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Abstract

The article reports the results from an evaluation of Springboard, a family support programme introduced in Ireland during 1998. The evaluation is based on a non-experimental design involving a pre-post comparison of 319 children and 191 parents who participated in the programme. The two main outcomes reported here are children's psychological well-being (measured by the Strengths and Difficulties Questionnaire – SDQ), and the parent-child relationship (measured by the Parent-Child Relationship Inventory - PCRI). Results showed improvements in SDQ and PCRI scores, equivalent to an effect size in the range 0.2 to 0.3, which is similar to the effect sizes produced by other family support programmes. At the end of the intervention, there was still a substantial amount of unmet need among children. The evaluation has two limitations: first, the use of a non-experimental method means that we cannot be certain that all of the improved outcomes can be attributed to Springboard; second, the diverse interventions which constitute Springboard, and family support programmes generally, means that it is impossible to separate effective from ineffective interventions within the programme.

Policy and Practice Implications

- The underlying patterns of thought and behaviour which create problems for children and parents are highly stable and there is no 'quick-fix' solution.
- Family difficulties have an inter-generational dimension because parents who have experienced abuse as children tend to have impaired parenting capacity which, in turn, may create difficulties for their own children.
- There are significant variations in the perceptions of parents and professionals as to what is 'normal' for children, illustrating the complexities of intervening in families.
- In this evaluation, maternal employment created a trade-off between the well-being of mothers and the well-being of their children because mothers' employment reduced their financial difficulties but also increased the difficulties for children and reduced parenting capacity. This suggests that arrangements for the care and protection of children when mothers are out at work cannot be taken for granted and the child's experience of their mother's employment should be taken into account.
- Springboard experienced difficulties engaging Traveller families and this suggests that staff may need to gain a better understanding of Traveller culture and how to support Traveller families.

Key Words: Springboard, SDQ, PCRI, effect size, Ireland, well-being.

1. Introduction

Like many countries, Ireland has a system which divides care services for children into categories called child protection, children in care, and family support. Also like other countries, most of the resources spent on these services are allocated to child protection and children in care. This has generated debate about the imbalance in child care services, prompted in part by concerns about the cost-benefit ratio associated with this system of resource allocation but also by concerns over the imbalance between prevention, early intervention and treatment. This has led to increased investment in family support services, of which the Springboard programme is a significant example in Ireland.

This article describes the evaluation of Springboard, which was based on a non-experimental design involving a pre-post comparison of programme participants on a range of well-being indicators. To date, there has been almost no evaluation of services involving child protection and children in care in Ireland, illustrating a general tendency that new services have to prove their value but existing services do not. We begin by providing a brief introduction to family support services in Ireland and by describing the specific features of Springboard as a family support programme. This is followed by a description of the methodology used in the evaluation, the key results which emerged, and the main conclusions and implications.

2. Evolution of Family Support Services in Ireland

The rationale for family support services is that families are a crucial influence on the well-being of children, and therefore supporting families is a way of supporting children. This has been recognised in many countries and has led to the development of a range of programmes to support families with young children in countries such as the US (for a review of these programmes, see Layzer, Goodson, Bernstein & Price, 2001; Nelson, Westhues & MacLeod, 2003; Hanson, Morrow & Bandstra, 2006) and the UK (for an evaluation of programmes under the auspices of SureStart, see SureStart, 2005; see also Smith, 2006).

In Ireland, the rationale for family support services was first articulated over the past 25 years ago by the Task Force on Child Care Services which stated boldly that “the welfare of children in general is inseparable from the well-being of families and therefore social policy should begin with families” (Task Force on Child Care Services, 1980: 38). This report

openly criticised the child care system in Ireland at that time for its over-reliance on the option of placing children in care and its lack of support to enable children to live with their families (Ibid: 69). In both its tone and content, the report makes the case for family support with a clarity which has not since been surpassed: “Since we consider that the primary emphasis of children’s services should be on the child within the context of his family, we attach particular importance to the services which can help families to care for their children in their own homes” (Ibid: 115).

The legislative basis for the existing child care system in Ireland is provided by The Child Care Act, 1991 which empowers the Health Services Executive (HSE) – formerly eight separate Health Boards until 2005 – to promote the welfare of those children “who are not receiving adequate care and protection” (Section 3, Subsection 1). In exercising this function, the HSE shall give “first and paramount importance” to the welfare of the child while also giving due regard to “the rights and duties of parents” and the principle that “it is generally in the best interests of a child to be brought up in his own family” (Section 3, Subsections 1 and 2). This legislative framework is clearly enabling of family support, particularly to families and children who are vulnerable, as specified in Section 8 of the Act.

In the mid-1990s, the establishment of a Commission on the Family (1995-1998) underlined the importance attached to the family within public policy, a view reinforced by the Commission’s conclusion that “the experience of family living is the single greatest influence on an individual’s life and the family unit is a fundamental building block for society” (Commission on the Family, 1996: 13). The Commission also reaffirmed the importance of family support services as a primary preventative strategy for all families, but particularly those who are living in stressful circumstances (Commission on the Family, 1998: 16).

The National Guidelines for the Protection and Welfare of Children were published in 1999 and affirm the statutory responsibility of the HSE to provide support services to the families of children who may be at risk of abuse or neglect (Department of Health & Children, 1999: 59). Equally important, the guidelines stressed the key role which family support services can play in prevention and early intervention given that “early intervention can help to prevent any worsening of current difficulties being experienced by a family and will assist the development and growth of protective factors” (Ibid).

In tandem with these developments, one also finds evidence from research of a growing concern about the appropriateness and effectiveness of services for families and children, particularly through the HSE's child protection system. In a study carried out in the South Eastern Health Board, for example, the authors observed that "the child welfare apparatus, in general, continues to be primarily child protection focused; ... assessments and interventions appear to be made more in the context of 'dangerousness' rather than 'need'" (Buckley, Skehill & O'Sullivan, 1997:206-207). The authors recommended that the focus on child protection needs to be complemented by a more holistic approach which protects children by supporting vulnerable families and communities through "a community social work service" (Ibid). Consistent with this, a study in the Mid-Western Health Board, concluded with the observation that distinguishing 'welfare' and 'protection' implies a false separation which endangers the provision of the full range of services needed for each child and family (Ferguson & O'Reilly, 2001:267). Both of these studies highlighted the need for a more integrated and balanced development of both child protection and family support services.

During the 1980s and 1990s there was a substantial growth in child protection services, following well-publicised cases of child abuse. An unintended consequence of this was that it overshadowed a wide range of existing services for families which were provided by HSE Social Workers and by organisations such as social service councils in the voluntary sector. These services were typically community-based, informed by a community development perspective, and had a focus on prevention and early intervention. The significance of these services in promoting the well-being of families is now being rediscovered under the rubric of family support.

The rediscovery of family support is particularly evident in the significant expansion of services towards the end of the 1990s. In 1998, for example, the Government launched the Springboard programme, an initiative of 15 family support projects which grew to 22 projects by 2005. In 1999, the Government also committed itself to establishing 100 Family and Community Centres throughout the country in line with a recommendation in the report of the Commission on the Family (Fianna Fáil and Progressive Democrats, 1999: 16; Commission on the Family, 1998: 17). In addition, the National Development Plan 2000-2006 contains a substantial allocation of funds to childcare, community and family support, and youth services, all of which are supportive, directly or indirectly, of family life (Ireland, 1999: 192-195; see also the Programme for Prosperity and Fairness, 2000).

These developments are consolidated in the current health strategy – Quality and Fairness: A Health System for You – which heralds a shift in policy towards a more preventative approach to child welfare, involving support to families and individual children, with the aim of avoiding the need for further more serious interventions later on (Department of Health & Children, 2001:71, see also 139-140). The current health strategy also makes the explicit commitment that “family support services will be expanded” through refocusing child welfare budgets and developing support services for parents and children (Department of Health & Children, 2001:165).

It is clear therefore that, over the course of two decades, services for families have moved centre-stage in public policy thinking about the needs of children, while services are increasingly informed by the twin principles enunciated in the National Children’s Strategy of being “child-centred” and “family-oriented” (National Children’s Strategy, 2000: 10). In practice, family support has attracted additional resources and recruited additional staff and this also raises challenges as to how these developments can be integrated within the existing framework of services for families and children, both within the HSE and in partnership with other agencies whose remit includes the support of families.

3. Springboard Programme

The purpose of Springboard was made clear in the call for project proposals issued by the Department of Health & Children in 1998, which stated that project proposals should demonstrate an ability to achieve the following:

- To identify the needs of parents and children in the proposed area. Specific attention given to those families where child protection concerns exist, to families with on-going health and welfare problems and/or families in once-off crisis situations.
- To target the most disadvantaged and vulnerable families in the area specifically focusing on improving parenting skills and child-parent relationships.
- To work in partnership with other agencies, key groups and individuals in the community and with families to develop programmes of family support services.

- To provide a direct service through a structured package of care, intervention, support and counselling to the targeted families and children, and to families within the wider community” (Department of Health & Children, 1998).

Following a selection process, 14 Springboard projects were established throughout the country, all in urban locations, and these are the basis of this evaluation. Seven of the projects were managed by Barnardos, three by community organisations, two by a Health Board, and a further two were jointly managed by the Health Board and a voluntary organisation. Projects were established during 1999 and most were fully operational by January 2000. This evaluation covers the period from January 2000 to May 2001.

All Springboard projects have a strategy of being open and available to all families in their communities as well as working more intensively with those parents and children who are most vulnerable. In the evaluation period, the projects saw over 685 parents and 1,569 children; of these, intensive supports were offered to 319 children (55% boys, 45% girls) and 191 parents (88% mothers, 12% fathers), and it is these ‘intensive cases’ which provide the basis for the evaluation. This means that the evaluation does not reflect the full impact of the Springboard programme, although the ‘intensive cases’ are likely to reflect the areas of greatest impact.

Springboard projects offer a range of interventions to children and parents and are highly diverse in their therapeutic approaches. In this sense, Springboard is not a homogenous therapeutic programme but a highly diverse set of interventions involving: (1) individual work such as one-to-one sessions with clients to assess needs and to offer advice, counselling and support; (2) group work and activities such as parenting and personal development groups, breakfast clubs, coffee mornings, homework and after-school activities, classes in arts, crafts, dancing, cookery, dress-making, swimming, etc; (3) family work such as counselling and therapy, family evenings and outings, or accompanying families on visits to hospital, court, school, the HSE, etc; (4) drop-in facilities for information, advice, recreation, coffee-breaks, etc. The average intervention for the children and parents in this evaluation took place over 46-48 weekly sessions, each session lasting an average of 1.7 hours (in the case of parents) and 2.2 hours (in the case of children). In addition to direct service provision, projects also spent time building up inter-agency networks with other statutory and voluntary services in the community.

It is important to note that the diversity of interventions which constitute the Springboard programme pose a challenge for the evaluation since it is not possible to link outcomes to specific therapeutic inputs, given that the inputs vary widely in their approach and content. In other words, the design of the Springboard programme – which is similar to the design of many other family support programmes – limits the capacity of the evaluation to elucidate the mechanisms by which programme inputs are linked to programme outcomes.

4. Methodology for Evaluation

The model of evaluation involved a pre-post comparison of children and parents who received intensive support through the Springboard programme (See McKeown, Haase & Pratschke, 2001; other reports produced as part of the evaluation are: McKeown, 2000; 2001; McKeown & Sweeney, 2001). This involved collecting data at baseline and follow-up on a range of outcome domains for children (notably psychological well-being, reductions in the risk of neglect or abuse, experiences at school, trouble with the law) and parents (stress, support networks, parent-child relationships). In this article we report on two of these outcomes – the psychological well-being of children and the parent-child relationship – which are among the more significant and detectable outcomes. In addition, information was collected on the background characteristics of Springboard participants including: age, sex, marital status, education, housing status, household composition, employment, financial well-being, support networks, number and severity of problems. Wherever possible, this data was collected using questions which allowed for comparison with national data sets such as the Census of Population, Quarterly National Household Survey, the Living in Ireland Survey, etc.

The psychological well-being of children was measured using the Strengths and Difficulties Questionnaire (SDQ). This instrument assesses behaviours, emotions and relationships, and was created by Robert Goodman at the Institute of Psychiatry in London during the 1990s as a screening instrument for detecting children with mental health or psychiatric needs. It is therefore a useful proxy measure of psychological well-being. The SDQ is a statistically robust scale in terms of validity and reliability, as a number of studies have confirmed (Goodman, 1997; Goodman, Meltzer & Bailey, 1998; Goodman & Scott, 1999; Goodman, 1999; Smedje, Broman, Hetta & von Knorring, 1999). The core scale has 25 items and five

sub-scales comprising: (i) conduct problems (ii) emotional symptoms (iii) hyperactivity (iv) peer problems (v) prosocial behaviour. The SDQ is suitable for 3-16 year olds and can be completed by the parent (for children aged 3+), the teacher (for children aged 3+), and the child (for children aged 11+). The responses to the SDQ can be classified according to whether the child falls within internationally accepted mental health categories of normal, borderline or abnormal.

The Parent-Child Relationship Inventory (PCRI) was developed, tested and validated in the US with over 1,000 parents, both fathers and mothers (Gerard, 1994). The original scale has 78 items and six sub-scales but in this evaluation we used just four sub-scales measuring: (i) support (ii) satisfaction (iii) involvement and (iv) communication. In the PCRI, support refers to “the practical help and emotional support which the client receives as a parent” (Gerard, 1994, p.9); satisfaction refers to “the enjoyment a client receives from being a parent” (Ibid); involvement in the PCRI refers to “the client’s propensity to seek out his or her children and manifest an interest in their activities” (Ibid); and communication refers to “the clients’ awareness of how well they communicate with their children in a variety of situations including simple conversation” (Ibid).

Baseline and follow-up questionnaires were completed by 319 children and 191 parents. Two types of analysis were undertaken using this data. First, we compared the mean scores of Springboard participants at baseline and follow-up. We did this by calculating the effect size, a simple way of standardising and comparing the two sets of scores. The formula involves subtracting the mean at baseline from the mean at follow-up and dividing by their pooled standard deviation. Thus, the effect size is measured in standard deviation units and the score varies from 0.0 to 3.0. As summarised in Table 1, most programmes in the area of family support tend to achieve effect sizes in the range 0.2 to 0.5. Effect sizes in this range, though regarded as small, can have substantial implications. For example, the effect size of the High / Scope Perry Pre-School Programme in the US when participants reached the age of 23 was 0.36 (Schweinhart & Weikhart, 1997) but the economic return at age 27 is estimated to be \$8 for every \$1 invested (Barnett, 1996) rising to \$17 for every \$1 invested by age 40 (Schweinhart, 2004). In the medical field, there are even more dramatic illustrations of how small effect sizes can have considerable practical significance. For example, the effect size of aspirin in reducing heart disease is 0.03, yet is widely prescribed by doctors because the

cost of the intervention is cheap and the potential benefits are very large (cited in McCartney & Dearing, 2002).

[Insert Table 1 here]

Second, we used a technique called Structural Equation Modelling to analyse the impact of Springboard on the two outcome variables (see Kaplan, 2000). The strength of the relationships depicted in the model is measured by a standardised regression coefficient which expresses change in standard deviation units. Each regression coefficient measures the impact of a given variable, controlling for all other variables which affect the outcome measure. The overall fit of the model to the data is estimated using ‘goodness of fit’ statistics that are designed to test if the model provides an adequate representation of the data. The computer programme EQS 6.1 (Bentler, 1995) was used to estimate the model and calculate the coefficients. One of the key advantages of this method of analysis is that it allows us to overcome the limitation of not having a control or comparison group; this limitation would otherwise prevent us from assessing the impact of Springboard.

5. Impact of Springboard on Psychological Well-Being of Children

Table 2 summarises the evaluation results on the psychological well-being of children, as measured by the SDQ. This reveals that 62% of children were rated by parents and teachers at baseline as being in the borderline or abnormal range which implies a significant level of need; a smaller proportion of children (44%) rated themselves in this range. Another way of expressing the depth of need among Springboard children is to compare their mean scores with a representative sample of British children, given that there is no comparable data for Ireland. To bring the Springboard children up to the level of the British sample would require an impact with a standardised effect size of 1.2 (based on the parent and teacher responses), which is well above the level of need that can normally be met through family support programmes.

[Insert Table 2 here]

The impact of Springboard can be expressed as the reduction at follow-up in the percentage of children within the borderline or abnormal ranges of the SDQ. The results show reductions

ranging from 10 percentage points (based on parent responses) to 15 percentage points (based on child responses), with no reduction in the case of teacher responses. Expressed in terms of effect sizes, Springboard improved the psychological well-being of children by 0.3 (based on parent and child responses) and by 0.16 (based on teacher responses).

These results indicate that Springboard had a modest impact on the psychological well-being of children, but one that is similar to the impacts achieved by other family support programmes. At the same time, a substantial level of need remains, as we find when SDQ follow-up scores (based on parent and teacher responses) are compared to the average British child. This differential would require an intervention with an effect size of about 1.0 in order to close the gap. In other words, a programme which produces a significant impact can still leave a large amount of unmet need, and this is true of children in the Springboard programme.

6. Factors Influencing Change in Children's Psychological Well-Being

We used Structural Equation Modelling to identify the factors which influenced change in SDQ scores and the results are graphically illustrated in Figure 1. As part of the analysis, we carried out a factor analysis of the SDQ and confirmed that the four dimensions of conduct, emotions, hyperactivity and peer relations capture its latent qualities. Given that Springboard does not have a 'logic model' of how each intervention is expected to work, and the fact that interventions tended to vary from one project to another, it was decided to test all of the variables for which we had data and report those which were statistically significant. Figure 1 summarises all the statistically significant results; however, other variables were found to have no statistical influence on change in SDQ, including the number of parents in the household, the number of children in the family, the frequency of contact with non-resident fathers, the father's employment, the severity of parents' problems, whether the family is known to the HSE's child protection services, whether a child has lived away from home, children's participation in organised out-of-school activities, parents' support network and the number of agencies involved. Bearing this in mind, four key findings emerge from the analysis, which we discuss in the following paragraphs.

[Insert Figure 1 here]

6.1 Stability of SDQ Scores

The main influence on children's psychological well-being at follow-up ('SDQ' 2) is, unsurprisingly, their well-being at baseline ('SDQ' 1). This is a very strong association (+0.8), indicating that the attributes and behaviours associated with the SDQ are highly stable.

6.2 Severity of Children's Problems

The severity of the child's problems as assessed by Springboard staff – notably abuse, neglect, family violence, anti-social behaviour, not attending school, etc. – had a moderate influence (+0.33) on children's psychological well-being at baseline ('SDQ' 1). Changes in the severity of problems had a moderate effect on changes in well-being between baseline and follow-up ('SDQ' 2) (+0.28). This finding confirms what is already known, namely that addressing the underlying problems of abuse and neglect in the child's life is essential to improving their psychological well-being.

Further inspection of the 'severity of child's problems' variable reveals a number of interesting associations. For example, boys are more likely to have severe problems than girls (+0.15) and to have higher SDQ scores (+0.22). Older children (i.e. 13 years and over) are likely to have more severe problems than younger children (+0.26), even though it is younger children who present as having higher SDQ scores. This somewhat paradoxical finding may be explained by the fact that SDQ scores are based on the parents' perceptions whereas the severity of child's problems are based on staff perceptions and it is possible that parents may come to see as normal what Springboard staff see as problematic. Traveller children present as having more severe problems than other children but they tend to receive less staff time than other children; this needs to be seen in the context that projects experience particular difficulties engaging Traveller families and interventions are sometimes interrupted because these families move home more frequently than settled families. When the characteristics of parents are taken into account, it emerges that children who experience severe problems of abuse, neglect and so on are more likely to have parents who have financial difficulties in making ends meet (+0.26) and are wholly dependent on social welfare income (+0.13), a finding which suggests that the objective and subjective aspects of poverty both diminish the well-being of children.

6.3 Mothers' Employment

The children of employed mothers tend to have greater difficulties ('SDQ' 1) than the children of full-time mothers (+0.21), although employed mothers are also less likely to have financial difficulties than full-time mothers (-0.21). Financial difficulties, as we have just seen, have a significant effect on the severity of children's problems (+0.26) and on children's difficulties (+0.29). This result underlines the importance of employment to the well-being of mothers but also suggests that inadequate childcare provisions or a child's existing difficulties may make separation from their mother particularly difficult.

6.4 Influence of Staff Time

The amount of hours spent by Springboard staff on each child had no influence on the change in psychological well-being (i.e. on 'SDQ' 2, controlling for 'SDQ' 1). The regression coefficient (+0.05) is statistically indistinguishable from zero. This suggests that the changes observed in SDQ scores for children may be the result of indirect effects via other kinds of inputs (support provided to parents, for example), as well as reflecting dimensions such as the perceptions and hopefulness which clients themselves bring to their encounter with Springboard. In addition, the lack of a 'dose-response' relationship may be due to the fact that Springboard, like family support programmes generally, comprise a range of diverse interventions which make it difficult to measure dosage consistently in terms of input hours, as we have done here.

Figure 1 identifies a number of factors which influence the amount of time received by each child. The most important is the severity of the child's problems at the time of first contact with Springboard: the more severe the problems as assessed by staff, the more time they receive (+0.20). Paradoxically, Traveller children receive less time than other children (-0.13), although there is a tendency for staff to assess their problems as being more severe (+0.14). The children of parents who are wholly dependent on social welfare tend to receive more staff time than other children (+0.15) which is consistent with the fact that these children also have more severe problems (+0.13). On balance, therefore, it would appear that staff time is allocated on the basis of need.

7. Impact of Springboard on the Parent-Child Relationship

Table 3 summarises the evaluation results for the parent-child relationship, as measured by the PCRI. The impact of Springboard, expressed in terms of effect sizes, shows that the biggest improvement occurred in the area of feeling supported as a parent (with an effect size of 0.3), followed by involvement and communication with children (both with an effect size of 0.2); there was no significant change in terms of satisfaction (indicated by an effect size of 0.07). These results indicate that Springboard had a modest impact on the parent-child relationship, somewhat similar to the impacts achieved by other family support programmes (see Table 1 above).

[Insert Table 3 here]

8. Factors Influencing Change in Parent-Child Relationship

We used Structural Equation Modelling to identify the factors which influenced change in PCRI scores and the results are graphically illustrated in Figure 2. These results are statistically significant but many others were tested and found to have no statistical influence on change in PCRI, including: gender of parent, number of parents in household, settled or Traveller, source of household income, financial difficulties, number of agencies involved with the family. As part of the analysis, we carried out a factor analysis of the different dimensions of the PCRI and found that three of the four dimensions (satisfaction, communication and involvement) are strongly related to each other; the other dimension (support) represents a rather different aspect of the parent-child relationship. We therefore decided to use the first three scales as indicators of a latent variable, denominated 'PCRI' in Figure 2, from which four key findings can once again be drawn.

[Insert Figure 2 here]

8.1 Stability of Parenting Capacity

Parenting ability is a relatively stable attribute, and the stability coefficient for the latent 'PCRI' variable is 0.64.

8.2 Influence of Staff time

The number of hours spent by Springboard on each parent had a relatively small but statistically significant influence on change in parenting capacity. Clearly, parenting capacity is influenced by a wide range of factors, many of them not captured in this evaluation. Nevertheless, the fact that the number of staff hours registers an impact on parenting capacity suggests that this may provide an acceptable measure of the Springboard intervention as far as adults are concerned. Figure 2 also reveals that the amount of time allocated by staff to each parent is influenced by whether a parent has had an abused childhood (+0.28) and whether the parent has four or more children (+0.17), which again suggests an allocation of staff time on the basis of need.

8.3 Influences on Parenting Capacity

Parenting capacity, as measured by the PCRI, is influenced by four main factors: (1) whether the parent is known to the HSE's child protection services; (2) the severity of the parent's problems; (3) whether the parent had an abused childhood and (4) whether the mother is in paid employment. Being known to the HSE's child protection services (-0.28) is indicative of deeper concerns about the protection and welfare of children and, for this reason, is probably a reasonably good indicator of weak parenting capacity. Parenting capacity is diminished by the severity of the parent's problems at the beginning of Springboard (-0.19), in the same way that having an abused childhood reduces the capacity of parents (-0.14). The fact that the employment of mothers has, according to our model, a negative influence on parenting capacity (-0.16), whilst being positively correlated with support networks (+0.17), is significant and draws attention to the trade-offs that may be inherent in maternal employment in certain circumstances.

8.4 Influences on Change in Parenting Capacity

Changes in parenting capacity are influenced by changes in the parent's support network (+0.21) and by the severity of their problems (-0.18). Each of these factors exercises a similar influence to Springboard staff (+0.20) on changes in parenting capacity ('PCRI' 2).

9. Conclusions and Implications

The main conclusion of this evaluation is that Springboard produced a small but statistically significant effect on the psychological well-being of children and on the parent-child relationship. This is equivalent to an effect size in the range of 0.2 to 0.3 which is similar to the effect size of family support programmes in the US; in other words, Springboard is “equivalent in efficacy” (Chambless & Hollon, 1998:11) to other family support programmes. At the same time, there remained a high level of unmet need among children after the programme, equivalent to an effect size of about 1.0, which is substantial relative to what can be achieved through existing family support programmes.

The results of this evaluation have two significant limitations from the point of view of identifying ‘what works’ in family support programmes. The first is that it is based on a non-experimental method with the result that it is not possible to control for all the factors which may have influenced the outcomes. We used Structural Equation Modelling to identify the independent influence of each of the variables that we measured, but it would have been preferable to employ an experimental method capable of controlling for all potentially confounding influences. For this reason, we cannot be certain that all of the outcomes observed can be directly attributed to the Springboard programme.

A second limitation lies in the nature of Springboard itself, and of family support programmes more generally. These programmes comprise a diverse range of interventions and it is difficult for an evaluation to identify the ‘active agent’ in change. A similar difficulty is reported in the evaluation of SureStart in the UK (see SureStart, 2005). As observed elsewhere, “Family support is an umbrella term covering a wide range of interventions which vary along a number of dimensions according to their target group (such as mothers, toddlers, teenagers, etc), the professional background of service provider (e.g. family worker, social worker, childcare worker, youth and community worker, public health nurses, community mother, psychologist, etc.), the orientation of service providers (e.g. therapeutic, child development, community development, youth work, etc), the problem addressed (e.g. parenting problems, family conflict, child neglect, educational underachievement, etc.), the programme of activities (e.g. home visits, pre-school facility, youth club, parenting course, etc.) and service setting (e.g. home-based, clinic-based or community-based)” (McKeown, 2000:4).

Without separate evaluations of the different interventions which make up family support services, it is impossible to distinguish effective from ineffective interventions; as a consequence, family support programmes like Springboard are likely to offer both effective and ineffective interventions without discrimination. In addition to these methodological issues, the evaluation draws attention to several substantive issues which may have more general relevance to services for children and families.

First, the underlying patterns of thought and behaviour which sustain and support SDQ and PCRI appear to be highly stable, which implies that children and parents with serious problems cannot expect a ‘miracle cure’. This is in line with the known impacts of other interventions which target children both in Ireland (Kellaghan, 1977; Kellaghan & Greaney, 1992; Educational Research Centre, 1998; see also Kellaghan, Weir, O’hUallachain & Morgan, 1995) and elsewhere (Hill, 1999; Hellinckz, Colton & Williams, 1997; McAuley, Pecora & Rose, 2006).

Second, parents who indicated that they experienced abuse during their childhood had weaker parent-child relationships compared to other parents. This illustrates how family difficulties have an inter-generational dimension as the childhood experiences of parents impacts on the childhood experiences of their own children. This finding is a powerful illustration of how family systems function over time and a strong argument in favour of intervening to break the harmful inter-generational cycle of family dysfunction.

Third, the results of the evaluation highlight how the definition of a ‘child with problems’ is heavily dependent on one’s perspective. For example, the evaluation revealed how parents tend to see younger children as more likely to have severe problems, even though Springboard staff assessed older children as more likely to have severe problems. Similarly, we saw that teachers assessed older children as having more problems while parents saw younger children as having more problems. These somewhat paradoxical findings seem to arise from the different perceptions of parents and professionals as to what is ‘normal’ for children and are indicative of the complex issues which arise when intervening with families, even at the point of assessing the needs of children.

Fourth, the modelling results suggest that maternal employment may, in certain circumstances, create additional problems for children who already have difficulties. Mothers' employment tends to increase the well-being of families by reducing their financial difficulties, alleviating their stress and improving their support networks while, on the other hand, it appears to increase the children's difficulties and to reduce parenting capacity. It is interesting that similar findings have emerged from some British studies (Ermisch & Francesconi, 2001; Joshi & Verropoulou, 2000), although there is less consensus from the findings of American studies (Haveman & Wolfe, 1995; Baydar & Brooks-Gunn, 1991; Belsky & Eggebeen, 1991).

Fifth, our analysis revealed that Traveller children present as having more severe problems than other children, although they tend to receive less staff time than other children. However this needs to be seen in the context that projects experience particular difficulties engaging Traveller families and interventions are sometimes interrupted because these families move home more frequently than settled families. This suggests that there may be a role for training to help staff gain a better understanding of Traveller culture and the issues entailed when intervening in Traveller families.

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Table 1 Effect sizes for family support programmes and pre-school prevention programmes

Outcome Domain	Average Effect Size: Short-term (end of treatment)	Average Effect Size Longer-term (follow-up)
<i>1. Meta-Analysis of 665 experimental and quasi-experimental studies of family support programmes</i>		
Child cognitive development	0.293	0.345
Child social-emotional development	0.223	0.150
Child physical health and development	0.123	0.112
Child injury, abuse, neglect	0.213	0.152
Parenting attitudes and knowledge	0.230	0.273
Parenting behaviour	0.257	0.204
Family functioning / family resources	0.169	0.002
Parent mental health / health risks	0.137	0.226
Family economic self-sufficiency	0.099	0.464
<i>2. Meta-Analysis of 34 experimental and quasi-experimental studies of pre-school prevention programmes for children</i>		
Cognitive impacts on children	0.52	0.30
Socio-emotional impacts on children	0.27	0.27
Parent / family wellness impacts	0.33	0.30
<i>3. Meta-Analysis of 2,513 experimental and quasi-experimental studies of psychotherapy</i>		
Psychotherapy	0.82	

Sources: 1. Layzer, Goodson, Bernstein and Price, 2001.

2. Nelson, Westhues and MacLeod, 2003

3. Asay and Lambert, 1999

Table 2 Changes in the psychological well-being of children, as measured by the SDQ, based on parents', teachers' and children's ratings before and after the Springboard programme

SDQ Total Difficulties	Parents (n=282)	Teachers (n=206)	Children (n=115)
<i>Baseline</i>			
% Borderline or Abnormal Range in Springboard	61	62	44
Mean Scores in Springboard at Baseline (standard deviation)	16.4 (8.1)	15.4 (8.3)	14.3 (5.8)
Mean Scores in British population (n=10,298) (standard deviation)	8.4 (5.8)	6.6 (6.0)	10.3 (5.2)
Depth of Need Before Springboard (effect size)	1.2	1.2	0.7
<i>Follow-up</i>			
% Borderline or Abnormal Range in Springboard	51	64	29
Mean Scores in Springboard at Follow-up (standard deviation)	14.1 (7.4)	14.1 (7.5)	12.7 (5.9)
<i>Impact of Springboard</i>			
Change in % in Borderline and Abnormal Range	-10	+2	-15
Change in Mean Scores (effect size)	0.30	0.16	0.27
Depth of Need After Springboard (effect size)	0.9	1.1	0.4

Figure 1 Path diagram showing factors which influence the impact of Springboard on SDQ scores¹

¹ The two 'SDQ' variables enclosed by ellipses are latent variables, each of which has four indicator variables based on scores for SDQ scales identified earlier as conduct, emotions, hyperactivity and peer relations. All correlations between the exogenous variables have been omitted from the graph for ease of interpretation. Where the omitted correlations may be of relevance to the interpretation of the results, this is noted in the text.

Table 3 Changes in the parent-child relationship before and after the Springboard programme, based on PCRI scores

SDQ Total Difficulties (n=191)	1. Support	2. Satisfaction	3. Involvement	4. Communication
Mean Scores at Baseline (standard deviation)	20.0 (5.1)	31.5 (4.8)	46.4 (5.8)	28.3 (4.0)
Mean Scores at Follow-up (standard deviation)	21.5 (5.1)	31.8 (4.7)	47.5 (5.4)	29.2 (3.7)
Change in Mean Scores (effect size)	0.30	0.07	0.21	0.23

Figure 2 Path diagram showing factors which influence the impact of Springboard on the parent-child relationship²

² The two 'PCRI' variables enclosed by an ellipse represent latent variables estimated using three indicator variables each, corresponding to the PCRI scale scores for Satisfaction, Communication and Involvement. These indicator variables are not included in the diagram for reasons of space and clarity. All correlations between the exogenous variables have been omitted from the graph for ease of interpretation. Where the omitted correlations may be of relevance to the interpretation of the results, this is noted in the text.