict drop-out of a program before completion, and how programs can be designed to ensure that they are non-stigmatising and seen as helpful. This is especially true for vulnerable and ‘hard to reach’ families [9, 10]. It is often not possible to link the severity of problems that families have with program outcomes, reflecting the fact that parental health and outcomes are often treated as a secondary outcome or focus, with the main focus being on child outcomes. More information is therefore needed on whether or not parenting programs have any real impact on parents themselves, as well as the kinds of parents who benefit from programs [8].

Risk factor research shows that child, family and community risks can be linked to outcomes. A complication to this is that both risks and outcomes are ‘over-determined’. This means that there are uncertain causal pathways and that the relative weight of risks is not always known. Sometimes it is: for example, high quality dental care and high quality childcare are both important to transition to school, but childcare is recognised as more important. But the relative importance of prevention of domestic violence and the prevention of child abuse is much less certain [2].

Finally, there are particular kinds of problems for which very little evidence is available. There are very few tested parenting programs for parents with mental illness, and even fewer specifically tailored for women [17]. There is ‘a virtual absence of proven, effective preventive training programs to increase parenting competence in the specific area of maltreatment reduction’ [3:
There are few studies on improving outcomes for children exposed to inter-parental violence [15].
Practice Lessons

In the specific areas discussed in this paper, there are a number of areas in which more information is needed to guide practice.

Assessment of Need

• There is very little known about proven, effective preventive training programs to increase parenting competence in the specific area of maltreatment reduction.
• It is not known if there are any particular outcomes which are not improved by parenting programs.
• Many interventions have not been subject to evaluations that meet contemporary standards of rigour, and are thereby excluded from consideration in analyses of ‘what works’.

Retention and Engagement

More needs to be known on:

• designing programs that are acceptable to families
• practice that is non-stigmatising and recognised as helpful
• effective interventions that engage and maintain participation

Implementation

More needs to be known on:

• the core elements or ‘active ingredients’ that cause change in services and programs, especially for families with multiple and complex problems
• the impact of families’ ability to choose between services and programs on retention, satisfaction and outcomes
the effect of family-driven services on service delivery and outcomes
the factors that enable families to become full partners in service planning and delivery.

Format

• Behaviourist approaches to programs have better evidence than relationship-based programs. This is partly because behaviourist approaches fit better with evaluation research.
• More needs to be known on the relationship between content elements and ingredients — for example, changing negative perceptions of the parent, enhancing parenting skills, improving material or social conditions — and effects.

Family Types; Problem Type and Severity

More needs to be known about:

• the relationship between program effects and family characteristics
• recruitment, participation and attrition rates from ethnic minorities are higher than for others
• translatability of generalist overseas programs to Australian context
• the local effectiveness of interventions of non-Australian origins that have been designed especially for minority groups
• which groups of parents are likely to have successful outcomes in particular programs and services;
• effective services providing education, information and support to women with mental illness who have young children
• effective services for children exposed to inter-parental violence
### INTERVENTIONS FOR FAMILIES WITH MULTIPLE AND COMPLEX PROBLEMS

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<thead>
<tr>
<th>Source</th>
<th>Program name</th>
<th>Program aims</th>
<th>Family type; eligibility</th>
<th>Content and Format</th>
<th>Evaluation</th>
<th>More information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref: [7]</td>
<td>Systematic Training for Effective Parenting (STEP)</td>
<td>Aimed at developing 3 specific skills in participating parents: developmentally appropriate and realistic expectations of children; effective communication and discipline of children; decreasing parental isolation</td>
<td>Families with parent-child relationship problems, including those at risk of child maltreatment, as well as families interested in enhancing child social and cognitive development. Early STEP is for families with children 0-6 years.</td>
<td>Highly structured parent training program led by a trained professional who is responsible for conducting four-hour weekly meetings. 8 child management training sessions. Implemented in hard-to-reach communities</td>
<td>(Burnett 1988, Adams 2001). A review of several evaluation indicates that the program is effective in improving child behaviour, self-concept and parental attitudes and behaviour; more recent evaluations support these findings</td>
<td>Pearson AGS</td>
</tr>
<tr>
<td>Ref: [7]</td>
<td>Triple P: Positive Parenting Program</td>
<td>Prevent severe emotional, behavioural and developmental problems in children by increasing parenting knowledge, skills, confidence, self-sufficiency and resourcefulness; enhance family environments; fostering</td>
<td>Multi-level, multi-disciplinary preventative family intervention designed to reach families with varying levels and types of support needs. Reach varies from 5 levels: from universal media information campaign with no practitioner contact to “enhanced” family intervention including intensive behavioural parent training</td>
<td>Existing evidence shows that program is effective in enhancing parental efficacy and competence, and reducing disruptive behaviour</td>
<td>website</td>
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Australian Research Alliance for Children & Youth
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<tr>
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<tr>
<td>Ref: [7]</td>
<td>Webster-Stratton/Incredible Years</td>
<td>Preventing, reducing and treating aggression and conduct problems in young children, enhancing child social competence.</td>
<td>2-10 year old children without clinically significant behavioural problems; parents of children with conduct problems aged 3-10 years; parents at risk for child abuse and/or neglect</td>
<td>Comprehensive set of interventions inc. videotape modelling, group discussion, role-playing and rehearsal techniques, homework activities, supportive telephone calls</td>
<td>evaluated in a great number of randomised controlled trials (RCT) (wikipedia definition) which demonstrated high effectiveness on a range of child and parent outcomes</td>
<td>[website]</td>
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<tr>
<td>Ref: [7]</td>
<td>Mellow Parenting (UK)</td>
<td>Empower parents by fostering reflexivity through encouraging parental insights into the effects of their own past and present experiences on behaviour towards children</td>
<td>Targets parents of children under the age of 5. Persistent child-parent relationship problems, maternal health problems, domestic violence</td>
<td>One full day per week over four month period. Group-based, structured, therapist-led intervention</td>
<td>(Puckering, Rogers, Mills, Cos and Mattson-Graff, 1994) Improvements shown but more methodologically rigorous evaluations needed</td>
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<tr>
<td>Ref: [7]</td>
<td>SPOKES (Supporting Parents on Kids Education) (UK)</td>
<td>Reduce parental stress and use of physical punishment, increasing parental involvement in learning</td>
<td>children at risk of social exclusion aged 5 and 6</td>
<td>delivered in primary schools and basic ‘Incredible Years’ Webster-Stratton videotape parenting programme, backed up by home visits</td>
<td>(Scott and Sylva 2003) effective in reducing antisocial behaviour and increasing reading ability</td>
<td>described in Current Controlled Trials</td>
</tr>
<tr>
<td>Ref: [3]</td>
<td>Parents Under Pressure</td>
<td>To improve child outcome in families in which there are multiple problems such as substance abuse, severe mental illness, family discord and child abuse and neglect by providing intensive treatments that focus on multiple domains</td>
<td>Parents at risk of abusing their children or with a substance abuse problem</td>
<td>12 sessions of about 1.5 hours duration each. The program is delivered by psychologists in families’ homes. The early part of the program addresses the parents’ view of</td>
<td>Dawe, Barnett, Rendalls and Stainger (2003) initial evaluation with recontact at 3 months. Self-reported improvements in parental functioning, parent-</td>
<td>Currently being trialled in 4 NSW AHS Griffith University</td>
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<tr>
<td>Source</td>
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<td>in which families live.</td>
<td>themselves as parents which is usually negative, and encourages them to acknowledge their strengths and to notice and comment on positive child behaviours. Daily child-focused playtimes are scheduled to build a positive parent-child relationship.</td>
<td>child relationship, parental substance abuse and risk behaviour</td>
<td>Nurse Family Partnership. In NSW: MESH (Miller Early Childhood Family Sustained Home Visiting Program)</td>
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<tr>
<td>Ref: [11]</td>
<td>Nurse Home Visiting</td>
<td>Improve pregnancy outcomes; improve child health and development; improve parents’ economic self-sufficiency</td>
<td>low income pregnant women; first time mothers; deprived neighbourhoods</td>
<td>Home visiting by nurses who have undergone extra training.</td>
<td>RCTs: differences between comparison and intervention groups in range of child and maternal areas (executive functioning, language, maltreatment, behaviour, health)</td>
<td>Nurse Family Partnership. In NSW: MESH (Miller Early Childhood Family Sustained Home Visiting Program)</td>
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<tr>
<td>Ref:[18]</td>
<td>Healthy Families America (US)</td>
<td>Program goals include prevention of negative birth outcomes (low birth weight, substance abuse, criminal activity, child abuse and neglect); increased parenting skills; healthy pregnancy practices; and the use of social systems. Assessments are conducted either prenatally or at the time of birth. Home visiting can begin either prenatally or within 90 days after birth.</td>
<td>The program serves families identified as at-risk, with children 0-5 years.</td>
<td>Voluntary home visitation program. The Family Support Worker (FSW) visits at least once a week for up to one year. The FSW helps establish support systems, teaches problem-solving skills, enhances positive parent-child interaction, offers information, education and referrals to community resources.</td>
<td>Model</td>
<td><a href="#">website</a></td>
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<tr>
<td>Ref:[18]</td>
<td>Homebuilders (USA)</td>
<td>Designed to break the cycle of family dysfunction by strengthening families, keeping children safe, and preventing foster care and other forms of out-of-home placement. The program goals include improving</td>
<td>The program is designed for the most seriously troubled families, who are referred by a number of child service agencies. Populations served</td>
<td>4-6 weeks of intensive, in-home services to children and families. A practitioner with a caseload of two families provides counselling, services such as financial and</td>
<td>Model</td>
<td><a href="#">described on Strengthening Families website</a></td>
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<tr>
<td>Source</td>
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<td>family functioning; increasing social support; increasing parenting skills; preventing or reducing child abuse and neglect; improving school and job attendance and performance; improving household living conditions; establishing daily routines; improving adult and child self-esteem; helping clients become self-directed; and enhancing motivation for change while decreasing family conflict and other problems</td>
<td>include newborns to teenagers, and their families.</td>
<td>housing assistance, develops community support, and spends an average of 8-10 hours per week in direct contact with the family, and is on call 24 hours a day, seven days a week for crisis intervention.</td>
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METHODOLOGY

For the purposes of this paper, families with multiple and complex problems were defined as:

Families with children aged 0-5 years who are experiencing multiple problems, which might be problems for the parents, for the children, or for the whole family. Examples of problems include problems relating to housing, finances, ill health, childcare, substance abuse, family violence and abuse, poor educational outcomes, truancy.

Although there are many reports of programs aimed at ‘high risk’ families, or families with particular difficulties, there are no programs in the literature which are specifically aimed at multi problem families. ‘Complex and multiple problems’ are described in some of the literature, but for the most part programs are targeted at individuals or families in a particular risk category (for example, ‘children at risk of maltreatment’) or families who live in a disadvantaged area. In addition, most programs for high risk families are not specifically targeted at children under five. Programs that do focus on children at risk of maltreatment or families in high risk categories often do not have community development approaches or emphases on promotion, prevention and early intervention. It was therefore necessary to set up a couple of criteria for risk factors to try and ensure that relevant interventions for families with multiple and complex problems were included, while interventions not relevant to Communities for Children were excluded. Low socio-economic status alone has not been regarded as a criteria for inclusion. Substance abuse, parental mental health problems and domestic violence have been considered as significant risk factors on their own and likely to be associated with others. Even here there are problems with definition and identification. Many families where drug use is present do not have multiple or
complex problems. Depression, one of the most commonly diagnosed mental disorders, is not linked with changes to parental style unless they occur under certain conditions, such as poverty. Other single risk/need/disadvantage categories have for the most part not been included.

A staged approach was adopted:

- Conduct of a literature review to a) provide background to the problems associated with families with multiple and complex problems, b) identify and critique research pertaining to interventions, and c) inform the development of criteria for the selection of studies to be used in the review of intervention research.
- An analysis of the evidence on interventions, as identified in Step 1
- Translation of the review evidence identified in Step 2 into messages that can be put into action.
- Development of an annotated bibliography of useful resources and websites.

Research pertaining to interventions for families with multiple and complex problems was initially identified by examining existing systematic reviews of the relevant research. These reviews were then supplemented as required, with primary research papers. Research literature was identified using:

- the research team’s knowledge of the field and in-house resources;
- academic databases such as Web of Science, ProQuest, Ingenta and Medline;
- search engines such as Google and Meta-search engines such as Kartoo;
- consultations with our existing network of researchers;
- bibliographies of relevant papers.
A substantial amount of literature was from outside Australia, particularly the USA. Extra effort was made to incorporate Australian research and the relevance of international research to Australia was considered.

It was anticipated that there would be very few, if any, interventions specifically designed for families with multiple and complex problems with young children. The majority of relevant interventions are aimed at ‘high-risk’ families, but these are generally drawn from disadvantaged communities, rather than being of necessity families with multi problems per se. Consequently, a staged approach was also used for identifying relevant program evaluations:

1. Search for evaluations of programs targeted specifically at families with multiple, complex difficulties with young children
2. Search for evaluations of other programs that have relevance for those families:
   - Programs targeted at all families with children aged 0-5 that have been modified or shown to be appropriate for families with multiple, complex difficulties;
   - Programs designed to address a single issue that have been modified or shown to be appropriate for families with multiple, complex difficulties; and
   - Programs designed for multi problem families that have been adapted or validated for families with young children.
These steps allowed us to distil a very large body of evidence into the analysis of evidence and translation into practice, described in the Section Translation of Research into Practice page 3 and the table of program references page 26 of this report.

Although the format of Section 2 is similar to larger and systematic reviews, there are some important caveats to place on these. For example, we have included ‘bad practice’ and ‘what’s unknown’ in our practice lessons. However, while this classification is familiar from experimental approaches to evidence, we employed a different method from these. For example, Moran, Ghate and van der Merwe [7] use the Scientific Maryland Scale (SMS), a criminological scale devised to communicate with policy makers and scholars, to show how studies differ in methodological quality, and to rank them. The development of the SMS was influenced by the Cochrane (http://www.cochrane.org/) and Campbell Collaborations (http://www.campbellcollaboration.org/index.asp), and has in turn become influential in early childhood and family support research. Their approach therefore conforms closely to the most stringent requirements for evidence-based findings, if we define ‘evidence-based’ in its original sense. Based on this, they use four categories: what works; what does not work; promising; and unknown:

**What works:** programs must have at least one level three to five SMS-rated evaluation showing statistical significant results and the preponderance of all available evidence must indicate effectiveness.
**What doesn’t work:** programs must have at least one level three to five level evaluation with statistical results showing ineffectiveness and the preponderance of evidence must support the same conclusion.

**What is promising:** where level of certainty is too low to support generalisable conclusions but where there is some empirical basis for suggesting effectiveness and it is reasonable to predict that further (better) research could support such conclusions.

**What is unknown:** any program not classified in one of the three above categories.

Our approach has been different. We haven’t included all programs which have been shown to not work. Instead, we have included general findings on ineffective or bad practice synthesised from other reviews. We also haven’t included everything that isn’t known, but have again focused on general practice findings. In both cases these inclusion criteria have been based on what we think will be relevant to the primary audience for this paper.

There are pragmatic reasons for our not adopting the systematic review of research promoted by the Cochrane/Campbell approach, but other reasons as well. The main reason is that there are arguments around ‘what counts’ as evidence, what’s valuable in approaches to evaluation, and how useful experimental approaches are to human services delivery: for a sample of the debate, again in the field of criminology, see Farrington [19] and Tilley [20]. Whereas the Cochrane/Campbell approach places a very strong emphasis on objective testing to ensure that true effects of programs are measured, alternatives such as the ‘realistic evaluation’ approach of Pawson and Tilley [20] emphasise local context and the dynamic interplay between program
theory and implementation. One product of this debate is that alternative models of knowledge have been proposed to the Cochrane/Campbell model. Among the most developed is that from the UK Social Care Institute for Excellence (SCIE). This proposes that different kinds of knowledge (organisational, practitioner, user and policy) should all be included as evidence, and that there is no hierarchy between these types of knowledge, but only between the quality and completeness of them [20].

Services for families and children have been discussed as particularly problematic for attributing cause and effect with any degree of confidence, even if the individualistic-experimental approach to evaluation is taken. Problems include finding appropriate outcome measures; timescale; small samples; disagreement over objectives and outcomes that should be measured; and complexity of family life:

> in the real world there are many influences on families’ lives that may be difficult to monitor and measure. External events such as a bereavement or illness, or a partner leaving or joining the household, are likely to have as much of an impact on the situation as any support services provided by external agencies … The evaluation of social interventions presents problems not generally encountered in more clinical settings [12: 4].

While we have not attempted to adjudicate between these arguments over evidence and evaluation, we do think it worthwhile to note the lack of consensus and complications to assessing ‘what works’, aside from the better known limitations on evidence (such as the fact that very few sustained evaluations have taken place). This is important because, while there is good empirical evidence for a range of programs and principles for good practice, the question of ‘what works’ is not as simple as it may first appear, and indeed as proponents of one approach or another may argue. Some of this
uncertainty is evident in the literature review and in the practice lessons. For example, ‘relationships’ approaches to parenting programs are less supported by evidence than ‘behavioural’ approaches, but this does not necessarily mean that the latter approach is proven beyond doubt and by universally agreed methods to be superior to the former in all circumstances and for all people. It may be that the suitability for behavioural programs to experimental research makes them appear stronger than relationship programs. Notwithstanding all of this, our approach has largely been based on research reviews that do adopt the experimental hierarchies of evidence set out above, as these are among the most systematic and validated data available. It is more difficult to find information of the type required by the SCIE model of knowledge types than it is to find conventional evidence.

For the most part we’ve included programs and lessons that have a whole-of-family approach, or at least have elements for parents and children. There are different types of programs that are based more closely on individual therapy for children: for example, resilient peer matching of children who have suffered trauma. This takes place in child care centres and pairs a resilient child with the traumatised child, with close supervision of an adult. Some encouraging results have come from this, as with other intensive therapeutic approaches with children. More information on this and similar programs can be found in Allin, Wathen and MacMillan [21]. Other approaches have been classified as family economic/welfare focused. These include direct payments to parents and case management, most particularly to assist parents in finding employment. Subsidies for formal child care are sometimes paid. A crucial component to these programs is that they intervene directly with family income and welfare payments are cut off after a specified time limit. Projects of this type include the New Hope Child and
Family Study and Florida Family Transition Project. More information on these programs can be found in Wise, Silva, Webster and Sanson [22]. These kinds of projects – that is, those based on individual therapy for children, and those based on control of family income – have not been included here. Again, this is based on our understanding of what will be most relevant to the CfC audience.

'Home visiting' is sometimes described as a program type. We have instead treated home visiting as a formal element of programs. This is because many programs have home visiting as an option or element, and it seems to us more important to consider who is doing the visiting, what happens during the visit, how the visits connect to other program elements, and what the goals and rationale for home visiting are, than to classify projects according to setting.
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<tr>
<th>Name</th>
<th>Origin</th>
<th>Description</th>
<th>URL</th>
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<tbody>
<tr>
<td>Harvard Family Research Project</td>
<td>USA</td>
<td>Focuses on evaluations and development of evidence based family support interventions. Very useful free newsletter The Evaluation Exchange is available on the website</td>
<td><a href="http://www.gse.harvard.edu/hfrp/index.html">http://www.gse.harvard.edu/hfrp/index.html</a></td>
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<tr>
<td>What works for children</td>
<td>UK</td>
<td>Website with various resources aimed at practitioners in different areas of children’s services. Includes ‘evidence based nuggets’.</td>
<td><a href="http://www.whatworksforchildren.org.uk/">http://www.whatworksforchildren.org.uk/</a></td>
</tr>
<tr>
<td>Communities And Families Clearinghouse Australia</td>
<td>AUS</td>
<td>Run by AIFS as part of the Stronger Families and Communities Strategy. Contains discussion groups, promising practice profile etc.</td>
<td><a href="http://www.aifs.gov.au/cafca">www.aifs.gov.au/cafca</a></td>
</tr>
<tr>
<td>National Investment for the Early Years</td>
<td>AUS</td>
<td>Website and email group giving up to date information on early intervention. Also runs a number of activities for practitioners.</td>
<td><a href="http://niftey.cyh.com/index.htm">http://niftey.cyh.com/index.htm</a></td>
</tr>
<tr>
<td>Research Into Practice</td>
<td>UK</td>
<td>Website aimed at policy makers and practitioners in children’s services. Contains many resources from comprehensive research reviews to short briefings.</td>
<td><a href="http://www.rip.org.uk">www.rip.org.uk</a></td>
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UK  
Focused on child protection and has a range of resources including weekly updates, on line library, research briefings etc,  
www.nspcc.org.uk/inform

Strengthening America’s Families  
USA  
Review in 1999 of ‘best practice’ family strengthening programs. Includes program matrix and extensive rating criteria  

What Works in Parenting Support: Online Database  
UK  
This database accompanies What Works in Parenting Support? A Review of the International Evidence by Patricia Moran, Deborah Ghate, and Amelia van der Merwe at the Policy Research Bureau. It contains details of 88 individual evaluation studies of parenting support interventions that informed the conclusions of the Review.  
http://www.prb.org.uk/wwiparenting/
REFERENCES

6. Watson, J., Active Engagement: strategies to increase service participation by vulnerable families, in Discussion Paper. 2005, NSW Centre for Parenting and Research, Department of Community Services: Sydney.
9. Smith, M., Evidence on Interventions with vulnerable children, young people and families: early interventions with young children and their parents in the UK, in Enhancing the Well-being of Children and Families through


